

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 an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

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

B. Program Title:

New Choices Waiver

C. Waiver Number: UT.0439

Original Base Waiver Number: UT.0439.

D. Amendment Number: UT.0439.R03.03

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

07/01/21

Approved Effective Date: 09/22/21

Approved Effective Date of Waiver being Amended: 07/01/20

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

- Aligned targeting criteria language for consistency in Appendix B-1(b) and the Brief Waiver Description section
- Expanded the list of items and devices covered under the Assistive Technology service
- Lowered insurance coverage amounts to align with requirements under Utah Administrative Code for Non-Medical Transportation providers
- Added spouses as providers of Attendant Care services

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (*check each that applies*):

Component of the Approved Waiver	Subsection(s)
Waiver Application	<div style="border: 1px solid black; width: 50%; height: 20px; margin: 0 auto;"></div>

Component of the Approved Waiver	Subsection(s)
Appendix A Waiver Administration and Operation	<input type="text"/>
Appendix B Participant Access and Eligibility	<input type="text"/>
Appendix C Participant Services	<input type="text"/>
Appendix D Participant Centered Service Planning and Delivery	<input type="text"/>
Appendix E Participant Direction of Services	<input type="text"/>
Appendix F Participant Rights	<input type="text"/>
Appendix G Participant Safeguards	<input type="text"/>
Appendix H	<input type="text"/>
Appendix I Financial Accountability	<input type="text"/>
Appendix J Cost-Neutrality Demonstration	<input type="text"/>

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment (*check each that applies*):

- Modify target group(s)**
 - Modify Medicaid eligibility**
 - Add/delete services**
 - Revise service specifications**
 - Revise provider qualifications**
 - Increase/decrease number of participants**
 - Revise cost neutrality demonstration**
 - Add participant-direction of services**
 - Other**
- Specify:

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*):

New Choices Waiver

C. Type of Request: amendment

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.0439

Waiver Number: UT.0439.R03.03

Draft ID: UT.008.03.01

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/20

Approved Effective Date of Waiver being Amended: 07/01/20

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 in 42 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:

Medicaid participants classified as meeting the Intensive Skilled level of care are not eligible for this waiver.

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 Eligibility 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 Utah New Choices Waiver focuses on offering a home and community-based option for individuals residing in medical institutions (non-IMD), nursing facilities, small health care facilities and licensed assisted living facilities. The waiver program is open to individuals who meet Medicaid financial eligibility criteria, nursing facility level of care criteria, and special targeting criteria. The special targeting criteria limits participation to individuals who at the time of application:

1. are 18 years of age or older;
2. (a) are receiving nursing facility care and have been continuously receiving nursing facility care for a minimum of 90 days prior to admission; or
(b) are receiving care in a Small Health Care Facility (Type N) and have been continuously receiving Type N facility care for a minimum of 365 days prior to application, or
(c) are receiving licensed assisted living facility care and have been continuously receiving assisted living facility care for a minimum of 365 days prior to application; or
(d) are receiving Medicare or Medicaid reimbursed care in another type of Utah licensed medical institution that is not an institution for mental disease (IMD), on an extended stay of at least 30 days, and will discharge to a nursing facility for an extended stay of at least 60 days absent enrollment into the waiver program; or
(e) are receiving Medicaid reimbursed services through another of Utah's 1915(c) waivers and have been identified in need of immediate (or near immediate) nursing facility admission absent enrollment into this waiver program; or
(f) have previously been enrolled in the New Choices Waiver but were disenrolled from the waiver due to a long term nursing facility admission or due to receipt of a lump sum payment or other financial settlement that resulted in loss of Medicaid financial eligibility. This re-entry after disenrollment is permitted only when there has been no interruption in services equivalent to nursing facility care including equivalent waiver services (paid privately or by another funding source) during the disenrollment period. A new nursing facility level of care assessment is required prior to readmission.
3. For individuals leaving acute care hospitals, specialty hospitals (non IMD), and Medicare skilled nursing facilities, participation is limited to those receiving a medical, non-psychiatric level of care. Individuals with co-occurring mental illness may be considered as long as it is not the primary need for services and the program can meet the individual's health and safety needs.
4. Individuals who meet the intensive skilled level of care as provided in R414-502 are not eligible for participation in the New Choices Waiver.
5. Individuals who meet the level of care criteria for admission to an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID) as provided in R414-502 are not eligible for participation in the New Choices Waiver. Individuals with co-occurring intellectual disability and related conditions may be considered as long as it is not the primary need for services and the program can meet the individual's health and safety needs.

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

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

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*):
- | |
|--|
| <p>Yes. This waiver provides participant direction opportunities. Appendix E is required.</p> <p>No. This waiver does not provide participant direction opportunities. Appendix E is not required.</p> |
|--|
- 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. Statewidness.** Indicate whether the state requests a waiver of the statewidness requirements in §1902(a)(1) of the Act (*select one*):
- No
- Yes
- If yes, specify the waiver of statewidness that is requested (*check each that applies*):
- Geographic Limitation.** A waiver of statewidness 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 inpatients 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 prepared a draft of the waiver amendment in May 2021 in response to legislative guidance received in the 2021 General Session (Senate Bill 63). Public comment on the waiver changes was solicited in the following ways: Beginning May 21, and for 30 days thereafter, a copy of the draft State Implementation Plan was posted online at <https://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) at their June meeting. The UIHAB represents all federally recognized Tribal Governments within the State. Additionally, a presentation of the changes was supplied to the Medical Care Advisory Committee (MCAC) during their May meeting. Information on the amendment 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. No comments were received.

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:

Ambrenac

First Name:

Josip

Title:

Director, Bureau of Long-Term Services and Supports

Agency:

Utah Division of Medicaid and Health Financing

Address:

288 N 1460 W

Address 2:

City:

State:

Zip:

Phone: **Ext:** **TTY**

Fax:

E-mail:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Zip:

Phone: **Ext:** **TTY**

Fax:

E-mail:

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously

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operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: Utah

Zip:

Phone: **Ext:** **TTY**

Fax:

E-mail:

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):

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:

Utah Division of Medicaid and Health Financing, Bureau of Authorization and Community-Based Services

(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:

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:

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

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:

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:

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:

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
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.

- 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.

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 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 SMA New Choices Waiver Unit, case management and/or direct care provider agencies requiring an immediate review and remediation of the issue, reporting the issue to Adult Protective Services and/or local law enforcement or the state’s Medicaid Fraud Control Unit, the licensing authority or the survey/certification authority. To assure the issue has been addressed, entities assigned the responsibility of review and remediation are required to report back to the 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 Quality Assurance Unit's final report. Issues that are less immediate are corrected within designated time frames and are documented through the SMA Quality Assurance Unit's final review report.

When the SMA determines that an issue is resolved, notification is provided to the waiver participant and documentation is maintained by the SMA.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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)	18	64	
		Disabled (Other)	18	64	
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			
		Intellectual Disability			
Mental Illness					
		Mental Illness			
		Serious Emotional Disturbance			

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

Participation in the New Choices Waiver is limited to individuals who at the time of application:

1. are 18 years of age or older;
2. (a) are receiving nursing facility care and have been continuously receiving nursing facility care for a minimum of 90 days prior to admission; or
 - (b) are receiving care in a small health care facility (Type N) and have been continuously receiving Type N facility care for a minimum of 365 days prior to application; or
 - (c) are receiving licensed assisted living facility care and have been continuously receiving licensed assisted living facility care for a minimum of 365 days prior to application; or
 - (d) are receiving Medicare or Medicaid reimbursed care in another type of Utah licensed medical institution that is not an institution for mental disease (IMD), on an extended stay of at least 30 days, and will discharge to a nursing facility for an extended stay of at least 60 days absent enrollment into the waiver program; or
 - (e) are receiving Medicaid reimbursed services through another of Utah's 1915(c) waivers and have been identified in need of immediate (or near immediate) nursing facility admission absent enrollment into this waiver program; or
 - (f) have previously been enrolled in the New Choices Waiver but were disenrolled from the waiver due to a long term nursing facility admission or due to receipt of a lump sum payment or other financial settlement that resulted in loss of Medicaid financial eligibility. Re-enrollment is permitted when there has been no interruption in services equivalent to nursing facility care including equivalent home and community-based waiver services paid privately or by another funding source. (A new nursing facility level of care assessment must be performed prior to readmission.)
3. For individuals leaving acute care hospitals, specialty hospitals (non IMD), and Medicare skilled nursing facilities, participation is limited to those receiving a medical, non-psychiatric level of care. Individuals with co-occurring mental illness may be considered as long as it is not the primary need for services and the program can meet the individual's health and safety needs.
4. Individuals who meet the intensive skilled level of care as provided in R414-502 are not eligible for participation in the New Choices Waiver.
5. Individuals who meet the level of care criteria for admission to an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-ID) as provided in R414-502 are not eligible for participation in the New Choices Waiver. Individuals with co-occurring intellectual disability and related conditions may be considered as long as it is not the primary need for services and the program can meet the individual's health and safety needs.

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

Not applicable. There is no maximum age limit

The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Specify:

Disabled transition to Aged

Appendix B: 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	2500
Year 2	2500
Year 3	2500
Year 4	

Waiver Year	Unduplicated Number of Participants
	2500
Year 5	2500

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	1925
Year 2	1925
Year 3	1925
Year 4	1925
Year 5	1925

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).

Purpose(s) the state reserves capacity for:

Purposes	
Focus on deinstitutionalization	

Appendix B: Participant Access and Eligibility

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

Purpose *(provide a title or short description to use for lookup):*

Focus on deinstitutionalization

Purpose *(describe):*

The main purpose for the reserved capacity is for the State to maintain an ability to offer a home and community-based option for those wishing to transition out of nursing facilities or other Utah licensed medical institutions (non-IMD) by controlling costs to the State’s long term care budget.

The New Choices Waiver program was designed to be a deinstitutionalization program with the original objective being to offer home and community-based options for people wishing to transition out of nursing facilities and Utah licensed medical institutions (non-IMD). In 2012, the waiver was expanded to include a second entry pathway for long term residents of licensed assisted living facilities. In order to ensure the majority of waiver slots are reserved for people wishing to transition out of nursing facilities or other Utah licensed medical institutions (non-IMD), each state fiscal year 540 waiver slots will be reserved for applicants residing in nursing facilities or other Utah licensed medical institutions (non-IMD).

Describe how the amount of reserved capacity was determined:

The waiver program added the assisted living facility (ALF) entry route in June 2012 and operated for 2.5 years without a reserved capacity in order to study enrollment and budget trends. Trending has shown a substantial increase in the number of applications from ALF residents over the study period from 9 per month in waiver year two to 22 per month in waiver year five. Considerable analysis and modeling was performed by the Division of Medicaid and Health Financing prior to determining the reserved capacity ratio. The State monitored expenditures and other trends and adjusted the reserved capacity in relation to the adjustments made to the unduplicated count.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	540
Year 2	540
Year 3	540
Year 4	540
Year 5	540

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:

The State admits individuals who meet the requirements in B-1-a and B-1-b until point-in-time service limits have been met. Applications for waiver slots are evaluated in the order in which they are received. (First come, first served).

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 (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)

Working individuals with disabilities who buy into Medicaid (TWWIA 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:

42 CFR 435.135,

1634(c)(DAC)/1634(d)

1619b

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 & 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: The limits specified in Utahs Title XIX State Plan for post-eligibility income deductions under 42 CFR 435.725, 435.726, 435.832 and Sec. 1924 of the Social Security Act. The limits are defined on supplement 3 to attachment 2.6A.

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:

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

Other

Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

Allowance is the same

Allowance is different.

Explanation of difference:

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:

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:

Waiver Case Management agencies contracted with SMA to perform reevaluations of level of care

Other

Specify:

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

Individuals performing the initial level of care evaluation are required to be Registered Nurses or Physicians licensed within the State of Utah.

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

Utah State administrative rule R414-502 delineates the nursing facility level of care criteria that must be met to qualify for the Medicaid State Plan nursing facility benefit. In accordance with R414-502, it must be determined whether an applicant has mental or physical conditions that 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 activities of daily living above the level of verbal prompting supervision or setting up;
- (b) The attending physician has determined that the applicant's level of dysfunction in orientation to person, place, or time requires nursing facility care; or equivalent care provided through a Medicaid Home and Community-Based Waiver program; or
- (c) The medical condition and intensity of services indicate that care need of the applicant cannot be safely met in a less structured setting, or without the services and supports of a Medicaid Home and Community-Based Waiver program.

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

The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.

A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.

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

The InterRAI MINIMUM DATA SET- HOME CARE (MDS-HC) serves as the standard comprehensive assessment instrument for this waiver and includes all the data fields necessary to measure the individuals level of care as defined in the States Medicaid nursing facility admission criteria. Persons responsible for collecting the needed information and for making level of care determinations are trained by staff of the SMA in the proper application of the MDS-HC instrument and the proper analysis of the MDS-HC data to perform level of care evaluations

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

Initial level of care screenings and evaluations:

- 1) For applicants who are currently receiving Medicaid reimbursed nursing facility services on an extended stay basis, and therefore have already had a level of care determination performed by the SMA under the nursing facility admission process, the prior determination may be considered as conditionally meeting the waiver level of care determination requirement. Alternatively, the SMA NCW Unit RN may conduct a review of the standard instrument/tool, medical records and physician orders from the nursing facility to determine initial level of care. Within fourteen working days of having received a referral, the applicant selected case management provider will validate that the individual continues to meet level of care requirements during the completion of the initial waiver comprehensive needs assessment, using the standard instrument/tool described in Appendix B-6(e). In the event the conditional determination is not validated by the case management provider, the individual will be advised through a written notice of agency action that the waiver eligibility criteria has not been met and offered an opportunity for a fair hearing.
- 2) For nursing facility applicants who have not had level of care eligibility previously determined through the nursing facility admission process, a Department of Health RN will conduct a review of the standard instrument/tool, medical records and physician orders from the nursing facility to perform the initial level of care screening. Within fourteen working days of having received a referral, the applicant selected case management provider will validate that the individual does meet level of care requirements during the completion of the initial waiver comprehensive needs assessment, using the standard instrument/tool described in Appendix B-6(e). In the event the conditional determination is not validated by the case management provider, the individual will be advised through a written notice of agency action that the waiver eligibility criteria has not been met and offered an opportunity for a fair hearing.
- 3) For small health care facility applicants and assisted living facility applicants, a Department of Health RN will conduct a review of medical records, service plans, physician orders and other pertinent case history to perform the initial level of care screening. Within fourteen working days of having received a referral, the applicant selected case management provider will validate that the individual does meet level of care requirements during the completion of the initial waiver comprehensive needs assessment, using the standard instrument/tool described in Appendix B-6(e). In the event the conditional determination is not validated by the case management provider, the individual will be advised through a written notice of agency action that the waiver eligibility criteria has not been met and offered an opportunity for a fair hearing.
- 4) For applicants who are currently receiving care in another of Utah's 1915(c) waiver programs and therefore have already had a nursing facility level of care determination performed by the designated level of care entity under that waiver's admission process, the prior determination will be considered as conditionally meeting the waiver level of care determination requirement. Within fourteen working days of having received a referral, the applicant selected NCW case management provider will validate that the individual does meet level of care requirements during the completion of the initial waiver comprehensive needs assessment, using the standard instrument/tool described in Appendix B-6(e). In the event the conditional determination is not validated by the case management provider, the individual will be advised through a written notice of agency action that the waiver eligibility criteria has not been met and offered an opportunity for a fair hearing.
- 5) For previously enrolled participants who were disenrolled due to long term nursing facility admission or due to receipt of a lump sum settlement that disqualified them from Medicaid benefits, a new level of care reassessment must be performed by the participant's selected NCW case management agency prior to re-enrollment.

Level-of-care reevaluations:

The contracted case management provider will validate that the individual continues to meet level of care requirements during the completion of the annual (at a minimum) comprehensive reassessment of the participant's needs, using the standard instrument/tool described in Appendix B-6(e), (MDS-HC). In the event the reevaluation indicates the participant no longer meets nursing facility level of care, the case management provider will contact a Department of Health RN to request a review of the standard level of care instrument/tool. If the Department of Health RN concurs that the participant no longer meets the nursing facility admission criteria, the individual will be advised through a written notice of agency action that the waiver eligibility criteria has not been met and offered an opportunity for a fair hearing.

The contracted case management provider will be required to maintain original records of all completed MDS-HCs. Copies of MDS-HCs must be made available to the Bureau of Long Term Services and Supports, Department of Health, upon request. Records will be reviewed as a component of the quality assurance monitoring completed by the SMA.

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

Every three months

Every six months

Every twelve months**Other schedule***Specify the other schedule:*

A full level of care reevaluation will be completed at a minimum of annually (no later than by the end of the same calendar month of the last level of care evaluation, one year later).

Health status screenings must be performed by the case management provider's RN any time a participant has experienced a substantial change in health status and at the conclusion of all inpatient stays in a medical institution to determine whether the participant's health status indicates:

- a. needs can continue to be safely met within the waiver program, and
- b. the participant continues to meet nursing facility level of care.

If during the health status screening it becomes evident that the participant's mental or physical condition has changed substantially, a new full level of care re-evaluation must be performed.

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

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

The case management providers are required to maintain records of level of care evaluations and reevaluations in the participant's waiver case record.

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:

The number and percentage of new participants who are admitted to the New Choices Waiver that meet nursing facility LOC. (N = # of participants who met level of care; D = total # of new participants).

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 = <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: 100px; text-align: center;">5</div>
Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: 20px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: 20px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: 20px;"></div>

	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

The number and percentage of initial screenings for level of care that are conducted for applicants who meet New Choices Waiver guidelines for enrollment. (N = # of screenings completed; D = total # of screenings required).

Data Source (Select one):

Other

If 'Other' is selected, specify:

SMA New Choices Waiver Unit Application Records

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review

Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="5"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

- 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:

The number and percentage of participants, for whom the Level of Care Determination Form accurately documents the LOC criteria based on the MDS-HC assessment. (N = # of determinations in compliance; D = total # of LoC determinations)

Data Source (Select one):

Other

If 'Other' is selected, specify:

LOC determination forms, MDS-HC, Participant Records

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

		5
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

The 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. (N = # of assessments in compliance; D = total # of assessments)

Data Source (Select one):

Other

If 'Other' is selected, specify:

MDS-HC

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

The number and percentage of new enrollees for whom the 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. (N = # of completed 927's; D = total # of 927's required)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Participant records, Form 927

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="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 <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
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.

All individuals who apply for New Choices Waiver services and who meet minimum requirements are evaluated by an R.N. using the Minimum Data Set for Home Care (MDS-HC) tool to determine if the applicant meets nursing facility level of care.

For Initial Level of Care Determinations:

The general requirements of this waiver provide upfront fail-safe mechanisms for assuring level of care determinations are completed by qualified individuals for all new entrants into the waiver.

Applicants from a nursing facility on a Medicaid reimbursed stay are determined to meet level of care criteria by the Utah Department of Health registered nurses who perform this task for all Medicaid nursing facility admissions. Prior to initiating admission to the NCW, the SMA NCW Unit must verify that the Utah Department of Health registered nurses or the SMA NCW Unit RN found the applicant to meet long term care criteria for nursing facility care.

Applicants in a skilled nursing facility on a Medicare reimbursed stay or on a hospice stay are not assessed the same way as those on a Medicaid reimbursed stay in a nursing facility. Medicare reimbursed residents and hospice patients will be screened for nursing facility level of care by a Utah Department of Health RN using the standard level of care instrument/tool, medical records and physician orders from the nursing facility. Applicants from a small health care facility (Type N) or from a licensed assisted living facility have not had a level of care evaluation prior to the time of NCW application because these types of facilities are not required to perform nursing facility level of care evaluations as a condition to admit private pay individuals. For each NCW applicant from a small health care facility or from an assisted living facility, the initial nursing facility level of care screening is performed by a Utah Department of Health RN who will conduct a review of medical records, service plans, physician orders and other pertinent case history from the facility.

This assures that 100% of the cases meet the requirement “LOC was conducted by a qualified registered nurse or physician licensed in the state.” In addition, to confirm that the level of care criteria is met following the screening by the Department of Health RN, the New Choices Waiver case management registered nurses complete a MDS-HC prior to enrollment in the waiver. This documentation is required to be submitted to the SMA NCW Unit by the case management agency prior to the applicant’s enrollment in the program. Applicants are not enrolled into the program without this documentation.

For Level of Care Re-evaluation Determinations:

Annually at a minimum, case management providers are required to submit level of care re-determinations and updated care plans. Annual care plans will not be authorized without receiving the written evidence that an annual level of care re-evaluation has been completed and the participant continues to meet nursing facility level of care. The written evidence must be completed by the registered nurse or physician who performed the annual level of care re-evaluation.

During the annual review, level of care determinations and redeterminations are reviewed against the performance measures. The SMA NCW Unit and the SMA QA Unit will collaborate to develop and implement an approved corrective action or quality improvement initiative.

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

b. Methods for Remediation/Fixing Individual Problems

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

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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).

1. The SMA NCW Unit will include a waiver fact sheet with all NCW applications that are sent to interested applicants. The waiver fact sheet provides a complete listing of all services available within the New Choices Waiver program.
2. As part of the application process, the applicant or the applicant’s legal representative completes and signs the Freedom of Choice Consent Form which is designed to:
 - a. Inform the applicant of any feasible alternatives under the waiver; and
 - b. Offer the choice of either institutional or home and community-based services.
3. The individual is informed that the State Medicaid Agency provides an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to nursing facility institutional care.

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 Consent forms will be maintained in the participant’s waiver case record maintained by the case management provider and also in the records maintained by the SMA NCW Unit.

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):

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

This information is also provided on the Utah Medicaid website: <https://medicaid.utah.gov/programs-and-services>

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 Care		
Statutory Service	Case Management		
Statutory Service	Habilitation		
Statutory Service	Homemaker		
Statutory Service	Respite		
Extended State Plan Service	Supportive Maintenance Services		
Supports for Participant Direction	Consumer Preparation Services		
Supports for Participant Direction	Financial Management Services		
Other Service	Adult Residential Services		
Other Service	Assistive Technology Devices		
Other Service	Attendant Care Services		

Service Type	Service		
Other Service	Caregiver Training		
Other Service	Chore Services		
Other Service	Community Living Services		
Other Service	Environmental Accessibility Adaptations		
Other Service	Home Delivered Meals		
Other Service	Medication Administration Assistance Services		
Other Service	Personal Budget Assistance		
Other Service	Personal Emergency Response System		
Other Service	Specialized Medical Equipment, Supplies and Supplements		
Other Service	Transportation - 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):

Adult Day Care

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Services generally furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the care plan, in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant.

Transportation between the participant's place of residence and the adult day care site is not provided as a component of adult day care services and the cost of this transportation is not included in the rate paid to adult day care providers.

Those receiving adult residential services in an assisted living facility, Type N facility or licensed community residential care facility are not eligible for Adult Day Health unless the case management agency assesses a client-specific need that cannot be otherwise met by the facility of residence. Documentation of the identified need must be included in the comprehensive care plan.

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

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

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	Licensed Adult Day Care Facilities

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Adult Day Care

Provider Category:

Agency

Provider Type:

Licensed Adult Day Care Facilities

Provider Qualifications

License (*specify*):

Adult Day Care Center: UAC R501-13-1-13 or R432-150-6 or R 432-270-29

Certificate (*specify*):

Other Standard (*specify*):

Medicaid Provider enrolled to provide adult day care services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid and Health Financing, Bureau of Long Term Services and Supports

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:

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:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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

- a) Complete the initial comprehensive assessment and periodic reassessments to determine the services and supports required by the participant to prevent unnecessary institutionalization;
- b) Perform reevaluations of participants' level of care;
- c) Complete the initial comprehensive care plan and periodic updates to maximize the participant's strengths while supporting and addressing the identified preferences, goals and needs;
- d) Research the availability of non-Medicaid resources needed by an individual to address needs identified through the comprehensive assessment process and assist the individual in gaining access to these resources;
- e) Assist the individual to gain access to available Medicaid State Plan services necessary to address identified needs;
- f) Assist the individual to select from available choices, an array of waiver services to address the identified needs and assist the individual to select from the available choice of providers to deliver each of the waiver services including assisting with locating an appropriate home and community-based setting and assisting with negotiation of a rental agreement when needed;
- g) Assist the individual to request a fair hearing if choice of waiver services or providers is denied, if services are reduced, terminated or suspended, or if the participant is disenrolled;
- h) Monitor to assure the provision and quality of services identified in the individual's care plan;
- i) Support the individual/legal representative/family to independently obtain access to services when other funding sources are available;
- j) Monitor on an ongoing basis the individual's health and safety status and investigate critical incidents when they occur. At least one (1) telephone or face-to-face contact directly with the waiver participant is required each month and a minimum of one (1) face to face contact with the participant is required every 90 days. When meaningful telephone contact cannot be achieved due to a participant's diminished mental capacity or inability to communicate by phone, in-person contact must be made with the participant monthly;
- k) Coordinate across Medicaid programs to achieve a holistic approach to care;
- l) Provide case management and transition planning services up to 180 days immediately prior to the date an individual transitions to the waiver program;
- m) Provide safe and orderly discharge planning services to an individual disenrolling from the waiver;
- n) Perform internal quality assurance activities, addressing all performance measures.
- o) Monitor participant medication regimens.

In order to facilitate transition, case management services may be furnished up to 180 days prior to transition and providers may bill for this service once the participant enters into the waiver program. 15 units per month or less is the expected typical case management utilization pattern. Plans that include utilization of 16 units or greater will require submission of additional documentation to justify the need for additional services.

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 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 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.

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.)

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	Division Services for People with Disabilities
Agency	Centers for Independent Living
Agency	Accredited Case Management Agencies
Agency	Prepaid Inpatient Health Plans
Agency	Area Agencies on Aging

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:

Division Services for People with Disabilities

Provider Qualifications

License (*specify*):

DSPD employees with RN and SSW licensure or other licensure that is at least equivalent to or higher than RN and SSW

Certificate (*specify*):

Other Standard (*specify*):

- a) Recognized Division of Service for People with Disabilities entity
- b) Medicaid provider enrolled to provide case management.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid and Health Financing, Bureau of Long Term Services and Supports

Frequency of Verification:

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

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:

Centers for Independent Living

Provider Qualifications

License (specify):

CIL employees with RN and SSW licensure or other licensure that is at least equivalent to or higher than RN and SSW

Certificate (specify):

Other Standard (specify):

- (a) Centers for Independent Living recognized through the State Office of Rehabilitation
 (b) Medicaid provider enrolled to provide case management.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid and Health Financing, Bureau of Long Term Services and Supports

Frequency of Verification:

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

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:

Accredited Case Management Agencies

Provider Qualifications

License (specify):

Case Management Agency employees with RN and SSW licensure or other licensure that is at least equivalent to or higher than RN and SSW

Certificate (*specify*):

Other Standard (*specify*):

- (a) Case Management Agency accredited by DMHF approved organization.
- (b) Medicaid provider enrolled to provide case management.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid and Health Financing, Bureau of Long Term Services and Supports

Frequency of Verification:

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

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:

Prepaid Inpatient Health Plans

Provider Qualifications

License (*specify*):

PIHP employees with RN and SSW licensure or other licensure that is at least equivalent to or higher than RN and SSW

Certificate (*specify*):

Other Standard (*specify*):

- (a) Recognized Division of Service for People with Disabilities entity
- (b) Medicaid provider enrolled to provide case management.
- (c) Services provided under this waiver are paid to PIHPs on a fee-for-service basis only.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid and Health Financing, Bureau of Long Term Services and Supports

Frequency of Verification:

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

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:

Area Agencies on Aging

Provider Qualifications

License (*specify*):

AAA employees with RN and SSW licensure or other licensure that is at least equivalent to or higher than RN and SSW

Certificate (*specify*):

Other Standard (*specify*):

- (a) Recognized Area Agency on Aging entity within the State
- (b) On Contract with the SMA

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid and Health Financing, Bureau of Long Term Services and Supports

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:

Statutory Service

Service:

Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Habilitation Services are active teaching/training therapeutic activities to supply a person with the means to develop or maintain maximum independence in activities of daily living and instrumental activities of daily living, socialization and adaptive skills necessary to reside successfully in home and community-based settings. Specific services include teaching/retraining the following:

- a. daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, money management and maintenance of the living environment);
- b. social skills training in appropriate use of community services; and
- c. development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion).

While it is recognized that observation of skills learned is a critical component of habilitation services, the expectation is that active teaching/training/therapeutic intervention will comprise the majority of each unit of service.

The following are specifically excluded from payment for habilitation services:

- a. vocational services,
- b. prevocational services,
- c. supported employment services,
- d. room and board,
- e. companion services, and
- f. services that are intended to compensate for loss of function such as would be provided by attendant care services.

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	Habilitation Providers

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Habilitation

Provider Category:

Agency

Provider Type:

Habilitation Providers

Provider Qualifications

License (specify):

R432-700
or
Current Business License

Certificate (specify):

Other Standard (specify):

Demonstrated ability to perform the tasks ordered on behalf of the waiver participant

Medicaid Providers enrolled to provide habilitation services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid and Health Financing, Bureau of Long Term Services and Supports

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:

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:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Services consisting of the performance of general household tasks (e.g., meal preparation, grocery shopping, laundry and routine household care including cleaning bathrooms, doing dishes, dusting, vacuuming, sweeping, mopping) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.

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

This service cannot be provided to participants receiving Adult Residential Services or any other waiver service in which the tasks performed are duplicative of the homemaker services.

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	Agency Based - Homemaker
Individual	Self-administered services Homemaker

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Agency Based - Homemaker

Provider Qualifications

License (specify):

Current Business License

Certificate (specify):

Other Standard (specify):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid and Health Financing, Bureau of Long Term Services and Supports

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Homemaker

Provider Category:

Individual

Provider Type:

Self-administered services Homemaker

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Demonstrated ability to perform the tasks authorized by the case management agency

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid and Health Financing, Bureau of Long Term Services and Supports

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:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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

Room and board will not be reimbursed in any private residence including:

- i. Individual's place of residence
- ii. Private residence of the respite care provider

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

Payments are not made for room and board except when provided as a part of overnight respite care in a facility approved by the State and enrolled as a NCW Respite Care provider. In the case of respite care services that are rendered in a facility overnight, this service will be billed under a specific Respite Care-Overnight, Out of Home, Room and Board Included billing code (H0045). Each Respite Care- Overnight, Out of Home, Room and Board Included episode is limited to a period of 13 consecutive days or less not counting the day of discharge. A day begins and ends at midnight. The number of Respite Care - Overnight, Out of Home, Room and Board Included episodes may not exceed three in any calendar year.

For facility based respite care that is not provided overnight, the provider should bill using the incremental rate (\$5150). The service is limited to a maximum of five hours of support per day.

Respite care provided in the client's own home or in the private residence of the respite care provider should be reimbursed using the incremental rate (\$5150 and is limited to a maximum of five hours of support per day).

Respite care is not available for those receiving Adult Residential Services.

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	Personal Care Agency
Agency	Residential Treatment Facility
Agency	Adult Day Care
Agency	Home Health
Agency	Nursing Facilities
Agency	Assisted Living Facilities
Individual	Self-administered services Respite

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Personal Care Agency

Provider Qualifications

License (specify):

R432-725

Certificate (specify):

[Empty text box]

Other Standard (*specify*):

Medicaid provider enrolled to provide respite services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid and Health Financing, Bureau of Long Term Services and Supports

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Residential Treatment Facility

Provider Qualifications

License (*specify*):

R501-19-13

Certificate (*specify*):

[Empty text box]

Other Standard (*specify*):

[Empty text box]

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid and Health Financing, Bureau of Long Term Services and Supports

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Adult Day Care

Provider Qualifications

License (specify):

R501-13-1

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid and Health Financing, Bureau of Long Term Services and Supports

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Home Health

Provider Qualifications

License (specify):

R432-700

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid and Health Financing, Bureau of Long Term Services and Supports

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Nursing Facilities

Provider Qualifications

License (specify):

Nursing Facilities R432-150

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid and Health Financing, Bureau of Long Term Services and Supports

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Assisted Living Facilities

Provider Qualifications

License (specify):

R432-270

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid and Health Financing, Bureau of Long Term Services and Supports

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Individual

Provider Type:

Self-administered services Respite

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Demonstrated ability to performs the tasks ordered on behalf of the waiver participant

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid and Health Financing, Bureau of Long Term Services and Supports

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:

Extended State Plan Service

Service Title:

Supportive Maintenance Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Services defined in 42 CFR 440.70 that are provided when home health aide services furnished under the approved State plan limits are exhausted. The scope and nature of these services do not differ from home health aide services furnished under the State plan. Services are defined in the same manner as provided in the approved State plan. The provider qualifications specified in the State plan apply.

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

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

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	Supportive Maintenance Services

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Supportive Maintenance Services

Provider Category:

Agency

Provider Type:

Supportive Maintenance Services

Provider Qualifications

License (*specify*):

Home Health Agency: UAC R432-700

Certificate (*specify*):

Other Standard (*specify*):

Under State contract with LTCB as an authorized provider of services and supports.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid and Health Financing, Bureau of Long Term Services and Supports

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:

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:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

Consumer Preparation Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (*Scope*):

Category 4:

Sub-Category 4:

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

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

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

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	Consumer Preparation Services

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction

Service Name: Consumer Preparation Services

Provider Category:

Agency

Provider Type:

Consumer Preparation Services

Provider Qualifications

License (specify):

Have entered into a Medicaid Provider Agreement with the Department of Health.
Current Business License

Certificate (specify):

Other Standard (specify):

- 1) Under State contract with BLTSS as an authorized provider of services and supports.
- 2) Must demonstrate competency in related topical area(s) of:
 - a. Self-determination
 - b. Natural supports
 - c. Instruction and/or consultation with families/siblings on:
 - i. Assisting self sufficiency
 - ii. Safety
 - d. Must be a professional with a bachelor’s degree in social or behavioral sciences or a mental health professional with a master’s degree in social or behavioral sciences.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid and Health Financing, Bureau of Long Term Services and Supports

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:

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:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Financial Management Services is offered in support of the self-administered services delivery option. Services rendered under this definition include those to facilitate the employment of individual service providers (employees) by the waiver participant (employer) 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 that 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	Financial Management Services

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:

Financial Management Services

Provider Qualifications

License (*specify*):

Certified Public Accountant
Sec 58-26A, UCA
And R 156-26A, UAC

Certificate (*specify*):

Other Standard (*specify*):

Under State contract with BLTSS 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 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 an accounting information system to invoice and receive Medicaid reimbursement funds.
 Utilize an 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 Medicaid and Health Financing, Bureau of Long Term Services and Supports

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:

Adult Residential Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Supportive services provided in an approved community-based adult residential facility. Supportive services are expected to meet scheduled and unpredictable participant needs and to provide supervision, safety and security in conjunction with residing in a homelike, non-institutional setting.

Adult Residential Services in licensed assisted living facilities and small health care facilities (HCPCS T2031) includes homemaking services, chore services, 24-hour on-site response capability, attendant care services, meal preparation, medication assistance/oversight, social/recreational programming, and nursing/skilled therapy services that are incidental rather than integral to the provision of Adult Residential Services.

Adult Residential Services in licensed assisted living facilities, memory care (HCPCS T2016) includes homemaking services, chore services, 24-hour on-site response capability, attendant care services, meal preparation, medication assistance/oversight, social/recreational programming, memory care services, and nursing/skilled therapy services that are incidental rather than integral to the provision of Adult Residential Services.

Adult Residential Services in licensed community residential facilities (HCPCS T2033) includes meal preparation, behavioral health services, 24-hour on-site response capability, homemaking services, chore services, and social/recreational programming.

Adult Residential Services in certified community residential facilities (independent living facilities, HCPCS H0043) includes homemaking services, meal preparation, 24-hour on-site response capability and daily status checks (or more frequently as deemed appropriate in the comprehensive needs assessment).

All Adult Residential Services no matter the setting includes 24 hour on-site response capability or other alternative emergency response arrangements determined appropriate to meet scheduled or unpredictable participant needs and to provide supervision, safety and security in conjunction with residing in a homelike, non-institutional setting.

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

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

Separate payment is not made for chore services unless an exceptional need is identified in the comprehensive needs assessment that is not specified in the formal lease agreement between the facility and the participant/family as being the responsibility of the facility. Example of an exceptional need: heavy cleaning resulting from hoarding behavior. Documentation of exceptional needs must be submitted with the care plan for approval. Exceptions will not be approved if the chore service is for the costs of general facility maintenance, upkeep or improvement.

Separate payment is not made for attendant care services furnished when the participant is actively receiving care inside the facility or during activities provided by the facility off campus. Attendant care may be provided when a need is identified for participation in off-campus activities not associated with the facility. Examples: personal shopping or accompanying the participant to doctor appointments.. Exceptions to the attendant care limitation are made for individuals residing in licensed community residential facilities and independent living facilities because neither type of facility is licensed to perform hands-on assistance with activities of daily living.

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

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	Certified Community Residential Care Facilities
Agency	Licensed Community Residential Care Facilities
Agency	Assisted Living Facilities

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Residential Services

Provider Category:

Agency

Provider Type:

Certified Community Residential Care Facilities

Provider Qualifications

License (specify):

Current Business License

Certificate (specify):

Other Standard (specify):

Medicaid provider enrolled to provide adult residential services and certification by the SMA NCW Unit initially and annually.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid and Health Financing, Bureau of Long Term Services and Supports

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Residential Services

Provider Category:

Agency

Provider Type:

Licensed Community Residential Care Facilities

Provider Qualifications

License (specify):

R432-270 or
R432-200 or
R432-300 or
R501-19

Certificate (*specify*):

Other Standard (*specify*):

All Providers: Medicaid provider enrolled to provide adult residential services

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid and Health Financing, Bureau of Long Term Services and Supports

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Adult Residential Services

Provider Category:

Agency

Provider Type:

Assisted Living Facilities

Provider Qualifications

License (*specify*):

R432-270

Certificate (*specify*):

Other Standard (*specify*):

Medicaid provider enrolled to provide adult residential services

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid and Health Financing, Bureau of Long Term Services and Supports

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:

Assistive Technology Devices

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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

- (A) The evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;
- (B) Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants;
- (C) Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
- (D) Coordination and use of necessary interventions, or services with assistive technology devices, such as interventions or services associated with other services in the care plan;
- (E) Training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and
- (F) Training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.

Devices that can be purchased:

Telephones and intercoms:

- Amplified phones
- Digital enhanced cordless telecommunications (DECT) phones
- Remote controlled phones with infrared technology
- Large print and talking caller ID
- Phone headsets
- Headset amplifiers and tone control
- Large button phones
- TDD and TTY
- Video phones

Hearing and Communication:

- Communication software
- Basic communicators
- Picture communicators
- Audio and voice recorders
- Speech generating devices
- Voice amplifiers and synthesizers
- Blinking light "doorbell"
- Intercom system
- Hearing amplifiers

Vision impairment adaptations:

- Screen readers
- Text to speech software
- Digital book players
- Talking products
- Magnifiers
- True color floor lamps
- Eye drop squeezer

Switches:

- Sip and Puff Switches

Sensitive switches
 Foot switches
 Switch interfaces
 Mounting devices
 Chin switch
 Safety alarms

Other:

Adaptive utensils
 Oversized utensil handles
 Adaptive cookware
 Modified pot handles
 Adaptive dishes Reaching aids
 Automatic clock with day and date display
 Jar opener
 Door knob adapters
 Car caddy
 Adaptive dressing aids
 Button hooks
 Adaptive grooming aids
 Sock and shoe aids
 Long handle grooming aids
 Easy grasp key holders and turners
 Rolling lotion applicators
 Weight sensitive alarms
 Non-slip mats
 Bedside beverage holders
 Burn resistant smokers apron
 Recliner lever extenders
 Portable access ramps
 Wheelchair trays
 Voice controlled devices/items found in a home environment

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

Service Limit: The maximum allowable cost per assistive technology device is \$2,000.00. At the point a waiver participant reaches the service limit, the care coordination team will conduct an evaluation to determine how the individuals health and safety can continue to be assured through authorization for additional service beyond the limit or alternative arrangements that meet the individuals 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	Assistive Technology Device Supplier

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Assistive Technology Devices

Provider Category:

Agency

Provider Type:

Assistive Technology Device Supplier

Provider Qualifications

License (*specify*):

Current Business License

Certificate (*specify*):

Other Standard (*specify*):

Medicaid provider enrolled to provide assistive technology device supplier

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid and Health Financing, Bureau of Long Term Services and Supports

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:

Attendant Care Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

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Category 2:

Sub-Category 2:

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Category 3:

Sub-Category 3:

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Service Definition (Scope):

Category 4:

Sub-Category 4:

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Attendant care services are those that reinforce an individuals strengths, while substituting or compensating for the absence, loss, diminution, or impairment of a physical or cognitive function. Attendant services incorporate and respond to the participants preferences and priorities.

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

This service cannot be provided to participants receiving Adult Residential Services or any other waiver service in which the tasks performed are duplicative of the attendant care services.

Spouses providing Personal Attendant Services through self-direction are limited to a maximum of 40 hours per week.

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	Attendant Care
Individual	Self-directed -- Attendant Care

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Attendant Care Services

Provider Category:

Agency

Provider Type:

Attendant Care

Provider Qualifications

License (specify):

Current Business License

Certificate (*specify*):

Other Standard (*specify*):

All providers: Medicaid providers enrolled to provide attendant care services

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid and Health Financing, Bureau of Long Term Services and Supports

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Attendant Care Services

Provider Category:

Individual

Provider Type:

Self-directed -- Attendant Care

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Demonstrated ability to performs the tasks ordered on behalf of the waiver participant

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid and Health Financing, Bureau of Long Term Services and Supports

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:

Caregiver Training

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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

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

No limits

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	Caregiver Trainer

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Caregiver Training

Provider Category:

Agency

Provider Type:

Caregiver Trainer

Provider Qualifications

License (specify):

R156 or R432 as applicable (providers of training in categories requiring license under State law) Or Current business license (formal training suppliers)

Certificate (specify):

Other Standard (specify):

- (a) Demonstrated ability to perform the tasks ordered by the case management agency.
- (b) Medicaid provider enrolled to provide caregiver training

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid and Health Financing, Bureau of Long Term Services and Supports

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:

Chore Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as carpet cleaning, pest eradication, cleaning windows and walls, tacking down loose rugs and tiles, lawn mowing, moving heavy items of furniture or snow removal which is necessary in order to provide safe access or egress.

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

These services are provided only when neither the participant nor anyone else in the household is capable of performing or financially providing for them, and where no other caregiver, landlord, community/volunteer agency, or third party payer is capable or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, is examined prior to any authorization of service. Additionally this service is not available concurrent with any other waiver service in which the tasks performed are duplicative of chore services.

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
Individual	Self-administered - Chore
Agency	Chore

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore Services

Provider Category:

Individual

Provider Type:

Self-administered - Chore

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Demonstrate ability to perform the tasks ordered on behalf of the waiver participant

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid and Health Financing, Bureau of Long Term Services and Supports

Frequency of Verification:

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

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:

Chore

Provider Qualifications

License (specify):

Current Business License

Certificate (specify):

Other Standard (specify):

- (a) Medicaid provider enrolled to provide chore services
- (b) demonstrated ability to perform the tasks ordered by case management provider

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid and Health Financing, Bureau of Long Term Services and Supports

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:

Community Living Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Provision of essential household items and services needed to establish and maintain basic living arrangements in a community setting that enable the individual to establish and maintain health and safety. Essential household items include basic furnishings; replacement of worn or soiled household items or furnishings; cleaning devices and supplies; and kitchen and bathroom equipment. This service also includes moving expenses, security deposits that are required to obtain a lease on an apartment or home; rental application fees; one-time non-refundable fees to establish utility services and other services essential to the operation of the residence; and services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy.

This service can be accessed for the following events:

1. upon initial waiver enrollment when transitioning to a home or community-based setting, or
2. when an established waiver participant moves to another setting that is determined to better meet the participant's needs, or
3. when an established waiver participant's assessed health and safety needs warrant the replacement of old depleted household items or furnishings when moving to a new setting or in order to retain the current community living arrangement. Replacement items include a new mattress, mattress protector, linens, table, chair, kitchen furnishings, bathroom furnishings, duplicate keys, locks, a vacuum and storage containers.

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

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

Storage fees are not covered.

This service cannot be accessed unless a waiver participant is transitioning (moving) from one setting to another or unless a waiver participant's current community living arrangement is in jeopardy without the replacement of depleted household items or furnishings.

Moving expenses are not covered if the new setting is not determined to better meet the participant's assessed needs.

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 Suppliers

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 Suppliers

Provider Qualifications

License *(specify):*

Current business license if applicable

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid and Health Financing, Bureau of Long Term Services and Supports

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:

Environmental Accessibility Adaptations

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (*Scope*):

Category 4:

Sub-Category 4:

Equipment and/or physical adaptations to the individuals residence or vehicle which are necessary to assure the health, welfare and safety of the individual or which enable the individual to function with greater independence in the home and in the community. The equipment/adaptations are identified in the individual's care plan and the model and type of equipment are specified by a qualified individual. The adaptations may include purchase, installation, and repairs. Other adaptation and repairs may be approved on a case by case basis as technology changes or as an individuals physical or environmental needs change. All services shall be provided in accordance with applicable State or local building codes and may include the following:

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

- Vehicle
Authorized vehicle adaptations such as:
 1. lifts
 2. door modifications
 3. steering/braking/accelerating/shifting modifications
 4. seating modifications
 5. safety/security modifications

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

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

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

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
Individual	Environmental Adaptations Supplier

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Environmental Accessibility Adaptations

Provider Category:

Individual

Provider Type:

Environmental Adaptations Supplier

Provider Qualifications

License (specify):

Current business license
and
Contractors license when applicable

Certificate (specify):

Other Standard (specify):

All providers: Demonstrated ability to to perform the tasks ordered by the case management agency.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid and Health Financing, Bureau of Long Term Services and Supports

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:

Home Delivered Meals

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (*Scope*):

Category 4:

Sub-Category 4:

Home Delivered Supplemental Meal provides a nutritionally sound and satisfying meal to individuals residing in non-facility settings 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.

A meal constitutes a supplemental meal when provided in an amount that meets the nutritional needs of the individual. Each supplemental meal provided shall provide a minimum of 33 1/3 percent of the daily Recommended Dietary Allowances (RDA) and Dietary Reference Intake (DRI) as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences, Institute of Medicine and Mathematica Policy Research, Incorporated.

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:

Individuals receiving Adult Residential Services are not eligible for 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	Home Delivered Meals

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Home Delivered Meals

Provider Qualifications

License *(specify):*

Current business license

Certificate *(specify):*

Other Standard *(specify):*

Compliance with UAC R70-530
All programs: Medicaid providers enrolled to provide home delivered meals

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid and Health Financing, Bureau of Long Term Services and Supports

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:

Medication Administration Assistance Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

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Service Definition (*Scope*):

Category 4:

Sub-Category 4:

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Medication Reminder System (Not Face-To-Face)

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

- Medication Set-Up and Administration

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

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

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

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	Medication Administration Assistance

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Medication Administration Assistance Services

Provider Category:

Agency

Provider Type:

Medication Administration Assistance

Provider Qualifications

License (*specify*):

UAC R156-31b (medication set-up)
 Current business license as applicable (reminder devices)

Certificate (*specify*):

Other Standard (*specify*):

Medicaid provider enrolled to provide medication administration assistance.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid and Health Financing, Bureau of Long Term Services and Supports

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 Budget Assistance

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (*Scope*):

Category 4:

Sub-Category 4:

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

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

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

Representative payee services designated through a mental health authority or through Social Security Administration are excluded from payment under Personal Budget Assistance.

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	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:

Personal Budget Assistance

Provider Qualifications

License *(specify):*

Current Business License

Certificate *(specify):*

Other Standard (*specify*):

Medicaid provider enrolled to provide personal budget assistance.
Demonstrated ability to perform task.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid and Health Financing, Bureau of Long Term Services and Supports

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 System

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (*Scope*):

Category 4:

Sub-Category 4:

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

- Personal Emergency Response Systems (PERS) Response Center Service

Provides ongoing access to a signal response center that is staffed twenty-four hours per day, seven days a week by trained professionals responsible for securing assistance in the event of an emergency.

- Personal Emergency Response System (PERS) Purchase, Rental & Repair

Provides an electronic device of a type that allows the individual to summon assistance in an emergency. The device may be any one of a number of such devices but must be connected to a signal response center. 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 a device with GPS tracking 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 the GPS surveillance, the requirements for modifications as described in CFR 442 § 441 apply.

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	Emergency Response System Supplier

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Personal Emergency Response System

Provider Category:

Agency

Provider Type:

Emergency Response System Supplier

Provider Qualifications

License (specify):

Current business license

Certificate (specify):

Other Standard (specify):

Equipment suppliers:
FCC registration of equipment placed in the individuals home.

Installers:
Demonstrated ability to properly install and test specific equipment being handled.

Response Centers:
24 hour per day operation, 7 days per week.

All providers:
Medicaid provider enrolled to provide personal emergency response system services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid and Health Financing, Bureau of Long Term Services and Supports

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:

Specialized Medical Equipment, Supplies and Supplements

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (*Scope*):

Category 4:

Sub-Category 4:

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

Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation. Coverage includes the costs of maintenance and upkeep of equipment, training the participant or caregivers in the operation and/or maintenance of the equipment or the use of a supply, and the performance of assessments to identify the type of equipment needed by the participant.

Items may only be provided under this service when prescribed by a physician or other appropriate health care provider (such as a physician’s assistant or advanced practice registered nurse or other medical care providers with prescriptive authority).

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	Medical equipment and supply suppliers - Nondurable medical supplies
Agency	Medical equipment and supply suppliers - Durable Medical Equipment

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Specialized Medical Equipment, Supplies and Supplements

Provider Category:

Provider Type:

Provider Qualifications

License (*specify*):

Current Business License

Certificate (*specify*):

Other Standard (*specify*):

Medicaid provider enrolled to provide nondurable medical supplies.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid and Health Financing, Bureau of Long Term Services and Supports

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Specialized Medical Equipment, Supplies and Supplements

Provider Category:

Agency

Provider Type:

Medical equipment and supply suppliers - Durable Medical Equipment

Provider Qualifications

License (*specify*):

Medical equipment and supply suppliers

Certificate (*specify*):

National Supplier Clearinghouse Letter from CMS

Other Standard (*specify*):

Medicaid provider enrolled to provide medical equipment and supplies.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid and Health Financing, Bureau of Long Term Services and Supports

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:

Transportation - Non-Medical

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Service offered in order to enable waiver participants to gain access to non-medical waiver and other community services, activities and resources, as specified by the care plan. Transportation services under the waiver are offered in accordance with the participant’s care plan.

This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, and does not replace them. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized.

Non-Medical transportation is not available for the provision of transportation to medical appointments. Medical appointments are defined as appointments which are covered by the Medicaid state plan, PMHP and/or VA for which medical transportation is available.

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	Non-Medical Transportation

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Transportation - Non-Medical

Provider Category:

Agency

Provider Type:

Non-Medical Transportation

Provider Qualifications

License (specify):

Non-Medical Transportation AND Valid Driver's License

Certificate (specify):

Other Standard (specify):

All providers:
 (a) Registered and insured vehicle: UCA 53-3-202, UCA 41-12s-301
 (b) Medicaid provider enrolled to provide non-medical transportation services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid and Health Financing, Bureau of Long Term Services and Supports

Frequency of Verification:

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

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:

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

Appendix C: 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):

The Utah Code, Section 26-21-9.5, requires that a Bureau of Criminal Identification screening, referred to as BCI, and a child or disabled or elderly adult licensing information system screening be conducted on each person who provides direct care to a patient for the following covered health care facilities:

- (1) Home health care agencies;
- (2) Hospice agencies;
- (3) Nursing Care facilities;
- (4) Assisted Living facilities;
- (5) Small Health Care facilities; and
- (6) End Stage Renal Disease Facilities.

The Utah Code, Section 26-21-9.5, does not require self-administered service providers to have a BCI screening and therefore, hiring is not contingent upon an investigation. However, under the law, a participant has the option of requesting that a self-administered service provider have a BCI screening completed (at the participant's expense) and the participant will be provided with a copy of the results. The law states that the participant receiving self-directed services can ask for the screening to be completed prior to or within 10 days of initial hiring.

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):

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).

i. **Types of Facilities Subject to §1616(e).** Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Assisted Living Facilities	
Licensed Community Residential Care Facility	

ii. **Larger Facilities:** In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

This information is now contained within section C-5.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Assisted Living Facilities

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Environmental Accessibility Adaptations	
Transportation - Non-Medical	
Personal Budget Assistance	
Consumer Preparation Services	
Chore Services	
Habilitation	

Waiver Service	Provided in Facility
Supportive Maintenance Services	
Respite	
Homemaker	
Adult Day Care	
Specialized Medical Equipment, Supplies and Supplements	
Home Delivered Meals	
Attendant Care Services	
Financial Management Services	
Assistive Technology Devices	
Caregiver Training	
Personal Emergency Response System	
Adult Residential Services	
Community Living Services	
Medication Administration Assistance Services	
Case Management	

Facility Capacity Limit:

No Limit

Scope of Facility Standards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	
Physical environment	
Sanitation	
Safety	
Staff : resident ratios	
Staff training and qualifications	
Staff supervision	
Resident rights	
Medication administration	
Use of restrictive interventions	
Incident reporting	
Provision of or arrangement for necessary health services	

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Licensed Community Residential Care Facility

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Environmental Accessibility Adaptations	
Transportation - Non-Medical	
Personal Budget Assistance	
Consumer Preparation Services	
Chore Services	
Habilitation	
Supportive Maintenance Services	
Respite	
Homemaker	
Adult Day Care	
Specialized Medical Equipment, Supplies and Supplements	
Home Delivered Meals	
Attendant Care Services	
Financial Management Services	
Assistive Technology Devices	
Caregiver Training	
Personal Emergency Response System	
Adult Residential Services	
Community Living Services	
Medication Administration Assistance Services	
Case Management	

Facility Capacity Limit:

No Limit

Scope of Facility Standards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	
Physical environment	
Sanitation	
Safety	
Staff : resident ratios	
Staff training and qualifications	
Staff supervision	
Resident rights	
Medication administration	
Use of restrictive interventions	
Incident reporting	
Provision of or arrangement for necessary health services	

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

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.*

- (a) Spouses of waiver participants may be eligible to perform Attendant Care in accordance with the definition for extraordinary care below and per the CMS Technical Guide, Version 3.6
- (b) To ensure the use of a legally responsible person to provide services is in the best interest of the participant, the following criteria must be met and documented in the participant's Person-Centered Care Plan:
1. Choice of the legally responsible person to provide waiver services truly reflects the participant's wishes and desires;
 2. The provision of services by the legally responsible person is in the best interests of the participant and his or her family;
 3. The provision of services by the legally responsible person is appropriate and based on the participant's identified support needs;
 4. The services provided by the legally responsible person will increase the participant's independence and community integration;
 5. There are documented steps in the PCCP that will be taken to expand the participant's circle of support so that he or she is able to maintain and improve his or her health, safety, independence, and level of community integration on an ongoing basis should the legally responsible person acting in the capacity of employee no longer be available;
 6. The legally responsible person must sign a service agreement to provide assurances to the State/OA that he or she will implement the service plan and provide the services in accordance with applicable federal and State laws and regulations governing the program.
- (c) From a financial perspective, the prior authorization of hours/coordination with FMS agencies will be used as a control, in addition to daily/weekly maximum of hours determined to be extraordinary care. State staff members will provide additional oversight and coordinate with Case Managers to ensure health and safety objectives are maintained, both for the waiver participant and the spouse rendering care.

In the approval process for spousal caregiver compensation, the state will conduct a holistic review of the individual's supports, including the likelihood of jeopardizing the well being of the spouse if engaging in additional direct care. (Caregiver burnout; physical limitations with needed ADL assistance; etc.)

The State uses the following definition for Spousal Extraordinary Care:

Extraordinary care means care exceeding the range of Activities of Daily living (ADLs) or Instrumental Activities of Daily Living (IADLs) that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age and which is necessary to assure the health and welfare of the participant and avoid institutionalization. Extraordinary care can include specialized skills/tasks which need to be performed for the waiver participant.

Spouses may be eligible to perform direct care when:

1. The proposed provider is the choice of the participant, which is supported by the team;
2. When a spouse is not also directing services on behalf of the participant;
3. The legally responsible person provides no more than 40-hours per week of the service that the agency approves the legally responsible person to provide; and
4. The legally responsible person has the unique ability to meet the needs of the participant (e.g. has special skills or training, like nursing licensure).

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.

Other policy.

Specify:

The State will permit the provision of waiver services furnished by relatives who are not legally responsible individuals whenever the relative is qualified to provide services as specified in Appendix C-3.

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

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

Information on additional qualifications for waiver providers can found on the State's website at: <https://medicaid.utah.gov/ltc/nc-providers/>. Providers typically have 30 days to complete their enrollment, but additional time may be provided to facilitate the submission of additional information. The effective date of the enrollment will be the day all provider qualifications are met and validated.

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

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 providers who initially meet the licensure or certification requirements. (N = # of new providers who initially meet the licensure or certification requirements; D = total # of new providers who enroll to provide services for New Choices Waiver)

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

Number and percentage of licensed health care facilities that maintain full compliance with State and Federal Regulations. (N = # of licensed health care facility providers in full compliance with State and Federal regulations; D = # of total licensed health care facility providers)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Bureau of Licensing Records

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100%

		Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="DOH Bureau of Licensing"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text" value="At a minimum every 3 years"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	SMA Quality Assurance Unit: At a minimum every 3 years

Performance Measure:

The number and percentage of CMA provider files that contain current business licenses and/or professional licenses. (N: # of providers in compliance; D: total # of providers)

Data Source (Select one):

Other

If 'Other' is selected, specify:

CMA Personnel Records

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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:

The number and percentage of Independent Living Facilities that initially meet and annually maintain NCW certification standards. (N = # of providers in compliance; D = total # of providers)

Data Source (Select one):

Other

If 'Other' is selected, specify:

SMA NCW Unit Records

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

Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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: <input type="text"/>	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):
	<input style="width: 100%; height: 30px;" type="text"/>

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:

The number and percentage of adult residential providers that receive annual training provided by the SMA NCW Unit. (N = # of adult residential providers who received training; D = total # of adult residential providers)

Data Source (Select one):

Other

If 'Other' is selected, specify:

SMA NCW Unit 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 = <input style="width: 100%; height: 30px;" type="text"/>
Other Specify:	Annually	Stratified Describe Group:

	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

The number and percentage of case management agencies that receive New Choices Waiver training annually. (N = # of CMAs who received training; D = total # of CMAs)

Data Source (Select one):

Other

If 'Other' is selected, specify:

SMA NCW Unit Files

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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

b. Methods for Remediation/Fixing Individual Problems

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

ii. Remediation Data Aggregation

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

Responsible Party (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

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, HCBS Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

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 SMA 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 SMA authorizing the CMA to perform the service on the care plan.

Direct oversight of this process is maintained by the SMA through the person-centered care planning process. All care plans (including amendments) require approval by the SMA. During this process, should a CMA request to provide direct service (other than Case Management), an evaluation would occur to confirm the CMA was the only willing/qualified provider. During enrollment activities, the SMA captures 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 Case Manager due to access to care issues). It is also during this evaluation that the State confirms 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 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 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).

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.

The participant, representative, primary paid care givers, the participant's case management agency and any other individuals of the waiver participant's choosing including family, friends and/or other caregivers are involved throughout the assessment and planning process and work together as a Person Centered Care Planning (PCCP) team. The case management agency completes the formal assessment process along with the PCCP team and the results are shared with all parties included in this process. A planning meeting is held in the development of the comprehensive care plan.

Participants identify personal goals and make decisions that are related to specific supports in their comprehensive care plan.

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):

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

The care plan is driven by the participant in alignment with the participant's goals and preferences. Care planning meetings are scheduled at times and locations convenient to the individual. Other representatives, primary paid care givers and any other individuals of the waiver participant's choosing will be involved in the care planning process. The participant or legal representative will be advised of any needs identified during the assessment process and given the opportunity to accept or decline services that would address those needs. The participant will be provided with the standardized form listing all waiver services and waiver providers available in their area and given the opportunity to select their service providers whenever there is more than one willing provider available in that service area.

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

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

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

The comprehensive care plan is updated at least one a year with changes made throughout the year as needed based on the participant's changing needs. Anytime during the plan year the waiver participant or the participant's representatives may also request updates or changes to the existing plan outside of annual reviews of the comprehensive care plan.

These requests would be addressed directly with the case manager. The participant selected Case Management agency will be responsible for implementing and coordinating the developed care plan. The care plan must be approved by the SMA New Choices Waiver Unit prior to implementation.

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 case management agency, during the comprehensive needs assessment process and care plan development process will complete a risk analysis to identify: Risks posed by the participant's physical and cognitive conditions and choice of services and supports to best meet the participant's needs. The plan will identify the assessed risks while considering the participant's right to assume some degree of personal risk, and will include resources and/or measures available to reduce risks or identify alternate ways to achieve personal goals.

In completing the risk analysis, specific emphasis will be placed on identifying risks that would result in a high likelihood of death or harm if an interruption in the delivery of a service and supports to the waiver participant occurred.

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

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

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.

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

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 sample of waiver enrollees care plans that is representative of the caseload distribution across the program. If the sample evaluation identifies system-wide care planning problems, an expanded review is initiated by the SMA.

The representative sample of participants reviewed for care planning measures follow random sampling with a 95% confidence interval, 5% margin of error and 50% response distribution found in associated performance measures. Should a CMA not be adequately represented, the SMA may make modifications to ensure a sufficient number of participants is included. The State may also make alterations based on prior performance if oversampling is necessary for program oversight. Representatives from either the SMA Quality Assurance or SMA New Choices Team (or both) conduct the review.

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:

The individual's care plan is reviewed at the time a substantial change in the individual's health status occurs to determine whether modifications to the care plan are necessary.

A full care plan review and update is conducted:

- a. Whenever indicated by the results of a health status change screening;
- b. In conjunction with completion of a full comprehensive assessment;
- c. At a minimum of annually (no later than by the end of the calendar month of the last care plan and no later than within 31 days of the annual MDS-HC).

All revisions must be reviewed and approved by the SMA New Choices Waiver Unit prior to implementation

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

Medicaid agency

Operating agency

Case manager

Other

Specify:

Appendix D: 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.

The case management agency has “front-line” responsibility for monitoring the health and welfare of waiver participants and to ensure the appropriate implementation of the care plan, including oversight to ensure the following:

1. Participants have access to waiver services identified in the comprehensive care plan,
2. Services meet the needs of the participant,
3. Back-up plans are effective,
4. Services are delivered within the scope, frequency and duration described in the comprehensive care plan,
5. Participants exercise free choice of providers, and
6. Participants have access to non-waiver services identified in the service plan including access to health services.

The assigned case manager from the case management agency will meet with the participant face to face as assessed necessary to insure the quality of services provided by the waiver service providers. Summarization of the performance of these oversight activities will be documented in the case management notes in the individual waiver participants’ case files.

During the care planning process it is the responsibility of the case manager 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).

The SMA New Choices Waiver Unit is responsible to review and approve all care plans prior to implementation.

All care plans are subject to annual and periodic reviews by the SMA New Choices Waiver Unit. A sample of care plans will be reviewed periodically. Significant findings from those reviews will be addressed with the case management agencies. The case management agencies will be required to develop a plan of correction with specific timeframes for completion to address identified concerns. The SMA Quality Assurance Unit will conduct follow-up reviews as necessary to ensure the plan of correction is implemented and sustained.

b. Monitoring Safeguards. *Select one:*

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

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

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

Safeguards to ensure appropriate care plan development will include utilization of a standardized Freedom of Choice of Providers form listing all potential providers of each service category within the participant's service area. Waiver participants will indicate their choice of provider(s) in writing and sign the standardized form. In this way, the participant acknowledges that they were given a choice of waiver providers. The case management agency will be required to maintain these forms in their files. These forms will be reviewed as a component of the quality assurance monitoring completed by the SMA.

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 that identify the personal goals of the waiver participant. (N = # of care plans that identify the personal goals of the waiver participant; D = total number of care plans reviewed)

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

	Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 0 auto;"></div>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>

Performance Measure:

The 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. (N = # of care plans in compliance; D = # of care plans reviewed)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Care Plan

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review

Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="5"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

The number and percentage of care plans which address all needs, including health and safety risk factors, that are identified in the full assessment. (N = # of care plans in compliance; D = # of care plans reviewed)

Data Source (Select one):

Other

If 'Other' is selected, specify:

MDS-HC, Care Plan

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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.

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:

The number and percentage of care plans that are updated when warranted by

changes in the waiver participant’s needs. (N = # of care plans in compliance; D = total # of care plans requiring updates)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Care Plan, Participant Records

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

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 <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

The number and percentage of care plans that are updated, at a minimum, annually (within the calendar month of the last care plan). (N = # of care plans in compliance; D = total # of care plans reviewed)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Care Plan, Participant Records

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="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:

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:

The 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 provided. (N = # of cases where evidence of monthly contact occurred; D = total # of cases reviewed)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Care Plan, Participant Records

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

The number and percentage of care plans that identify the type, scope, amount, frequency and duration for each waiver service. (N = # of care plans in compliance; D = # of care plans reviewed)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Care Plan, Participant Records

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="5"/>
Other	Annually	Stratified

Specify: <input style="width: 100%; height: 20px;" type="text"/>		Describe Group: <input style="width: 100%; height: 20px;" type="text"/>
	Continuously and Ongoing	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

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:

The number and percentage of participants who were offered the choice between available waiver providers as documented on the Freedom of Choice of Waiver Providers Form. (N = # of cases in compliance; D = # of cases reviewed)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Care Plan, Participant Records

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

The number and percentage of participants who received a list of all NCW services as documented on the Freedom of Choice of Waiver Providers Form. (N = # of cases in compliance; D = # of cases reviewed)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Care Plan, Participant Records

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="5"/>
Other	Annually	Stratified

Specify: <input type="text"/>		Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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

b. Methods for Remediation/Fixing Individual Problems

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 that affect the health and welfare of individual participants are addressed immediately. Issues that are less immediate are corrected within designated time frames and are documented through the SMA Quality Assurance 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 <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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.

Participant direction will be limited to participation in decision-making related to employer related activities. The waiver will not involve participation in budget decision making.

The State authorized waiver services to be provided through two service delivery methods as defined below:

Agency Based Provider Service delivery means the provision of services through a licensed or certified agency or through a contracted vendor. Under this method, participants choose from which provider they wish to receive services. Services are then provided by the chosen agency. It is then the responsibility of the provider agency to perform the functions of supervising, hiring, assuring that provider qualifications are met, scheduling, paying the wages, etc. of the agency's employees. All waiver service categories are available under the Agency Based Provider Service delivery method.

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

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

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

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

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

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:

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

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

Appendix E: Participant Direction of Services

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

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

Initially, the SMA NCW Unit will provide a general orientation to the self-administered approach, including written materials, to each individual during the waiver eligibility determination and enrollment process. At the time information will be provided regarding the freedom to choose self-administration, the mandatory use of a Financial Management Agent, and the responsibilities/risks of the waiver enrollee and the case management agency related to self-administration.

During the comprehensive needs assessment process, the case management agency will identify each individual's needs that can be addressed through one or more of the available self-administered waiver services. The case management agency will inform the individual of the opportunity to utilize self-administration for the identified services and discuss the option to directly employ the provider or to utilize an agency based provider.

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

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:

Individuals possessing decision making capability, but having communication deficits or Limited English Proficiency (LEP) may select a representative to communicate decisions on the individual's behalf.

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
Chore Services		

Waiver Service	Employer Authority	Budget Authority
Respite		
Homemaker		
Attendant Care 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 service.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

Payment for FMS is a monthly unit that is paid to the providers.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide (*check each that applies*):

Supports furnished when the participant is the employer of direct support workers:

Assist participant in verifying support worker citizenship status

Collect and process timesheets of support workers

Process payroll, withholding, filing and payment of applicable federal, state and local employment-

related taxes and insurance**Other***Specify:*

In support of self-administration, Financial Management Services will assist individuals in the following activities:

1. Verify that the employee completed the following forms
 - a. Form I-9, including supporting documentation (i.e. copies of driver's license, social security card, passport). If fines are levied against the person for failure to report INS information, the Fiscal Agent shall be responsible for all such fines.
 - b. Form W-4
2. Obtain a completed and signed Form 2678, Employer Appointment of Agent, from each person receiving services from the Financial Management Services provider, in accordance with IRS Revenue Procedure 70-6.
3. Provide persons with a packet of all required forms when using a Financial Management Services provider, including all tax forms (IRS Forms I-9, W-4 and 2678), payroll schedule, Financial Management Services provider's contact information, and training material for the web-based timesheet.
4. Process and pay approved employee timesheets, including generating and issuing paychecks to employees hired by the person.
5. Assume all fiscal responsibilities for withholding and depositing FICA and SUTA/FUTA payments on behalf of the person. Any federal and/or State penalties assessed for failure to withhold the correct amount and/or timely filing and depositing will be paid by the Financial Management Services provider.
6. Maintain a customer service system for persons and employees who may have billing questions or require assistance in using the web-based timesheet. The Financial Management Services provider will maintain an 800-number for calls received outside the immediate office area. Messages must be returned within 24 hours Monday thru Friday. Messages left between noon on Friday and Sunday evening shall be returned the following Monday.
 - a. Must have capabilities in providing assistance in English and Spanish. Fiscal Agent must also communicate through TTY, as needed, for persons with a variety of disabilities.
7. File consolidated payroll reports for multiple employers. The Financial Management Services provider must obtain federal designation as Financial Management Services provider under IRS Rule 3504, (Acts to be Performed by Agents). A Financial Management Services provider applicant must make an election with the appropriate IRS Service Center via Form 2678, (Employer Appointment of Agent). The Financial Management Services provider must carefully consider if they want to avail the Employers of the various tax relief provisions related to domestics and family employers. The Financial Management Services provider may forego such benefits to maintain standardization. Treatment on a case-by-case basis is tedious, and would require retroactive applications and amended employment returns. The Financial Management Services provider will, if required, comply with IRS Regulations 3306(a)(3)(c)(2), 3506 and 31.3306(c)(5)-1 and 31.3506 (all parts), together with IRS Publication 926, Household Employer's Tax Guide. In order to be fully operational, the Form 2678 election should be postured to fall under two vintages yet fully relevant Revenue Procedures; Rev. Proc. 70-6 allows the Financial Management Services provider file one employment tax return, regardless of the number of employers they are acting for, provided the Financial Management Services provider has a properly executed Form 2678 from each Employer. Rev. Proc 80-4 amplifies 70-6, and does away with the multiple Form 2678

Supports furnished when the participant exercises budget authority:

Maintain a separate account for each participant's participant-directed budget

Track and report participant funds, disbursements and the balance of participant funds

Process and pay invoices for goods and services approved in the service plan

Provide participant with periodic reports of expenditures and the status of the participant-directed budget

Other services and supports

Specify:

Additional functions/activities:

Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency

Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency

Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget

Other

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

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

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 case management team will identify each individuals needs that can be addressed through one or more of the available self-administered waiver services. The case management team will inform the individual of the opportunity to utilize self-direction for the identified services and discuss the option to directly employ the provider or to utilize an agency based provider.

Waiver Service Coverage.

Information and assistance in support of participant direction are provided through the 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
Environmental Accessibility Adaptations	
Transportation - Non-Medical	
Personal Budget Assistance	
Consumer Preparation Services	
Chore Services	
Habilitation	
Supportive Maintenance Services	
Respite	
Homemaker	
Adult Day Care	
Specialized Medical Equipment, Supplies and Supplements	
Home Delivered Meals	
Attendant Care Services	
Financial Management Services	
Assistive Technology Devices	
Caregiver Training	
Personal Emergency Response System	
Adult Residential Services	
Community Living Services	
Medication Administration Assistance Services	
Case Management	

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)

i. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

In the event the individual make a voluntary declaration to terminate self-direction of one or more waiver services, the case management provider will revise the care plan to address access to necessary services through agency based providers. This includes a process to phase-in/phase-out services as necessary to ensure continuity, prevent duplication, and ensure participant health and welfare during the transition. This process will include all aspects of care plan development including participation by the participant and individuals of his or her choosing and offering choice of providers.

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.

Prior to enrolling in self-administered services, the participant/representative is informed of their responsibilities and the rules that must be followed in order to participate. The individual is provided with the Self-Administered Services Packet which outlines the rules for participating in self-administered services. In addition, the participant/representative is required to sign a self-administered services agreement which outlines the conditions which the participant must comply with in order to use the self-administered services method. Only after a participant has demonstrated an incapacity for self-administration, including the inability to perform the essential functions of managing employees, hiring, training, scheduling or firing etc. or problems with fraud or malfeasance have been identified and has no qualified appointed person to direct the services on behalf of the participant, would involuntary termination of self-administered services occur. Prior to that occurrence however, the state offers participants who are struggling with self-administering their services assistance through case managers and/or Consumer Preparation Services. Health and welfare and continuity of services are assured during the transition process because the consumer continues to receive services under the self-administered services method until the transfer to the agency-based provider method is made. This process will include all aspects of care plan development including participation by the participant and individuals of his or her choosing and offering choice of providers.

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	35	
Year 2	40	
Year 3	45	
Year 4	50	
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:

The employee pays for the BCI

Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

Requirements do 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.

- . Upon the individual's choice of home and community based services, the case management agency conducts a comprehensive assessment. The comprehensive assessment identifies; (a) the individual's needs related to assuring health, welfare, and safety in a home or community setting in lieu of institutionalization and (b) the individual's goals related to enhancing community integration and quality of life.
2. The individual is informed of the results of the assessment and the specific needs identified as related to assuring health, welfare, and safety in a home or community setting in lieu of institutionalization.
3. The individual is informed that the SMA provides an opportunity for a fair hearing, under 42 CFR Part 431, Subpart E, to individuals who are not advised of the results of the comprehensive assessment or feel the assessment results do not accurately reflect the individual's preferences, strengths, and goals related to enhancing their community integration and quality of life, or their needs related to assuring health, welfare, and safety in a home and community setting in lieu of institutionalization.
4. Written documentation of the individual's acknowledgement that the case management agency fully disclosed the results of the comprehensive assessment and the right to a fair hearing is documented.
5. From the comprehensive assessment, a written care plan is developed by the case management agency in accordance with Appendix D-1 to address the individual's identified needs through a specified array of services and supports. The written care plan may also incorporate other optional services and supports that are not primary to preventing institutionalization or protecting health and safety but will contribute in assisting the individual to achieve personal goals for independence and community integration. The care plan will identify these other services and support as optional and will identify funding sources other than Medicaid to cover any associated costs.
6. The individual is informed that the SMA provides an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to individuals who are not advised of the content of the care plan, are not advised of the specific service providers responsible for providing identified services, or who feel the care plan does not accurately reflect the individual's needs related to assuring health, welfare, and safety in a home and community setting in lieu of institutionalization or the individual's preferences, strengths and goals related to enhancing the participant's community integration and quality of life.
7. Written documentation of the individual's acknowledgement that the case management agency fully disclosed the results of the care plan development, afforded free choice of providers, and the right to a fair hearing is documented.
8. The Division of Medicaid and Health Financing provides an individual applying for or receiving waiver services an opportunity for a hearing upon written request, if the individual is:
 - a) Not given the choice of institutional (NF) care or HCBS waiver services.
 - b) Denied the waiver provider(s) of choice if more than one provider is available to render the service(s).
 - c) Denied access to waiver services identified as necessary to prevent institutionalization or given services that are insufficient in amount, duration or frequency to meet the identified need.
 - d) Experiences a reduction, suspension, or termination of waiver services identified as necessary to prevent institutionalization.
9. An individual and the individual's legal representative, as applicable, will receive a written Notice of Agency Action from the Single State Medicaid Agency if the individual is denied a choice of institutional or New Choices Waiver program, or found ineligible for the waiver program. Copies of notices of adverse action are kept on file with the SMA NCW Unit and with the Fair Hearings Unit within the SMA.
10. An individual and the individual's legal representative, as applicable, will receive a written Notice of Agency Action from the SMA if the individual is denied access to the provider of choice for a covered waiver service. The Notice of Agency Action delineates the individual's right to appeal the decision.
11. An aggrieved individual may request a formal hearing within 30 calendar days from the date written notice is issued or mailed, whichever is later. The Division of Medicaid and Health Financing may reinstate services for recipients or suspend any adverse action for providers if the aggrieved person requests a formal hearing not more than ten calendar days after the date of action.
12. The individual is encouraged to utilize an informal dispute resolution process to expedite equitable solutions but may forgo

or interrupt the available informal resolution process at any time by completing a request for hearing and directing the request be sent to the Department of Health for a formal hearing and determination. Participants are informed in the Utah Medicaid Member Guide that the Additional Dispute Resolution is not a pre-requisite for a Fair Hearing.

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

Appendix F: 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.

The CMA will describe the participants ability to contact the SMA constituent services line to discuss issues or concerns. The SMA constituent services representative will log the issue and will assign the review to the Bureau of Long Term Services and Supports staff to review and follow-up as necessary. Documentation of the issue and outcome will be retained by the SMA.

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

Types of disputes that can be brought to the informal dispute resolution process include:

1. Denial of choice of home and community-based services as an alternative to institutional care,
2. Denial, reduction, termination or suspension of a waiver service, and/or
3. Denial of a service of the participant's choice or choice of providers when there is more than one willing, qualified provider in the service area.

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

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

Appendix F: 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:

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

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

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

The grievance/complaint resolution activities will either be completed within the time limits allowed for filing a request for a fair hearing or the waiver participants will be advised of the need to file a request for a fair hearing within the allowed time limits and the option to begin the informal dispute resolution process during the interim period until the fair hearing is actually scheduled and conducted. The grievance/complaint system is not a re-requisite or substitute for a fair hearing.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program. *Select one:*

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.

Standard Operating Procedure for Critical Incidents and Events Reporting Requirements: Any person, provider or other entity can report incidents.

Reporting requirements:

The case management agency will notify the SMA NCW Unit of any negative events/incidents experienced by participants within 24 hours or on the first business day after the incident.

The SMA NCW Unit will notify the SMA QA Unit of any Level I critical events/incidents within 24 hours of the incident or on the first business day after being notified of the incident. Level II critical incidents will be reported to the SMA QA Unit on a quarterly basis.

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

Reportable Critical Incidents/Events:

The following list Level I Critical Incidents must be reported by the SMA NCW Unit to the SMA QA Unit. This is not an all-inclusive list. Other incidents that rise to a comparable level must be reported to the SMA QA Unit.

1. Unexpected Hospitalization

Admission to the hospital for medical treatment related to one or more of the following reasons:

- a. Injuries that result in the loss of physical or mental function. (ie; loss of limb, paralysis, brain injury or memory loss);
- b. Alleged/substantiated abuse or neglect;
- c. Attempted suicide;
- d. Medication errors;
- e. Self-Injurious behavior; and/or
- f. Substance Abuse

2. Exploitation (Either Alleged or Substantiated)

Unfairly taking advantage of a participant due to his/her age, health, and/or disability.

- a. Serious and/or patterned/repeated event(s)- involving a single participant,
 - b. Involving multiple participants.
- 3. Human Rights Violations**
- a. Serious infringements of participant human rights (jeopardizing the health and safety of the participant);
 - b. Exceptions;
 - i. Restrictive/intrusive intervention(s) must be clearly defined in individualized Behavior Support Plans and/or Care Plan/Person Centered Support Plans pursuant to 42 CFR §441.301(c)(4)(5).
 - ii. Emergency Behavioral Interventions as defined by Utah Administrative Code, Title R539-4-6 are not considered a Human Rights Violation.

4. Incidents Involving the Media or Referred by Elected Officials

Incidents that have or are anticipated to receive public attention (i.e. events covered in the media or referred by the Governor, legislators or other elected officials).

5. Missing Persons

For reporting purposes, the following participants are considered to be missing:

- a. Participants who have been missing for at least twenty-four hours; or
- b. Regardless of the number of hours missing – any participant who is missing under unexplained, involuntary or suspicious circumstances and is believed to be in danger because of age, health, mental or physical disability, environment or weather or who could be in the company of a potentially dangerous person or some other factor that places the participant in peril.

6. Unexpected Deaths

All deaths are considered unexpected with the exception of:

- a. Participants receiving hospice care; and/or

b. Deaths due to natural causes, general system failure or terminal/chronic health conditions.

A death related to an adverse event that occurs while the participant is receiving treatment in an in-patient facility, which is regulated by Health Facilities Licensing and Certification, should be reported as an unexpected death, the QA/SMA team may opt not to require an investigation. (Reportable to Health Facilities Licensing)

7. Waste, Fraud or Abuse of Medicaid Funds

Alleged or confirmed waste, fraud or abuse of Medicaid funds

a. Perpetrated by the provider, or

b. Perpetrated by the participant.

8. Law Enforcement Involvement

Charges filed against the participant for activities resulting in the:

a. Hospitalization of another (i.e. aggravated assault),

b. Death of another; and/or

c. Abuse and or exploitation of a vulnerable person, due to age, health, and/or disability.

9. Private Health Information (PHI)/Personal Identifiable Information (PII) Security Breach

Any activity that could potentially put sensitive information at risk of unauthorized use, access, disclosure, or modification.

Procedure for Reporting Level I Critical Incidents and Events to the SMA QA Unit:

- On the first business day after a critical incident has occurred, a representative from the SMA NCW Unit will notify a member of the SMA QA Unit via email, telephone or in person. If the SMA NCW Unit has any question about whether a case meets the criteria for reporting to the SMA QA Unit, the SMA NCW Unit will contact the SMA QA Unit for technical assistance.

- Within ten business days after notification, the SMA NCW Unit will submit a completed Critical Incident Investigation form to the SMA QA Unit.

- Within five business days after receiving the Critical Incident Investigation form the SMA QA Unit will review the investigation form submitted by the SMA NCW Unit and will contact the SMA NCW Unit if additional information or action is required.

- When the SMA QA Unit determines the investigation is complete, the SMA QA Unit will document any findings or corrective action requirements on the SMA QA Unit portion of the investigation form. The SMA QA Unit will send the SMA NCW Unit a copy of the finalized document, closing the case. In some cases, the SMA QA Unit may continue to monitor findings or corrective actions.

- Within two weeks after closing the case, the SMA QA Unit will notify the participant or the participant's representative of the investigation results. A copy of the notification letter will be provided to the SMA NCW Unit. The following types of incidents are excluded from the notification letter requirement: suicide attempt, missing person, death and investigations that conclude with dis-enrollment and/or are not concluded within six months of the original incident date.

In some cases it will not be possible to report the incident by the next business day after occurrence. In those cases, the incident must be reported the first business day after discovery. The SMA will review cases that are reported after discovery to evaluate whether the case should have been reported after occurrence, and if so, where the breakdown in reporting occurred.

The following list of Level II Critical Incidents must be reported by providers, participants and/or their representatives to the SMA NCW Unit, but are not required to be reported to the SMA QA Unit. This is not an all-inclusive list. Other incidents that rise to a comparable level must be reported to the NCW Unit.

1. Unexpected Medical Treatment (requiring immediate medical treatment at an emergency room)

Medical treatment related to one or more of the following reasons:

a. Abuse/Neglect/Exploitation (Either Alleged or Substantiated);

b. Medication Errors and/or;

c. Substance Abuse.

2. Abuse/Neglect/Exploitation (Either Alleged or Substantiated)

a. Exploitation of a participant's funds or property;

b. Theft and/or diverting of a participant's medication(s); and/or

c. Sexual assault/abuse/exploitation (regardless of medical treatment).

3. Human Rights Violations

Such as:

a. Unauthorized use of restrictive interventions- including but not limited to restraints (physical, mechanical or

chemical) ;

- b. Misapplied restrictive interventions, (included in the BSP);
- c. Unauthorized use of seclusion; and/or
- d. Unwelcome infringement of personal privacy rights;
- e. Violations of individual rights to dignity and respect.
- f. Exceptions;
- i. Restrictive/intrusive intervention(s) must be clearly defined in individualized Behavior Support Plans and/or Care Plan/Person Centered Support Plans pursuant to 42 CFR §441.301(c)(4)(5).
- ii. Emergency Behavioral Interventions as defined by Utah Administrative Code, Title R539-4-6 are not considered a Human Rights Violation.

Operating Agencies are responsible to ensure providers are compliant with 42 CFR §441.301(c)(4)(5)

4. Attempted Suicides

An attempted suicide which did not result in the participant being admitted to a hospital. (Suicide attempts do not include suicidal thoughts or threats without actions)

5. Compromised Working or Living Environment

An event in which the participant's working or living environment (e.g. roof collapse, fire, etc.) is compromised and the participant(s) require(s) evacuation.

6. Law Enforcement Involvement

a. Participant(s)

- i. Criminal charges filed (Not including those reportable to the SMA)

b. Staff

- i. Criminal charges filed (Make report to APS/CPS (when necessary)).
- ii. When staff is issued a moving violation while transporting participant(s).

For this category, the date of the incident will be recorded as the date on which the filing of charges occurred.

7. Unexpected Hospitalization

Admission to the hospital for medical treatment related to one or more of the following reasons:

- a. Injuries
- b. Aspiration
- c. Serious burns
- d. Choking

These do not include medical diagnoses that pose an expected risk for aspiration or choking. Also excluded from this category are self-injurious behavior or injuries resulting in loss of physical or mental function such as a loss of limb, paralysis, brain injury or memory loss experienced by a participant that resulted in admission to a hospital for medical treatment (which is reportable to the SMA).

Procedure for Reporting Level II Critical Incidents and Events to the SMA NCW Unit

- On the first business day after a critical incident has occurred , a representative from the case management or support coordination agency (case manager) will notify the SMA NCW Unit via email, telephone or in person.
- Within ten business days after notification, the case manager will submit a completed Critical Incident Investigation form to the SMA NCW Unit.
- Within five business days after receiving the Critical Incident Investigation form the SMA NCW Unit will review the investigation form submitted by the case manager and will contact the case manager if additional information or action is required.
- When the SMA NCW Unit determines the investigation is complete, the SMA NCW Unit will document any findings or corrective action requirements on the SMA NCW Unit portion of the investigation form. The SMA NCW Unit will send the case manager a copy of the finalized document, closing the case. In some cases, the SMA NCW Unit may continue to monitor findings or corrective actions.

Within two weeks after closing the case, the case manager will notify the participant or the participant's representative (in person, phone or in writing) of the investigation results and document notification in the participant's record. The following types of incidents are excluded from the notification requirement: suicide attempt, death, and investigations that conclude with dis-enrollment and/or are not concluded within six months of the original incident date.

2 In some cases it will not be possible to report the incident by the next business day after occurrence. In those cases, the incident must be reported the first business day after discovery. The OA will review cases that are reported after discovery to evaluate whether the case should have been reported after occurrence, and if so, where the breakdown in reporting occurred.

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.

As a component of the NCW application process, each applicant or designated representative will be provided with a list of rights and responsibilities, including protections related to abuse, neglect and exploitation. Applications will not be considered complete without this form signed by the participant or representative.

Furthermore, during the annual assessment and care planning process, the waiver case management agency will review participant rights and responsibilities with each participant and/or their representative and will provide avenues through which to notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation. Each participant and/or representative will be provided with a copy of their rights and responsibilities and with contact information to notify appropriate authorities or entities.

Participants receiving Consumer Preparation Services are provided with information/training on the following topics:

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

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

The SMA QA Unit is the entity that receives reports of level one incidents. Within ten days of reporting these types of incidents to SMA QA Unit, the RN case manager will investigate the incident and submit the Critical Incident Investigation document on which the details of the incident are recorded. Cases that are complicated and involve considerable investigation may require additional time to complete the Critical Incident Investigation document.

The SMA QA Unit then reviews the Critical Incident Investigation document 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 PCCP have been made, if any systemic issues were identified and a plan to address systemic issues developed. The SMA QA Unit then completes its portion of the Critical Incident Investigation document which includes a summary of the incident, remediation activities and findings and recommendations. At the conclusion of the investigation, participants are informed in writing of the investigation results within two weeks of the closure of the case by the SMA QA Unit when appropriate to the nature of the incident.

The State will apply the following burden of proof standard to determine if an alleged instance is substantiated: The probability that the incident occurred as a result of the alleged/suspected abuse, neglect and/or exploitation is clear and convincing.

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.

The Bureau of Long Term Services and Supports is the entity responsible for overseeing the reporting and response to level one critical incidents that affect waiver participants. Information about critical incidents is collected in the Bureau of Long Term Services and Supports critical incident database. This information is analyzed and an annual report is submitted to the State Medicaid Director which describes the number of incidents by category, number of incidents that resulted in corrective action by the RN case managers or the provider, number of corrective actions that were implemented and a summary analysis of systemic trends that required additional intervention or process improvement steps.

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:

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

During routine on-site visits to monitor quality of care, case managers observe residents in their daily environment and interview them to determine overall level of satisfaction with care and to determine whether any restraints, seclusions or other rights restrictions have occurred. Case management agencies are required to notify the SMA anytime a participant has been physically or chemically restrained or secluded in a facility, and the SMA is required to notify Licensing.

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:

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

During routine on-site visits to monitor quality of care, case managers observe residents in their daily environment and interview them to determine overall level of satisfaction with care and to determine whether any restraints, seclusions or other rights restrictions have occurred. Case management agencies are required to notify the SMA anytime a participant has been physically or chemically restrained or secluded in a facility, and the SMA is required to notify Licensing.

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:

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

During routine on-site visits to monitor quality of care, case managers observe residents in their daily environment and interview them to determine overall level of satisfaction with care and to determine whether any restraints, seclusions or other rights restrictions have occurred. Case management agencies are required to notify the SMA anytime a participant has been physically or chemically restrained or secluded in a facility, and the SMA is required to notify Licensing.

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.

The case management agency has primary responsibility for monitoring participant medication regimens within the scope of a Utah RN license as defined in the State's Nurse Practice Act Rule R156-31b. This monitoring process consists of reviewing the participants medication administration sheets at the assisted living facility to assure medications are being given as prescribed. In addition, periodic reviews to look for things like medication interactions or appropriate medication related laboratory testing are conducted as well. This is accomplished through ongoing interaction with the participant and provider of residential care services. The case management agency will address concerns with residential care service providers directly and document interaction and outcome. This record will be maintained and reviewed as part of the QA process. The case management agency will notify the SMA NCW Unit for additional follow up should issues remain unresolved.

Assisted Living rule R432-270-19 delineates the requirements for medication administration. Currently, assisted living facilities are surveyed every 2 years by HFLCRA nursing and social work staff. During these surveys, medication records are reviewed, and residents are observed in their daily environment and interviewed to determine facility compliance with these rules. HFLCRA also investigates complaints pertaining to issues with medication errors in facilities. Serious medication errors, if found, are cited as a violation. HFLCRA will require corrective actions. In addition, the SMA entered into a contract with HFLCRA to assure that New Choices Waiver recipients are included in the licensing review sample. If a specific issue is identified with a waiver participant during the licensing review, HFLCRA notifies the SMA immediately.

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

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

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

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

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).

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

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

Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).

Complete the following three items:

- (a) Specify state agency (or agencies) to which errors are reported:

- (b) Specify the types of medication errors that providers are required to *record*:

- (c) Specify the types of medication errors that providers must *report* to the state:

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.

Specify the types of medication errors that providers are required to record:

As per Administrative Rule - R432-270-19. Medication Administration. The SMA also requires that medication errors resulting in hospitalization, death or other serious outcomes are reported as per the Critical Incident/Events Reporting Protocol. The state does not have a rule that delineates the type of medication errors that providers are required to report.

- iv. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

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

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

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 instances of 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:

The number and percentage of referrals made to Adult Protective Services and/or law enforcement, according to state law, when there was reason to believe that abuse, neglect and/or exploitation had occurred. (N = # of referrals made; D = total # of referrals required)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Incident Reports, Participant Records

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number and percentage of Level I and Level II Critical Incidents involving abuse, neglect and exploitation of waiver participants where actions to protect health and welfare were implemented. (N = the number of reported incidents where actions to protect health and welfare were implemented; D = the total number of reportable incidents)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Incident Reports, Participant Records

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

		<input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number and percentage of unexplained or suspicious waiver participant deaths which were reviewed. (N = the # of deaths on the waiver which were reviewed; D = total # of waiver participant deaths)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Incident Reports, Participant Records

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

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: <input type="text"/>	Annually
	Continuously and Ongoing

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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:

The number and percentage of Level I and Level II Critical Incidents in which the case manager, when warranted, put effective safeguards and interventions in place that address the participant’s health and welfare needs. (N = # of incidents in compliance; D = total # of reportable incidents)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Incident Reports, Participant Records

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

The number and percentage of Level I and Level II Critical Incidents in which the case manager verified the effectiveness of new safeguards and interventions following an incident. (N = # of incidents in which safeguards were reviewed; D = total # of incidents requiring follow-up)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Incident Reports, Participant Records

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

The number and percentage of Level I and Level II Critical Incidents which were reported per the Standard Operating Procedure for Critical Incidents and Events Reporting Requirements (N = # of incidents reported; D = total # of reportable incidents)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Incident Reports, Participant Records

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>

	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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:

and % of Level I/II Critical Incidents identifying unauthorized use of restrictive interventions that were appropriately reported per the SOP for Critical Incidents and Events Reporting Requirements. (N = the # of incidents identifying the use of unauthorized interventions which were appropriately reported; D= total # of reportable incidents involving the use of unauthorized interventions)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Incident Reports, Participant Records

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input data-bbox="1078 1093 1264 1178" type="text"/>
Other Specify: <input data-bbox="408 1317 647 1402" type="text"/>	Annually	Stratified Describe Group: <input data-bbox="1078 1317 1264 1402" type="text"/>
	Continuously and Ongoing	Other Specify: <input data-bbox="1078 1541 1264 1626" type="text"/>
	Other Specify: <input data-bbox="718 1765 954 1850" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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 percentage of participants who were assessed to need medication assistance whose care plan addressed this need, either through the provision of waiver services, or natural supports. (N = # of participants where this need was addressed; D = total # of participants reviewed who required medication assistance)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Participant Records

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

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: <input type="text"/>	Annually
	Continuously and Ongoing

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Other Specify: <input type="text"/>

Performance Measure:

The number and percentage of participants using the self-administered model for service delivery for which the Emergency Back-up Plan Form was completed and current. (N = # of SAS users with a current and complete back-up plan; D = total # of SAS users requiring a back-up plan)

Data Source (Select one):

Other

If 'Other' is selected, specify:

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 = <input type="text" value="5"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other	

	Specify: <input style="width: 100%;" type="text"/>	
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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: <input style="width: 100%; height: 30px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 30px;" type="text"/>

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

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

The SMA NCW Unit and the SMA QA Unit follows the Standard Operating Procedure for Critical Incident and Events Reporting Requirements 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 SMA NCW Unit will notify the SMA QA Unit via email, telephone or in person. After reviewing the information provided describing the critical incident/event, the SMA QA Unit determines on a case-by-case basis if the incident or event requires an investigation. In cases where further investigation is required the operating agency completes the form "Critical Incident/Event Findings Operating Agency Report". The SMA QA Unit reviews the information provided 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 SMA NCW Unit and/or provider. 3) Findings and Recommendations including an assessment of the response to the incident/event and the identification of any issues related to reporting protocols. The SMA QA Unit notifies the SMA NCW Unit representative when the critical incident/event has been resolved.

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

b. Methods for Remediation/Fixing Individual Problems

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

ii. Remediation Data Aggregation

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

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/>	
	Continuously and Ongoing
	Other Specify: <input type="checkbox"/>

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 years results, thus allowing for tracking and trending of performance measures. After a three-year cycle of reviews (and annually thereafter), the performance measures will be analyzed to determine if, over time, a negative trend has occurred and if a systems improvement will address the problem. System improvement initiatives may be prioritized based on several factors including the health and welfare of participants, financial considerations, the intensity of the problem and the other performance measures relating to assurance being evaluated.

- ii. System Improvement Activities

Responsible Party(<i>check each that applies</i>):	Frequency of Monitoring and Analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Quality Improvement Committee	Annually
Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	Other Specify: <div style="border: 1px solid black; width: 100%; padding: 2px;">Third year of waiver operation</div>

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 Unit, the SMA New Choices Waiver Unit, and others. The team will meet to assess the results of the systems design changes. The success of the systems changes will be based on criteria that must be met to determine that the change has been accomplished and also criteria that will determine that the systems change has been sustained or will be sustained. The Quality Improvement Committee will determine the sustainability criteria. Results of system design changes will be communicated to participants and families, providers, agencies and others through the Medicaid Information Bulletin and the New Choices Waiver website.

- 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 SMAs quality management team. The team evaluates the data collection process and makes changes as necessary to allow for accurate data collection and analysis. In addition the Quality Improvement Committee will evaluate the QIS after the third year of the waiver operation. This committee will meet to discuss the elements of the QIS for each assurance, the findings relative to each performance measure and the contributions of all parties that conduct quality assurance of the New Choices waiver. Improvements to the QIS will be made at this time and submitted in the following waiver renewal application.

Appendix 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.

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.

During annual reviews, the State determines the random sample of waiver participants to be reviewed. Applicable care plans to the review period are selected, and claims pertinent to those care plan periods are reviewed.

The claims/providers reviewed are determined by the individuals included in the representative sample. A statistically significant sample of participants is reviewed annually. Applicable care plans to the review period are selected, and claims pertinent to those care plan periods are reviewed.

The State conducts a single audit in conformance with the Single Audit Act. The Office of the Utah State Auditor performs this audit. 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.

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.

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:

The number and percentage of claims that paid for services that do not exceed, individually or in the aggregate, the amount, frequency and duration identified on the participant's care plan. (N = # of claims in compliance; D = total # of claims paid).

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 = <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: 100px; text-align: center;">5</div>
Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 10px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 10px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 10px;"></div>
	Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 10px;"></div>	

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: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 10px;"></div>	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):
	<input type="text"/>

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):

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 = <input type="text" value="5"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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):
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other</i> Specify: <input type="text"/>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<i>Other</i> Specify: <input type="text"/>

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:

Paid claims review

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):
<i>State Medicaid Agency</i>	<i>Weekly</i>	<i>100% Review</i>
<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<i>Representative Sample</i> <i>Confidence Interval =</i> <input type="text" value="5"/>
<i>Other</i>	<i>Annually</i>	<i>Stratified</i>

<i>Specify:</i> <input style="width: 100%; height: 30px;" type="text"/>		<i>Describe Group:</i> <input style="width: 100%; height: 30px;" type="text"/>
	<i>Continuously and Ongoing</i>	<i>Other Specify:</i> <input style="width: 100%; height: 30px;" type="text"/>
	<i>Other Specify:</i> <input style="width: 100%; height: 30px;" type="text"/>	

Data Aggregation and Analysis:

<i>Responsible Party for data aggregation and analysis (check each that applies):</i>	<i>Frequency of data aggregation and analysis (check each that applies):</i>
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other Specify:</i> <input style="width: 100%; height: 30px;" type="text"/>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<i>Other Specify:</i> <input style="width: 100%; height: 30px;" type="text"/>

Performance Measure:

The number and percentage of claims, which paid for services identified on a participant's Comprehensive Care Plan. (N = # of claims paid in compliance; D = total # of claims paid)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Care Plans, Claims Data

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	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: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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 participant claims in a representative sample that paid for services using the correct HCPCS as identified on the comprehensive care plan. (N = # of claims in compliance; D = total # of paid claims)

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 = <div style="border: 1px solid black; display: inline-block; padding: 2px 10px;">5</div>
Other	Annually	Stratified

<i>Specify:</i> <input style="width: 100%; height: 20px;" type="text"/>		<i>Describe Group:</i> <input style="width: 100%; height: 20px;" type="text"/>
	<i>Continuously and Ongoing</i>	<i>Other Specify:</i> <input style="width: 100%; height: 20px;" type="text"/>
	<i>Other Specify:</i> <input style="width: 100%; height: 20px;" type="text"/>	

Data Aggregation and Analysis:

<i>Responsible Party for data aggregation and analysis (check each that applies):</i>	<i>Frequency of data aggregation and analysis (check each that applies):</i>
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other Specify:</i> <input style="width: 100%; height: 20px;" type="text"/>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<i>Other Specify:</i> <input style="width: 100%; height: 20px;" type="text"/>

Performance Measure:

Number of recoveries in a representative sample that are returned to the federal government in accordance with federal regulations. (N = # of claims returned; D = total # of claims requiring return)

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):
<i>State Medicaid Agency</i>	<i>Weekly</i>	<i>100% Review</i>
<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<i>Representative Sample</i> <i>Confidence Interval =</i> 5
<i>Other</i> <i>Specify:</i> <input type="text"/>	<i>Annually</i>	<i>Stratified</i> <i>Describe Group:</i> <input type="text"/>
	<i>Continuously and Ongoing</i>	<i>Other</i> <i>Specify:</i> <input type="text"/>
	<i>Other</i> <i>Specify:</i> <input type="text"/>	

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):
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other</i> <i>Specify:</i> <input type="text"/>	<i>Annually</i>

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: <input type="text"/>

Performance Measure:

Number and percentage of claims paid at the rate consistent with the approved waiver. (N = number of claims paid at the rate consistent with the approved waiver; D = total number of claims 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 = <input type="text" value="5"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify:	

	<input style="width: 80%; height: 30px;" type="text"/>	
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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):
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other</i> Specify: <input style="width: 100%; height: 30px;" type="text"/>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<i>Other</i> Specify: <input style="width: 100%; height: 30px;" type="text"/>

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

b. Methods for Remediation/Fixing Individual Problems

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.

Recovery of Funds:

When payments are made for a service not identified on the Comprehensive Care Plan: a recovery of unauthorized paid claims based upon the Federal Medical Assistance Percentage (FMAP) will be required.

When the amount of payments exceeds the amount, frequency, and/or duration identified on the Comprehensive Care Plan: a recovery of unauthorized paid claims based upon the Federal Medicaid Percentage (FMAP) will be required.

When payments are made for services based on a coding error: The coding error will be corrected by withdrawing the submission of the claim and submitting the correct code for payment.

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

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

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

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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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.

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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 process and annually as the rates are adjusted. Information about payment rates will be communicated using provider bulletins and letters, annual public notices, annual waiver training, and the New Choices Waiver website.

The State uses the following methodology to establish rates paid under the New Choices Waiver program:

The following services pay the same rate as Attendant Care under the State Plan:

-Attendant Care Services

The following services pay the same rate as Personal Care under the State Plan:

-Caregiver Training

-Consumer Preparation Services

-Homemaker

-Habilitation

-Medication Set-Up

-Personal Budget Assistance

-Respite Care (15 Min)

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 invoiced/market rate:

-Chore Service

-Community Transition Service

-Environmental Accessibility Adaptations (Home/Vehicle)

-Medication Reminder System

-Personal Emergency Response Systems

-Specialized Medical Equipment/Supplies/Assistive Technology

-Home Delivered Meals

-Assistive Technology Devices

-Transportation Non-Medical - Public Transit Pass

There are caps on the invoiced/market rate services listed above. Requests are evaluated on appropriateness which may include 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, mileage) – Uses current IRS rate of \$0.575 per mile

-Transportation (non-medical, one-way) – Uses current IRS rate of \$0.575 per mile for an encounter of 26 miles

-Case Management: Pays 124% of the State’s Targeted Case Management rate

For Adult Residential Rates, the State conducts a cost survey at least every 5 years on annual cost data to ensure average revenue is between 100 – 120% of allowable costs. Adult Residential Services - Certified Independent Living Facilities is calculated based on 57% of the Assisted Living Level I/II rate.

All service rates are posted on the state’s HCBS waiver website and rate change notices are published in newspapers and in the Utah State Bulletin which is located at rules.utah.gov. Rates can be adjusted based on appropriation changes from the Utah legislature.

All rate changes will be reviewed to identify whether the rate change adheres to existing policy including the methodologies described in the implementation plan. In addition, the data used to derive a particular rate is evaluated

and validated for completeness, accuracy, and reasonableness prior to a new rate being approved. If issues arise between BFS and BLTSS regarding rates setting methodologies, the appropriate resolution will be determined by the Medicaid Director's office. The State Medicaid Agency retains all authority over rate setting.

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

Waiver services providers submit claims directly to the SMA, the SMA then pays the waiver service provider directly. For individuals participating in the self-administered services delivery method, the participant submits their staff time sheet(s) to the FMS Agent. The FMS Agent pays the claim(s) and submits a bill to the SMA. The SMA reimburses the FMS.

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. A participant's Medicaid eligibility is determined by the Office of Health and Eligibility within the Department of Workforce Services or the Bureau of Eligibility Services within the Department of Health. The information is entered into the Public Assistance Case Management Information System (PACMIS). PACMIS is an on-line, menu-driven system which automates Medicaid eligibility decisions, benefits amounts, participants' notices and administrative reports. PACMIS interfaces with other governmental agencies such as, Social Security, Employment Security, and the Internal Revenue Service. The system is a Federally-Approved Management Information System (FAMIS). In Utah, the following programs are accessed through PACMIS: Aid to Families with Dependent Children (AFDC), Medicaid, Food Stamps, and two state-administered programs - General Assistance and the Primary Care Network (PCN). The Medicaid Management Information System (MMIS) accesses PACMIS to ensure the participant is Medicaid eligible before payment of claims is made.

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

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

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

Appendix I: 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:

The state utilizes some county agencies (Area Agencies on Aging) as case management providers. All other providers are private.

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.

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:

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:

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

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

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

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

Appendix I: 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	23158.07	3513.18	26671.25	58927.17	5909.00	64836.17	38164.92
2	23158.07	3513.18	26671.25	58927.17	5909.00	64836.17	38164.92
3	23158.07	3513.18	26671.25	58927.17	5909.00	64836.17	38164.92
4	23158.07	3513.18	26671.25	58927.17	5909.00	64836.17	38164.92
5	23158.07	3513.18	26671.25	58927.17	5909.00	64836.17	38164.92

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	2500		2500
Year 2	2500		2500

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 3	2500		2500
Year 4	2500		2500
Year 5	2500		2500

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): 284 Days

Used the average LOS count for the past 3 State fiscal years (2017, 2018, 2019)

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
 -WY1 unduplicated count estimates were based off of WY5 enrollment. Due to the tie between Reserved Capacity and Assisted Living enrollment, the State monitors enrollment figures and commits to amending the waiver should adjustments in these amounts be necessary.
 -An anticipated rate of growth has not been included in the estimates where rate adjustments are subject to legislative approval and may not occur on a scheduled basis. The State will seek approval on any substantive changes (>10%) 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'
 -An anticipated rate of growth has not been included in the estimate where there does not appear to be a trend in expenditures. The State has used information from recent experience and agrees to modify amounts should 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 year 2018 and 2019 and multiplied by actual NCW waiver LOS to get fiscal year 2021 base estimate
 -An anticipated rate of growth has not been included in the estimate where there does not appear to be a trend in expenditures. The State has used information from recent experience and agrees to modify amounts should 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 year 2018 and 2019 and multiplied by actual NCW waiver LOS to get fiscal year 2021 base estimate
 -The state utilizes the MMIS Categories of Service and Provider Type functionality to account for and exclude the costs of prescribed drugs from D'
 -An anticipated rate of growth has not been included in the estimate where there does not appear to be a trend in expenditures. The State has used information from recent experience and agrees to modify amounts should 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.

<i>Waiver Services</i>	
<i>Adult Day Care</i>	
<i>Case Management</i>	
<i>Habilitation</i>	
<i>Homemaker</i>	
<i>Respite</i>	
<i>Supportive Maintenance Services</i>	
<i>Consumer Preparation Services</i>	
<i>Financial Management Services</i>	
<i>Adult Residential Services</i>	
<i>Assistive Technology Devices</i>	
<i>Attendant Care Services</i>	
<i>Caregiver Training</i>	
<i>Chore Services</i>	
<i>Community Living Services</i>	
<i>Environmental Accessibility Adaptations</i>	
<i>Home Delivered Meals</i>	
<i>Medication Administration Assistance Services</i>	
<i>Personal Budget Assistance</i>	
<i>Personal Emergency Response System</i>	
<i>Specialized Medical Equipment, Supplies and Supplements</i>	
<i>Transportation - Non-Medical</i>	

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 Care Total:						72245.16
Adult Day Care	Day	13	129.00	43.08	72245.16	
Case Management Total:						6129680.48
Case Management	15 Minute	2486	119.00	20.72	6129680.48	
Habilitation Total:						94503.84
Habilitation	15 Minute	59	284.00	5.64	94503.84	
Homemaker Total:						1049310.72
Homemaker	15 Minute	144	1292.00	5.64	1049310.72	
Respite Total:						241819.50
Hourly	15 Minute	14	2916.00	5.64	230247.36	
Overnight, Out of Home, Room and Board Included	Day	3	19.00	203.02	11572.14	
Supportive Maintenance Services Total:						51208.20
Supportive Maintenance Services	Visit	9	145.00	39.24	51208.20	
Consumer Preparation Services Total:						56.40
Consumer Preparation Services	15 Minute	1	10.00	5.64	56.40	
Financial Management Services Total:						42858.00
Financial Management Services	Month	45	10.00	95.24	42858.00	
Adult Residential Services Total:						42825365.60
Licensed Community Residential Care	Day	28	320.00	103.25	925120.00	
Licensed Assisted Living Facilities, Memory Care Unit	Day	322	184.00	79.96	4737470.08	
GRAND TOTAL:						57895164.82
Total Estimated Unduplicated Participants:						2500
Factor D (Divide total by number of participants):						23158.07
Average Length of Stay on the Waiver:						284

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Living Facilities, Level I, Level II and Type N	Day	2037	260.00	69.01	36549076.20	
Certified Independent Living Facilities	Day	73	221.00	38.04	613699.32	
Assistive Technology Devices Total:						1187.30
Assistive Technology Devices	Per Item	5	2.00	118.73	1187.30	
Attendant Care Services Total:						2499266.56
Attendant Care Services	15 Minute	833	586.00	5.12	2499266.56	
Caregiver Training Total:						56.40
Caregiver Training	15 Minute	1	10.00	5.64	56.40	
Chore Services Total:						31917.60
Chore Services	Each	31	10.00	102.96	31917.60	
Community Living Services Total:						534125.10
Community Living Services	Per Service	443	2.00	602.85	534125.10	
Environmental Accessibility Adaptations Total:						5441.78
Home Modifications	Per Service	7	1.00	773.86	5417.02	
Vehicle modification	Per Service	1	1.00	24.76	24.76	
Home Delivered Meals Total:						168522.51
Home Delivered Meals	Per Meal	93	263.00	6.89	168522.51	
Medication Administration Assistance Services Total:						73055.34
Medication Reminder System	Month	53	6.00	56.49	17963.82	
Medication Set-up	15 Minute	37	264.00	5.64	55091.52	
Personal Budget Assistance Total:						195708.00
Personal Budget Assistance	15 Minute	347	100.00	5.64	195708.00	
Personal Emergency Response System						115130.51
GRAND TOTAL:					57895164.82	
Total Estimated Unduplicated Participants:					2500	
Factor D (Divide total by number of participants):					23158.07	
Average Length of Stay on the Waiver:						284

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:						
Purchase, Rental, Repair	Per Item	54	1.00	229.92	12415.68	
Response Center Service Fee	Month	175	11.00	51.59	99310.75	
Installation, Testing & Removal	Per Service	68	1.00	50.06	3404.08	
Specialized Medical Equipment, Supplies and Supplements Total:						2645145.00
Specialized Medical Equipment, Supplies and Supplements	Per Item	1367	180.00	10.75	2645145.00	
Transportation - Non- Medical Total:						1118560.82
Per Mile	Per Mile	1	100.00	0.57	57.00	
Per One-Way Trip	Per Trip	742	94.00	14.84	1035060.32	
Public Transit Pass	Month	135	10.00	61.81	83443.50	
GRAND TOTAL:					57895164.82	
Total Estimated Unduplicated Participants:					2500	
Factor D (Divide total by number of participants):					23158.07	
Average Length of Stay on the Waiver:						284

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 Care Total:						72245.16
Adult Day Care	Day	13	129.00	43.08	72245.16	
Case Management Total:						6129680.48
Case Management	15 Minute				6129680.48	
GRAND TOTAL:					57895164.82	
Total Estimated Unduplicated Participants:					2500	
Factor D (Divide total by number of participants):					23158.07	
Average Length of Stay on the Waiver:						284

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		2486	119.00	20.72		
Habilitation Total:						94503.84
Habilitation	15 Minute	59	284.00	5.64	94503.84	
Homemaker Total:						1049310.72
Homemaker	15 Minute	144	1292.00	5.64	1049310.72	
Respite Total:						241819.50
Hourly	15 Minute	14	2916.00	5.64	230247.36	
Overnight, Out of Home, Room and Board Included	Day	3	19.00	203.02	11572.14	
Supportive Maintenance Services Total:						51208.20
Supportive Maintenance Services	Visit	9	145.00	39.24	51208.20	
Consumer Preparation Services Total:						56.40
Consumer Preparation Services	15 Minute	1	10.00	5.64	56.40	
Financial Management Services Total:						42858.00
Financial Management Services	Month	45	10.00	95.24	42858.00	
Adult Residential Services Total:						42825365.60
Licensed Community Residential Care	Day	28	320.00	103.25	925120.00	
Licensed Assisted Living Facilities, Memory Care Unit	Day	322	184.00	79.96	4737470.08	
Assisted Living Facilities, Level I, Level II and Type N	Day	2037	260.00	69.01	36549076.20	
Certified Independent Living Facilities	Day	73	221.00	38.04	613699.32	
Assistive Technology Devices Total:						1187.30
Assistive Technology Devices	Per Item	5	2.00	118.73	1187.30	
Attendant Care Services Total:						2499266.56
Attendant Care Services	15 Minute				2499266.56	
GRAND TOTAL:						57895164.82
Total Estimated Unduplicated Participants:						2500
Factor D (Divide total by number of participants):						23158.07
Average Length of Stay on the Waiver:						284

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		833	586.00	5.12		
Caregiver Training Total:						56.40
Caregiver Training	15 Minute	1	10.00	5.64	56.40	
Chore Services Total:						31917.60
Chore Services	Each	31	10.00	102.96	31917.60	
Community Living Services Total:						534125.10
Community Living Services	Per Service	443	2.00	602.85	534125.10	
Environmental Accessibility Adaptations Total:						5441.78
Home Modifications	Per Service	7	1.00	773.86	5417.02	
Vehicle modification	Per Service	1	1.00	24.76	24.76	
Home Delivered Meals Total:						168522.51
Home Delivered Meals	Per Meal	93	263.00	6.89	168522.51	
Medication Administration Assistance Services Total:						73055.34
Medication Reminder System	Month	53	6.00	56.49	17963.82	
Medication Set-up	15 Minute	37	264.00	5.64	55091.52	
Personal Budget Assistance Total:						195708.00
Personal Budget Assistance	15 Minute	347	100.00	5.64	195708.00	
Personal Emergency Response System Total:						115130.51
Purchase, Rental, Repair	Per Item	54	1.00	229.92	12415.68	
Response Center Service Fee	Month	175	11.00	51.59	99310.75	
Installation, Testing & Removal	Per Service	68	1.00	50.06	3404.08	
Specialized Medical Equipment, Supplies and Supplements Total:						2645145.00
Specialized					2645145.00	
GRAND TOTAL:						57895164.82
Total Estimated Unduplicated Participants:						2500
Factor D (Divide total by number of participants):						23158.07
Average Length of Stay on the Waiver:						284

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Medical Equipment, Supplies and Supplements	Per Item	1367	180.00	10.75		
Transportation - Non-Medical Total:						1118560.82
Per Mile	Per Mile	1	100.00	0.57	57.00	
Per One-Way Trip	Per Trip	742	94.00	14.84	1035060.32	
Public Transit Pass	Month	135	10.00	61.81	83443.50	
GRAND TOTAL:						57895164.82
Total Estimated Unduplicated Participants:						2500
Factor D (Divide total by number of participants):						23158.07
Average Length of Stay on the Waiver:						284

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 Care Total:						72245.16
Adult Day Care	Day	13	129.00	43.08	72245.16	
Case Management Total:						6129680.48
Case Management	15 Minute	2486	119.00	20.72	6129680.48	
Habilitation Total:						94503.84
Habilitation	15 Minute	59	284.00	5.64	94503.84	
Homemaker Total:						1049310.72
Homemaker	15 Minute	144	1292.00	5.64	1049310.72	
Respite Total:						241819.50
Hourly	15 Minute	14	2916.00	5.64	230247.36	
GRAND TOTAL:						57895164.82
Total Estimated Unduplicated Participants:						2500
Factor D (Divide total by number of participants):						23158.07
Average Length of Stay on the Waiver:						284

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Overnight, Out of Home, Room and Board Included	Day	3	19.00	203.02	11572.14	
Supportive Maintenance Services Total:						51208.20
Supportive Maintenance Services	Visit	9	145.00	39.24	51208.20	
Consumer Preparation Services Total:						56.40
Consumer Preparation Services	15 Minute	1	10.00	5.64	56.40	
Financial Management Services Total:						42858.00
Financial Management Services	Month	45	10.00	95.24	42858.00	
Adult Residential Services Total:						42825365.60
Licensed Community Residential Care	Day	28	320.00	103.25	925120.00	
Licensed Assisted Living Facilities, Memory Care Unit	Day	322	184.00	79.96	4737470.08	
Assisted Living Facilities, Level I, Level II and Type N	Day	2037	260.00	69.01	36549076.20	
Certified Independent Living Facilities	Day	73	221.00	38.04	613699.32	
Assistive Technology Devices Total:						1187.30
Assistive Technology Devices	Per Item	5	2.00	118.73	1187.30	
Attendant Care Services Total:						2499266.56
Attendant Care Services	15 Minute	833	586.00	5.12	2499266.56	
Caregiver Training Total:						56.40
Caregiver Training	15 Minute	1	10.00	5.64	56.40	
Chore Services Total:						31917.60
Chore Services	Each	31	10.00	102.96	31917.60	
Community Living Services Total:						534125.10
Community Living Services	Per Service	443	2.00	602.85	534125.10	
GRAND TOTAL:						57895164.82
Total Estimated Unduplicated Participants:						2500
Factor D (Divide total by number of participants):						23158.07
Average Length of Stay on the Waiver:						284

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Accessibility Adaptations Total:						5441.78
Home Modifications	Per Service	7	1.00	773.86	5417.02	
Vehicle modification	Per Service	1	1.00	24.76	24.76	
Home Delivered Meals Total:						168522.51
Home Delivered Meals	Per Meal	93	263.00	6.89	168522.51	
Medication Administration Assistance Services Total:						73055.34
Medication Reminder System	Month	53	6.00	56.49	17963.82	
Medication Set-up	15 Minute	37	264.00	5.64	55091.52	
Personal Budget Assistance Total:						195708.00
Personal Budget Assistance	15 Minute	347	100.00	5.64	195708.00	
Personal Emergency Response System Total:						115130.51
Purchase, Rental, Repair	Per Item	54	1.00	229.92	12415.68	
Response Center Service Fee	Month	175	11.00	51.59	99310.75	
Installation, Testing & Removal	Per Service	68	1.00	50.06	3404.08	
Specialized Medical Equipment, Supplies and Supplements Total:						2645145.00
Specialized Medical Equipment, Supplies and Supplements	Per Item	1367	180.00	10.75	2645145.00	
Transportation - Non- Medical Total:						1118560.82
Per Mile	Per Mile	1	100.00	0.57	57.00	
Per One-Way Trip	Per Trip	742	94.00	14.84	1035060.32	
Public Transit Pass	Month	135	10.00	61.81	83443.50	
GRAND TOTAL:						57895164.82
Total Estimated Unduplicated Participants:						2500
Factor D (Divide total by number of participants):						23158.07
Average Length of Stay on the Waiver:						284

Appendix J: Cost Neutrality Demonstration

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 Care Total:						72245.16
Adult Day Care	Day	13	129.00	43.08	72245.16	
Case Management Total:						6129680.48
Case Management	15 Minute	2486	119.00	20.72	6129680.48	
Habilitation Total:						94503.84
Habilitation	15 Minute	59	284.00	5.64	94503.84	
Homemaker Total:						1049310.72
Homemaker	15 Minute	144	1292.00	5.64	1049310.72	
Respite Total:						241819.50
Hourly	15 Minute	14	2916.00	5.64	230247.36	
Overnight, Out of Home, Room and Board Included	Day	3	19.00	203.02	11572.14	
Supportive Maintenance Services Total:						51208.20
Supportive Maintenance Services	Visit	9	145.00	39.24	51208.20	
Consumer Preparation Services Total:						56.40
Consumer Preparation Services	15 Minute	1	10.00	5.64	56.40	
Financial Management Services Total:						42858.00
Financial Management Services	Month	45	10.00	95.24	42858.00	
Adult Residential Services Total:						42825365.60
Licensed					925120.00	
GRAND TOTAL:						57895164.82
Total Estimated Unduplicated Participants:						2500
Factor D (Divide total by number of participants):						23158.07
Average Length of Stay on the Waiver:						284

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Residential Care	Day	28	320.00	103.25		
Licensed Assisted Living Facilities, Memory Care Unit	Day	322	184.00	79.96	4737470.08	
Assisted Living Facilities, Level I, Level II and Type N	Day	2037	260.00	69.01	36549076.20	
Certified Independent Living Facilities	Day	73	221.00	38.04	613699.32	
Assistive Technology Devices Total:						1187.30
Assistive Technology Devices	Per Item	5	2.00	118.73	1187.30	
Attendant Care Services Total:						2499266.56
Attendant Care Services	15 Minute	833	586.00	5.12	2499266.56	
Caregiver Training Total:						56.40
Caregiver Training	15 Minute	1	10.00	5.64	56.40	
Chore Services Total:						31917.60
Chore Services	Each	31	10.00	102.96	31917.60	
Community Living Services Total:						534125.10
Community Living Services	Per Service	443	2.00	602.85	534125.10	
Environmental Accessibility Adaptations Total:						5441.78
Home Modifications	Per Service	7	1.00	773.86	5417.02	
Vehicle modification	Per Service	1	1.00	24.76	24.76	
Home Delivered Meals Total:						168522.51
Home Delivered Meals	Per Meal	93	263.00	6.89	168522.51	
Medication Administration Assistance Services Total:						73055.34
Medication Reminder System	Month	53	6.00	56.49	17963.82	
Medication Set-up	15 Minute	37	264.00	5.64	55091.52	
Personal Budget Assistance Total:						195708.00
GRAND TOTAL:						57895164.82
Total Estimated Unduplicated Participants:						2500
Factor D (Divide total by number of participants):						23158.07
Average Length of Stay on the Waiver:						284

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Budget Assistance	15 Minute	347	100.00	5.64	195708.00	
Personal Emergency Response System Total:						115130.51
Purchase, Rental, Repair	Per Item	54	1.00	229.92	12415.68	
Response Center Service Fee	Month	175	11.00	51.59	99310.75	
Installation, Testing & Removal	Per Service	68	1.00	50.06	3404.08	
Specialized Medical Equipment, Supplies and Supplements Total:						2645145.00
Specialized Medical Equipment, Supplies and Supplements	Per Item	1367	180.00	10.75	2645145.00	
Transportation - Non-Medical Total:						1118560.82
Per Mile	Per Mile	1	100.00	0.57	57.00	
Per One-Way Trip	Per Trip	742	94.00	14.84	1035060.32	
Public Transit Pass	Month	135	10.00	61.81	83443.50	
GRAND TOTAL:					57895164.82	
Total Estimated Unduplicated Participants:					2500	
Factor D (Divide total by number of participants):					23158.07	
Average Length of Stay on the Waiver:						284

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 Care Total:						72245.16
Adult Day Care	Day	13	129.00	43.08	72245.16	
GRAND TOTAL:					57895164.82	
Total Estimated Unduplicated Participants:					2500	
Factor D (Divide total by number of participants):					23158.07	
Average Length of Stay on the Waiver:						284

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						6129680.48
Case Management	15 Minute	2486	119.00	20.72	6129680.48	
Habilitation Total:						94503.84
Habilitation	15 Minute	59	284.00	5.64	94503.84	
Homemaker Total:						1049310.72
Homemaker	15 Minute	144	1292.00	5.64	1049310.72	
Respite Total:						241819.50
Hourly	15 Minute	14	2916.00	5.64	230247.36	
Overnight, Out of Home, Room and Board Included	Daily	3	19.00	203.02	11572.14	
Supportive Maintenance Services Total:						51208.20
Supportive Maintenance Services	Visit	9	145.00	39.24	51208.20	
Consumer Preparation Services Total:						56.40
Consumer Preparation Services	15 Minute	1	10.00	5.64	56.40	
Financial Management Services Total:						42858.00
Financial Management Services	Month	45	10.00	95.24	42858.00	
Adult Residential Services Total:						42825365.60
Licensed Community Residential Care	Day	28	320.00	103.25	925120.00	
Licensed Assisted Living Facilities, Memory Care Unit	Day	322	184.00	79.96	4737470.08	
Assisted Living Facilities, Level I, Level II and Type N	Day	2037	260.00	69.01	36549076.20	
Certified Independent Living Facilities	Day	73	221.00	38.04	613699.32	
Assistive Technology Devices Total:						1187.30
Assistive Technology Devices	Per Item	5	2.00	118.73	1187.30	
Attendant Care						2499266.56
GRAND TOTAL:						57895164.82
Total Estimated Unduplicated Participants:						2500
Factor D (Divide total by number of participants):						23158.07
Average Length of Stay on the Waiver:						284

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services Total:						
Attendant Care Services	15 Minute	833	586.00	5.12	2499266.56	
Caregiver Training Total:						
Caregiver Training	15 Minute	1	10.00	5.64	56.40	
Chore Services Total:						
Chore Services	Each	31	10.00	102.96	31917.60	
Community Living Services Total:						
Community Living Services	Per Service	443	2.00	602.85	534125.10	
Environmental Accessibility Adaptations Total:						
Home Modifications	Per Service	7	1.00	773.86	5417.02	
Vehicle modification	Per Service	1	1.00	24.76	24.76	
Home Delivered Meals Total:						
Home Delivered Meals	Per Meal	93	263.00	6.89	168522.51	
Medication Administration Assistance Services Total:						
Medication Reminder System	Each	53	6.00	56.49	17963.82	
Medication Set-up	15 Minute	37	264.00	5.64	55091.52	
Personal Budget Assistance Total:						
Personal Budget Assistance	15 Minute	347	100.00	5.64	195708.00	
Personal Emergency Response System Total:						
Purchase, Rental, Repair	Per Item	54	1.00	229.92	12415.68	
Response Center Service Fee	Month	175	11.00	51.59	99310.75	
Installation, Testing & Removal	Per Service	68	1.00	50.06	3404.08	
Specialized Medical Equipment, Supplies and Supplements						
						2645145.00
GRAND TOTAL:						57895164.82
Total Estimated Unduplicated Participants:						2500
Factor D (Divide total by number of participants):						23158.07
Average Length of Stay on the Waiver:						284

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:						
Specialized Medical Equipment, Supplies and Supplements	Per Item	1367	180.00	10.75	2645145.00	
Transportation - Non-Medical Total:						1118560.82
Per Mile	Per Mile	1	100.00	0.57	57.00	
Per One-Way Trip	Per Trip	742	94.00	14.84	1035060.32	
Public Transit Pass	Month	135	10.00	61.81	83443.50	
GRAND TOTAL:					57895164.82	
<i>Total Estimated Unduplicated Participants:</i>					2500	
<i>Factor D (Divide total by number of participants):</i>					23158.07	
<i>Average Length of Stay on the Waiver:</i>						284