Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.5

Includes Changes Implemented through November 2014

Submitted by:

Utah Department of Health and Human Services, Division of Integrated Healthcare

Submission Date:	

CMS Receipt Date *(CMS Use)*	

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

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 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.

1. Request Information

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

B. **Program Title** (*optional – this title will be used to locate this waiver in the finder*): Acquired Brain Injury Waiver

C. Type of Request: *(the system will automatically populate new, amendment, or renewal)*

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

○	**3 years**
X	**5 years**

□	**New to replace waiver** Replacing Waiver Number:		
□	**Migration Waiver** – this is an existing approved waiver Provide the information about the original waiver being migrated		
	Base Waiver Number:		
	Amendment Number (if applicable):		
	Effective Date: (mm/dd/yy)		

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

○	**Model Waiver**
X	**Regular Waiver**

E. Proposed Effective Date:

Approved Effective Date *(CMS Use):*

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

□	**Hospital** *(select applicable level of care)*
	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 under age 21 as provided in 42 CFR § 440.160
X	**Nursing Facility** *(select applicable level of care)*
X	**Nursing Facility as defined in 42 CFR §440.40 and 42 CFR §440.155** If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140

□	**Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)** If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID facility level of care:

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

Select one:

X	**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)(3) (employ cost savings to furnish additional services)
□	§1915(b)(2) (central broker)	□	§1915(b)(4) (selective contracting/limit number of providers)

□	**A program operated under §1932(a) of the Act.** *Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:*
□	**A program authorized under §1915(i) of the Act.**
□	**A program authorized under §1915(j) of the Act.**
□	**A program authorized under §1115 of the Act.** Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The purpose of the Acquired Brain Injury Waiver (ABI Waiver) is to offer supportive services statewide to meet the needs of individuals with acquired brain injuries who satisfy the eligibility criteria of the waiver and to assist these voluntary participants to live as independently as possible while residing in the community based setting of their choice.

The Utah Department of Health and Human Services (DHHS), Division of Integrated Healthcare, serves as the State Medicaid Agency and the Division of Services for People with Disabilities (DSPD), also within DHHS, is the Operating Agency. The functions of each are specified in Appendix A of this application. DSPD utilizes an array of service providers in the community that comprise the direct service workforce for this population.

The ABI Waiver offers both an agency-based provider model along with a self-administered services model as the service delivery options available to waiver participants.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. *(Select one)*:

X	**Yes. This waiver provides participant direction opportunities.** *Appendix E is required*.
○	**No. This waiver does not provide participant direction opportunities.** *Appendix E is not required*.

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

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

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

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

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

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

○	**Not Applicable**

○	**No**
X	**Yes**

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

X	**No**
○	**Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

□	**Geographic Limitation**. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. S*pecify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area*:
□	**Limited Implementation of Participant-Direction**. A waiver of statewideness is requested in order to make ***participant direction of services*** as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State. *Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area*:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in
Appendix C are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services.

Appendix B specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are:
(1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431

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

42 CFR §431.210.

H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified throughout the application and in **Appendix H**.

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

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

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

7. Contact Person(s)

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

Last Name:	**Ambrenac**

First Name:	**Josip**				
Title:	Director, Office of Long Term Services and Supports				
Agency:	Utah Department of Health and Human Services, Division of Integrated Healthcare				
Address :	288 N. 1460 W.				
Address 2:	PO Box 143112				
City:	Salt Lake City				
State:	Utah				
Zip:	84114-3112				
Phone:	(801) 538-6090	**Ext:**		□	**TTY**
Fax:	801-323-1588				
E-mail:	**jambrena**@utah.gov				

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

Last Name:	Pinna
First Name:	Angie
Title:	Division Director

Agency:	Utah Department of Health and Human Services, Division of Services for People with Disabilities				
Address:	**288 N 1460 W**				
Address 2:	**PO Box 145145**				
City:	Salt Lake City				
State:	Utah				
Zip :	**84114**				
Phone:	(801) 448-1782	**Ext:**		□	**TTY**
Fax:	(801) 538-4279				
E-mail:	apinna@utah.gov				

8. Authorizing Signature

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

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

Signature:

_____

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:	Strohecker				
First Name:	Jennifer				
Title:	Division Director				
Agency:	Utah Department of Health and Human Services, Division of Integrated Healthcare				
Address:	288 N. 1460 W.				
Address 2:	PO Box 143101				
City:	Salt Lake City				
State:	Utah				
Zip:	84114-3101				
Phone:	385-280-3659	**Ext:**		□	**TTY**
Fax:	(801) 538-6860				

E-mail:	jstrohecker@utah.gov

Attachment #1: Transition Plan

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.

All HCBS 1915(c) waiver settings were required to come into compliance by March 17, 2023. The SMA and DSPD settings team worked with settings to bring all settings into compliance with the federal settings rule. Settings that were not compliant or new settings went through the heightened scrutiny process to work through a planned remediation and public comment process. Settings compliance is not a one time activity, and The State will continue with ongoing monitoring efforts to aid and reinforce the core tenants of the Rule as well as for the development and dissemination of best practices.

An overview of this plan is on our website and included in prior plans.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

The State has implemented the Settings Rule at all settings and has now moved onto the ongoing monitoring phase outlined in the Statewide Transition Plan. Additionally, the State applied for a Corrective Action Plan (CAP) for the Acquired Brain Injury, New Choices, and Community Supports Waivers. The CAP was approved by CMS in April 2023 made effective March 17th 2023. The CAP included milestones and timeframes for activities for validation visits and heightened scrutiny. A copy of the CAP is included on Utah's HCBS website.

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)*:

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver *(select one)*:

○	The waiver is operated by the State Medicaid agency. Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one)*:		
	○	The Medical Assistance Unit *(specify the unit name) (Do not complete Item A-2*)	
	○	Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit. Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency. (*Complete item A-2-a)*	
X	The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency. Specify the division/unit name:		
	The Division of Services for People with Disabilities		
	In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (*Complete item A-2-b).*		

2. 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.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

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

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

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

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

8. Monitoring, Quality Assurances and Quality Improvement 9. Reports The SMA monitors the interagency agreement through a series of quality assurance activities, provides ongoing technical assistance, and reviews and approves all rules, regulations and policies that govern waiver operations. There is a focused program review conducted annually by the SMA's Quality Assurance Team. If ongoing or formal annual reviews conducted by the Quality Assurance Team reveal concerns with compliance DSPD is required to develop plans of correction within specific time frames to correct the problems. The Quality Assurance Team conducts follow up activities to ensure that corrections are sustaining.

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (s*elect 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.*
X	**No**. **Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

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

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

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

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

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

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

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	x	x	☐	☐
Waiver enrollment managed against approved limits	x	x	☐	☐
Waiver expenditures managed against approved levels	x	x	☐	☐
Level of care evaluation	x	x	☐	☐
Review of Participant service plans	x	x	☐	☐
Prior authorization of waiver services	x	x	☐	☐

Utilization management	x	x	☐	☐
Qualified provider enrollment	x	x	☐	☐
Execution of Medicaid provider agreements	x	☐	☐	☐
Establishment of a statewide rate methodology	x	x	☐	☐
Rules, policies, procedures and information development governing the waiver program	x	x	☐	☐
Quality assurance and quality improvement activities	x	x	☐	☐

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

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.

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

	Specify:

Performance Measure:	***Number and percentage of newly enrolled waiver providers with a Medicaid provider agreement that has been approved prior to receiving reimbursement for waiver services. The numerator is the total number of newly enrolled waiver providers with approved Medicaid provider agreements in place prior to receiving reimbursement; the denominator is the total number of newly enrolled waiver providers receiving reimbursement.***
Data Source *(Select one) (Several options are listed in the on-line application):Other*	
If 'Other' is selected, specify: Approval documentation and Correspondence	

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

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

Performance Measure:	***& % of applicants who did not meet the LOC at the time of application and were provided timely notice of appeal rights. Numerator is the total number of applicants who did not meet the LOC at the time of application and received a timely notice of appeal rights; denominator is the total number of applicants who did not meet LOC at the time of application.*** ***.***
Data Source *(Select one) (Several options are listed in the on-line application):Other*	
If 'Other' is selected, specify: DSPD application denial records and Participant records	

	Responsible Party for data collection/generation	***Frequency of data collection/generation:***	***Sampling Approach*** *(check each that applies)*

	(check each that applies)	*(check each that applies)*	
	☐State Medicaid Agency	*☐Weekly*	*X 100% Review*
	X Operating Agency	*☐Monthly*	*☐Less than 100% Review*
	☐Sub-State Entity	*☐Quarterly*	*☐Representative Sample; Confidence Interval =*
	☐Other *Specify:*	*☐Annually*	
		X Continuously and Ongoing	*☐Stratified: Describe Group:*
		☐Other *Specify:*	
			☐Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

	Specify:

Performance Measure:	***Number and percentage of participants who have a) had a reduction/denial of a waiver service; b) been denied choice of provider if more than one was available; or c) been determined ineligible when previously receiving services, who were provided timely notice of appeal rights. N = # of compliant cases in compliance; D = total # of cases with or without timely notification requiring notification.***
Data Source *(Select one) (Several options are listed in the on-line application):Other*	
If 'Other' is selected, specify: Participant records/USTEPS	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	*☐Weekly*	*☐100% Review*
	X Operating Agency	*☐Monthly*	*X Less than 100% Review*
	☐Sub-State Entity	*☐Quarterly*	*X Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error*
	☐Other *Specify:*	*☐Annually*	
		X Continuously and Ongoing	*☐Stratified: Describe Group:*
		☐Other *Specify:*	
			☐Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

Performance Measure:	***# and percentage % of participants who have a) had a reduction/denial of a waiver service; b) been denied choice of provider if more than one was available; or c) been determined ineligible when previously receiving services, who were provided timely notice of appeal rights. N = # of compliant cases in compliance; D = total # of cases with or without timely notification requiring notification.***
Data Source *(Select one) (Several options are listed in the on-line application):Other*	
If 'Other' is selected, specify: Participant records/USTEPS	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐State Medicaid Agency	*☐Weekly*	*X 100% Review*
	X Operating Agency	*☐Monthly*	*☐Less than 100% Review*
	☐Sub-State Entity	*☐Quarterly*	*☐Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error*
	☐Other *Specify:*	*☐Annually*	
		X Continuously and Ongoing	*☐Stratified: Describe Group:*
		☐Other *Specify:*	
			☐Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

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

Add another Performance measure (button to prompt another performance measure)

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

The SMA demonstrates ultimate administrative authority and responsibility for the operation of the Acquired Brain Injury Waiver program through numerous activities including the issuance of Acquired Brain Injury waiver provider agreement approvals as well as the review of the following: applicants denied entry to the Acquired Brain Injury waiver to determine if timely appeal rights were provided; applicants accessing the waiver from the DSPD waiting list to identify if entry occurs according to proper numerical ranking; participants who have had a reduction/denial of a waiver service, been denied choice of provider if more than one was available or been determined ineligible when previously receiving services who were provided timely notice of appeal rights; and participant critical incidents and events to assure appropriate notification and remediation was completed. The SMA also conducts quarterly meetings with staff from DSPD, monitors compliance with the interagency Memorandum of Agreement, conducts annual quality assurance reviews of the Acquired Brain Injury Waiver program and provides technical assistance to DSPD and other entities within the state that affect the operation of the waiver program.

The SMA verifies compliance with the Administrative Authority performance measures at least annually. The SMA is the entity responsible for official communication with CMS for all issues related to the Acquired Brain Injury Waiver

b. Methods for Remediation/Fixing Individual Problems

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

Individual issues identified that affect the health and welfare of individual recipients are addressed immediately. These issues are addressed in a variety of ways, and may include: a) direct contact for additional information if any, and b) informal discussion or formal (written) notice of adverse findings. The SMA will use discretion in determining notice requirements depending on the findings. Examples of issues requiring intervention by the SMA would include: overpayments; allegations or substantiated violations of health and safety; necessary involvement of APS and/or local law enforcement; or issues involving the State's Medicaid Fraud Control Unit.

To assure the issue has been addressed, DSPD is required to report back to the SMA on the results of their interventions within designated time frames. These time frames are outlined in standard operating procedures or protocols or are stipulated on a case by case basis depending on the nature of a specific issue. A description of issues requiring immediate attention and outcomes are documented through the SMA final report.

Issues that are less immediate are corrected within designated time frames and are also documented through the SMA final review report. When the SMA 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*** *(check each that applies)*	***Frequency of data aggregation and analysis:*** *(check each that applies)*
	X State Medicaid Agency	*☐Weekly*
	☐Operating Agency	*☐Monthly*

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

c. Timelines

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

X	**No**
O	**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

Appendix B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each subgroup in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Select one Waiver Target Group	Target Group/Subgroup		Minimum Age	Maximum Age	
				Maximum Age Limit: Through age –	No Maximum Age Limit
☐	**Aged or Disabled, or Both - General**				
	☐	Aged (age 65 and older)			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
X	**Aged or Disabled, or Both - Specific Recognized Subgroups**				
	X	Brain Injury	18		X
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☐	**Intellectual Disability or Developmental Disability, or Both**				
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Mental Retardation			☐
☐	**Mental Illness** *(check each that applies)*				
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

Commented [1]: Intellectual Disability

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

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

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

2. Individuals must meet a qualifying International Classification of Diseases code diagnosis from the most recent revision of the classification, clinical modification, as outlined in Division Directive 1.40 Qualifying Acquired Brain Injury Diagnoses.

State:	
Effective Date	

3. Individual must score between 36 and 136 on the Comprehensive Brain Injury Assessment (CBIA) form as outlined in R539-1-6 (2) (d)~~8 (1)(c)~~, UAC.

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

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

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

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

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

Appendix B-2: Individual Cost Limit

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

X	**No Cost Limit**. The State does not apply an individual cost limit. *Do not complete Item B-2-b or Item B-2-c.*		
○	**Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.* The limit specified by the State is *(select one)*:		
	○	**%**	A level higher than 100% of the institutional average 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.**

State:	
Effective Date	

	○	**The following percentage that is less than 100% of the institutional average:**		
	○	**Other:** *Specify:*		

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

☐	**The participant is referred to another waiver that can accommodate the individual's needs.**
☐	**Additional services in excess of the individual cost limit may be authorized.** Specify the procedures for authorizing additional services, including the amount that may be authorized:
☐	**Other safeguard(s)** *(Specify)*:

Appendix B-3: Number of Individuals Served

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a	
Waiver Year	**Unduplicated Number of Participants**
Year 1	164~~142~~
Year 2	164~~142~~
Year 3	164~~142~~
Year 4 (only appears if applicable based on Item 1-C)	164~~142~~
Year 5 (only appears if applicable based on Item 1-C)	164~~142~~

Commented [2]: 164 is the number of unduplicated users as of 08/09/2023

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	157~~135~~
Year 2	157~~135~~
Year 3	157~~135~~
Year 4 (only appears if applicable based on Item 1-C)	157~~135~~
Year 5 (only appears if applicable based on Item 1-C)	157~~135~~

State:	
Effective Date	

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

X	**Not applicable**. **The state does not reserve capacity.**
O	**The State reserves capacity for the following purpose(s).** Purpose(s) the State reserves capacity for:

Table B-3-c

Waiver Year	**Purpose** (provide a title or short description to use for lookup):	**Purpose** (provide a title or short description to use for lookup):
	Purpose (describe):	**Purpose** (describe):
	Describe how the amount of reserved capacity was determined:	**Describe how the amount of reserved capacity was determined:**
Waiver Year	**Capacity Reserved**	**Capacity Reserved**
Year 1		
Year 2		
Year 3		
Year 4 (only if applicable based on Item 1-C)		
Year 5 (only if applicable based on Item 1-C)		

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

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

e. Allocation of Waiver Capacity.

Select one:

State:	
Effective Date	

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

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

Medicaid recipients who meet the programmatic eligibility requirements as defined in Appendix B-1 are given a choice (in writing) to either receive services to meet their identified needs in a Nursing Facility (NF), or through the Acquired Brain Injury Waiver. If the individual chooses to receive services through the Waiver, available capacity is determined.

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

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

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

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

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

Commented [3]: @abarr@utah.gov
Assigned to abarr@utah.gov

Commented [4]: @jblanc@utah.gov
Assigned to jblanc@utah.gov

Commented [5]: I have made some edits.

State:	
Effective Date	

B-3: Number of Individuals Served - Attachment #1

Waiver Phase-In/Phase Out Schedule

Based on Waiver Proposed Effective Date:

a. The waiver is being *(select one)*:

○	Phased-in
○	Phased-out

b. **Phase-In/Phase-Out Time Schedule.** Complete the following table:

Beginning (base) number of Participants:

Phase-In or Phase-Out Schedule			
Waiver Year:			
Month	**Base Number of Participants**	**Change in Number of Participants**	**Participant Limit**

c. **Waiver Years Subject to Phase-In/Phase-Out Schedule** *(check each that applies)*:

Year One	Year Two	Year Three	Year Four	Your Five
☐	☐	☐	☐	☐

State:	
Effective Date	

d. Phase-In/Phase-Out Time Period. *Complete the following table:*

	Month	Waiver Year
Waiver Year: First Calendar Month		
Phase-in/Phase out begins		
Phase-in/Phase out ends		

State:	
Effective Date	

Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

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

O	§1634 State
X	SSI Criteria State
O	209(b) State

2. Miller Trust State.

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

X	No
O	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			
X	SSI recipients			
☐	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121			
X	Optional State supplement recipients			
X	Optional categorically needy aged and/or disabled individuals who have income at: *(select one)*			
	X	100% of the Federal poverty level (FPL)		
	O	%	of FPL, which is lower than 100% of FPL Specify percentage:	
X	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)			
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)			
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)			
☐	Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)			
☐	Medically needy in 209(b) States (42 CFR §435.330)			
X	Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)			
X	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:			
	42 CFR 435.135			

State:	
Effective Date	

	1634(c)/1634(d) 1902(a)(10)(A)(i)(II)

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

○	**No**. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.
X	**Yes**. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. *Select one and complete Appendix B-5*.

○	All individuals in the special home and community-based waiver group under 42 CFR §435.217	
X	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 *(check each that applies)*:	
X	A special income level equal to (select one):	
X	300% of the SSI Federal Benefit Rate (FBR)	
○	%	A percentage of FBR, which is lower than 300% (42 CFR §435.236) Specify percentage:
○	$	A dollar amount which is lower than 300% Specify percentage:
☐	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%
☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:	

State:	
Effective Date	

Appendix B-5: Post-Eligibility Treatment of Income

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. 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 five-year period beginning January 1, 2014, 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 December 31, 2018.*

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

X	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State elects to (*select one*):	
	X	Use *spousal* post-eligibility rules under §1924 of the Act. *Complete ItemsB-5-b-2 (SSI State and §1634) or B-5-c-2 (209b State) and Item B-5-d.*
	○	Use *regular* post-eligibility rules under 42 CFR §435.726 (SSI State and §1634) (*Complete Item B-5-b-1*) or under §435.735 (209b State) (*Complete Item B-5-c-1). Do not complete Item B-5-d.*
○	Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse. *Complete Item B-5-c-1 (SSI State and §1634) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.*	

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules. However, for the five-year period beginning on January 1, 2014, post-eligibility treatment-of-income rules may not be determined in accordance with B-5-b-1 and B-5-c-1, because use of spousal eligibility and post-eligibility rules are mandatory during this time period.

State:	
Effective Date	

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

b-1. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. 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** $ ____ If this amount changes, this item will be revised.
  Specify dollar amount:
- X **The following formula is used to determine the needs allowance:**
  Specify:
  Up to $125 of any earned income and a general disregard of 100% of the FPL for one person; plus shelter cost deduction for mortgage and related costs (property taxes, insurance, etc.) or rent, not to exceed $300; plus the standard utility allowance Utah uses under Section 5(e) of the Food Stamp Act of 1977. Total shelter costs cannot exceed $300 plus the standard utility allowance.
- ○ Other
  Specify:

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

- X **Not Applicable**

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

- ○ **SSI standard**
- ○ **Optional State supplement standard**
- ○ **Medically needy income standard**
- ○ **The following dollar amount:** $ ____ If this amount changes, this item will be revised.

State:	
Effective Date	

	Specify dollar amount:		
O	**The amount is determined using the following formula:** *Specify:*		
iii. Allowance for the family *(select one)*:			
O	**Not Applicable *(see instructions)***		
O	**AFDC need standard**		
X	**Medically needy income standard**		
O	**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.		
O	**The amount is determined using the following formula:** *Specify:*		
O	**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:			
O	**Not applicable *(see instructions)*** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*		
O	**The State does not establish reasonable limits.**		
X	**The State establishes the following reasonable limits** *Specify*:		
	The State establishes the following reasonable limits: The limits specified in Utah's Title XIX State Plan for post-eligibility income deductions under 42 CFR 435.725, 435.726, 435.832 and Sec. 1924 of the Social Security Act. The limits are defined on supplement 3 to attachment 2.6A.		

State:	
Effective Date	

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

c-1. Regular Post-Eligibility Treatment of Income: 209(B) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):					
○	The following standard included under the State plan *(select one)*				
	○	The following standard under 42 CFR §435.121 *Specify*:			
	○	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 percentage:	
		○	$	A dollar amount which is less than 300% of the FBR 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*:				
○	Other (specify)				
ii. <u>Allowance for the spouse only</u> (*select one*):					
○	Not Applicable (see instructions)				
○	The following standard under 42 CFR §435.121 *Specify:*				
○	Optional State supplement standard				

State:	
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O	Medically needy income standard		
O	The following dollar amount: Specify dollar amount:	$	If this amount changes, this item will be revised.
O	The amount is determined using the following formula: *Specify:*		

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

O	Not applicable *(see instructions)*		
O	AFDC need standard		
O	Medically needy income standard		
O	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.
O	The amount is determined using the following formula: *Specify:*		
O	Other (specify):		

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

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

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

Select one:

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

NOTE: Items B-5-b-2 and B-5-c-2 are for use by states that use spousal impoverishment eligibility rules *and* elect to apply the spousal post eligibility rules.

State:	
Effective Date	

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

b-2. 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** $ ____ If this amount changes, this item will be revised.
  Specify dollar amount:
- ○ **The following formula is used to determine the needs allowance:**
  Specify:
- ○ **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*):

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Effective Date	

○	**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. <u>Allowance for the family</u> *(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*:

State:	
Effective Date	

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

c-2. Regular Post-Eligibility Treatment of Income: 209(B) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ○ The following standard included under the State plan
  (Select one):
  - ○ **The following standard under 42 CFR §435.121:**
    Specify:
  - ○ **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** $ If this amount changes, this item will be revised.
  Specify dollar amount:
- ○ **The following formula is used to determine the needs allowance:**
  Specify:
- ○ **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:**

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	Specify:

Specify the amount of the allowance (*select one*):			
○	**The following standard under 42 CFR §435.121:** *Specify:*		
○	**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. <u>Allowance for the family</u> *(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.*

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○	**The State does not establish reasonable limits.**
○	**The State establishes the following reasonable limits** *Specify*:

State:	
Effective Date	

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**		
○	%	Specify percentage:	
○	**The following dollar amount:**	$	If this amount changes, this item will be revised
X	**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 and related costs (property taxes, insurance, etc.) or rent, not to exceed $300; plus the standard utility allowance Utah uses under Section 5(e) of the Food Stamp Act of 1977. Total shelter costs cannot exceed $300 plus the standard utility allowance.		
○	**Other** *Specify***:**		

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

Select one:

X	**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.**
X	**The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

NOTE: Items B-5-e, B-5-f and B-5-g only apply for the five-year period beginning January 1, 2014. If the waiver is effective during the five-year period beginning January 1, 2014, and if the state indicated in B-5-a that it uses spousal post-eligibility rules under §1924 of the Act before January 1, 2014 or after December 31, 2018, then Items B-5-e, B-5-f and/or B-5-g are not necessary. The state's entries in B-5-b-2, B-5-c-2, and B-5-d, respectively, will apply.

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

e. Regular Post-Eligibility Treatment of Income: SSI State and §1634 state – 2014 through 2018. 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** | $ | If this amount changes, this item will be revised.
  Specify dollar amount:
- ○ **The following formula is used to determine the needs allowance:**
  Specify:
- ○ **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**

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○	**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*:

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

f. Regular Post-Eligibility: 209(b) State – 2014 through 2018. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ○ The following standard included under the State plan *(Select one):*
  - ○ **The following standard under 42 CFR §435.121:** *Specify:*
  - ○ **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:
- ○ **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*):

○	**The following standard under 42 CFR §435.121:** *Specify:*		
○	**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.**

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Effective Date	

○	**The State establishes the following reasonable limits** *Specify*:

State:	
Effective Date	

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).

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**		
○	%	Specify percentage:	
○	**The following dollar amount:**	$	If this amount changes, this item will be revised
○	**The following formula is used to determine the needs allowance:** *Specify formula:*		
○	**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.**

State:	
Effective Date	

○	**The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

State:	
Effective Date	

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

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

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

i.	**Minimum number of services**. The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is*:* 1	
ii.	**Frequency of services**. The State requires (select one):	
	X	**The provision of waiver services at least monthly**
	O	**Monthly monitoring of the individual when services are furnished on a less than monthly basis** If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

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

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

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

Acquired Brain Injury Waiver support coordinator (ABISC) - Certified by DSPD

Qualified support coordinators shall possess at least a Bachelor's degree in nursing, behavioral science, or a human services related field such as social work, sociology, special education,

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rehabilitation counseling, or psychology and demonstrate competency relating to the planning and delivery of health services to the Acquired Brain Injury population through successful completion of a training and testing program approved by the State Medicaid Agency. Although a variety of degrees may satisfy the requirements, majors such as geology and chemical engineering are not acceptable.

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

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

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

(2) 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

(3) The medical condition and intensity of services indicate that the care needs of the applicant cannot be safely met in a less structured setting, or without the services and supports of a Medicaid Home and Community-Based Waiver program.

The tool used to make this determination for the Acquired Brian Injury Waiver is the Comprehensive Brain Injury Assessment (CBIA). The applicant must score between 36 - 136 on this assessment.

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

O	**The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
X	**A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.** Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.
	The primary instrument used to determine level of care in nursing facilities is the Minimum Data Set (MDS) assessment. Because this assessment was designed to determine the needs of individuals residing in facility based settings, the state utilizes a tool that assesses the same elements, but that is geared toward assessing a person's needs and abilities in a community based setting. The Comprehensive Brain Injury Assessment (CBIA) serves as the standard comprehensive assessment instrument for this waiver and includes all the data fields necessary to measure the individual's level of care as defined in the state's Medicaid nursing facility

	admission criteria. It contains a thorough assessment of the individual's diagnostic and other health considerations, the individual's ability to complete activities of daily living and instrumental activities of daily living, and to assess additional services needed.

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

The process for evaluation and reevaluation of level of care is the same. The Comprehensive Brain Injury Assessment (CBIA) is the assessment tool used to assess the applicant, including this individual's diagnoses, ADL, IADL, medical and social needs. The CBIA is completed at the initial level of care evaluation and during the reevaluation process.

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**
X	**Other schedule** *Specify* the other schedule:
	A full level of care reevaluation is conducted at a minimum within 12 consecutive months of the last recorded full level of care evaluation or more frequently as indicated by a significant change in health status.

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 Utah Systems for Tracking Eligibility, Planning, and Services (USTEPS), developed and maintained by the Division of Services for People with Disabilities, provides an automated tickler "to do" message that is sent to the Acquired Brain Injury Support Coordinator (ABISC) at the beginning of the month in which a re-evaluation is due.

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

State:	
Effective Date	

Electronically retrievable documentation of all evaluations and re-evaluations are maintained within the USTEPS system.

Quality Improvement: Level of Care

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

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

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.

i. 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 individuals who had a level of care evaluation completed when seeking waiver services. Numerator is the number of LOC reviews completed; Denominator is the number of individuals requiring review.*
Data Source *(Select one) (Several options are listed in the on-line application):Other*	
If 'Other' is selected, specify: Participant records, CBIA and USTEPS	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*

Commented [6]: @jessicahooper@utah.gov _Assigned to jessicahooper@utah.gov_

Commented [7]: OSR does not provider oversight on PMs for Level of Care because this is done by DSPD employees not private contractors.

Commented [8]: @jordynpeterson@utah.gov _Assigned to jordynpeterson@utah.gov_

Commented [9]: QA reviewed completed, feedback below.

Commented [10]: PM should be same as LSW: Number and percentage of individuals who had a level of care evaluation completed, within 45 days of submitting a completed intake packet, when seeking waiver services. Numerator is the number of LOC reviews completed within the required time frame; Denominator is the number of individuals requiring review.

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

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

Add another Performance measure (button to prompt another performance measure)

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

i. 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.

State:	
Effective Date	

Performance Measure:	

Data Source *(Select one) (Several options are listed in the on-line application):*

If 'Other' is selected, specify:

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

Add another Data Source for this performance measure

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:*

State:	
Effective Date	

Add another Performance measure (button to prompt another performance measure)

c ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine the initial participant level of care.***

i. 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 initial Level of Care determinations documented in USTEPS. The numerator is the number of initial Level of Care determinations which have been documented in USTEPS; the denominator is the total number of initial Level of Care determinations completed.*
Data Source *(Select one) (Several options are listed in the on-line application):Other*	
If 'Other' is selected, specify: Participant records and Participant interviews	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =95% Confidence Level, 5% Margin of Error*
	☐ Other Specify:	*X Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Commented [11]: Is this PM captured in the PM that ensures the correct assessments were used? No heartburn if we keep it just wondering.

@glarsen@utah.gov

Commented [12]: I think we should delete it.

State:	
Effective Date	

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

Performance Measure:	*Number and percentage of initial level of care determinations completed correctly using the assessments/tools stated in the waiver. Numerator is the number of correct LOC determinations; Denominator is the total number of LOC determinations performed.*
Data Source *(Select one) (Several options are listed in the on-line application):Other*	
If 'Other' is selected, specify: Participant records and Participant interviews	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation :*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =95% Confidence Level, 5% Margin of Error*
	☐ Other Specify:	*X Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*

State:	
Effective Date	

		☐ *Other Specify:*		
				☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

Data Aggregation and Analysis

State:	
Effective Date	

Performance Measure:	*Number and percentage of initial Level of Care evaluations performed by an ABI Support Coordinator certified by DSPD. The numerator is the number of initial Level of Care evaluations which were performed by a certified ABI support coordinator; the denominator is the total number of initial Level of Care evaluations which were performed and reviewed.*
Data Source *(Select one) (Several options are listed in the on-line application):Other*	
If 'Other' is selected, specify: Participant records/USTEPS	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation :*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error*
	☐ Other Specify:	*☐ Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		X Other Specify: Every two years	
			☐ Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

State:	
Effective Date	

	Specify: Every two years

Performance Measure:	*Number and percentage of initial Level of Care determinations documented in USTEPS. The numerator is the number of initial Level of Care determinations which have been documented in USTEPS; the denominator is the total number of initial Level of Care determinations completed.*

Commented [13]: Duplicate PM.

Data Source *(Select one) (Several options are listed in the on-line application):Other*

If 'Other' is selected, specify: Participant records/USTEPS

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation :*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error*
	☐ Other Specify:	*X Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

State:	
Effective Date	

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

Add another Performance measure (button to prompt another performance measure)

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

Individuals entering DSPD services are evaluated for level of care by a certified ABI Waiver support coordinator (ABISC) and that evaluation is documented in USTEPS. DSPD reviews monthly reports to verify that ongoing nursing facility level of care evaluations are completed within designated time frames.

b. Methods for Remediation/Fixing Individual Problems

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

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Individual issues regarding the accuracy of level of care determination are addressed and corrected immediately by DSPD to assure that all participants meet nursing facility level of care. Plans of correction such as additional training may be required to assure future compliance. To assure all issues have been addressed, DSPD is required to report back to the SMA on the results of their interventions within the time frame stipulated in standard operating procedures and protocols or are stipulated on a case by case basis depending on the nature of a specific issue. Results of the reviews will be documented in the SMA's Final Reports which ~~which~~Reports~~which~~ are shared with SMA quality assurance staff and operating agency partners including representatives from the Office of Quality and Design, the DSPD, the Division of Licensing, and the waiver manager The SMA provides these reports following the review of Corrective Action Plans/Quality Improvement Plans when they are utilized. In addition, CMS will receive summaries during 372 reporting, or upon request.

Additionally, State staff run the USTEPS level of care report before the end of the month to identify any level of care recertifications for waiver participants that may have been missed. Eligibility specialists are notified immediately so a level of care determination can be made within the required timeframe.

Waiver participants determined not to meet level of care requirements are given formal written notice of the decision and information about how to request a Division Resolution, an Informal Hearing with the Department of Human Services, or a Fair Hearing with the Department of Health to appeal if they choose. If the Informal Hearing or Fair Hearing is chosen, an administrative law judge will schedule the hearing, listen to both sides of the dispute, and issue a written decision indicating whether the operating agency decision followed established protocols and procedures. The written decision may order the operating agency to reverse their determination.

Commented [14]: From LSW

ii Remediation Data Aggregation

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

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)*
[redacted]	*X State Medicaid Agency*	*☐ Weekly*
	X Operating Agency	*☐ Monthly*
	☐ Sub-State Entity	*☐ Quarterly*
	☐ Other: Specify:	*☐ Annually*
		☐ Continuously and Ongoing
		X Other: Specify: Every two years

c. Timelines

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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.

X	**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.

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Effective Date	

Appendix B-7: Freedom of Choice

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

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

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

Freedom of Choice is documented on the Form 818b.

Freedom of choice procedures:

1. When an individual is determined eligible for waiver services, the individual and the individual's legal representative, if applicable, will be informed of the alternatives available under the waiver and offered the choice of institutional care in a nursing facility (NF) or home and community-based care. A copy of the Acquired Brain Injury Waiver fact sheet, which describes the array of services and supports available, is given to each individual applying for waiver services.

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

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

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

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

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

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The Freedom of Choice form, 818b, is electronically maintained in USTEPS by the Operating Agency.

State:	
Effective Date	

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

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

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

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

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

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

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Appendix C-2: General Service Specifications

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services *(select one)*:

X	**Yes**. Criminal history and/or background investigations are required. Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):
	UCA 62A-2-120 and R501-14, of the Utah Human Services Administration, require that all persons having direct access to children or vulnerable adults must undergo a criminal history/background investigation. The Office of Licensing, an agency within the Utah Department of Human Services, has the responsibility of conducting background screenings on all direct care workers who provide waiver services. The scope of the investigation includes a check of the State's child and adult abuse registries, a check of State and regional criminal background databases, a review of the State's juvenile court records and a criminal history search of applicable national criminal background databases. If a person has spent time outside of the United States and its territories during the last five years, submission of additional documentation may be required to establish whether there was a conviction of a crime during that time period. For providers under the Self-Administered Service Model, the state will withhold payments for services for anyone who has not completed a background screening within the first 30 days of being hired. DSPD has the ability to view the database of the Office of Licensing in regards to the status of employees hired under the self-administered model. All employees are required to have a current background screening approval and must submit their renewal application no more than one year from the date the previous background screening was approved. Background screening approvals are issued by the Office of Licensing in accordance with UCA 62A-2-120 and R501-14. Providers on the Office of Inspector General List of Excluded Individuals and Entities (LEIE) are not eligible to render waiver services. The health and safety of participants are ensured by routinely scheduled face-to-face visits by support coordinators and by quality monitoring reviews performed by both DSPD and the SMA.
O	**No**. Criminal history and/or background investigations are not required.

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

X	**Yes**. The State maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and

	policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):
	UCA 62A-2-120 and R501-14 require that all persons having direct access to children or vulnerable adults must undergo an abuse screening Designated staff within DHS, Office of Licensing, completes all screenings. DSPD maintains a database on all approved employees. DSPD will not approve payments if the required screenings have not been completed.
○	**No**. The State does not conduct abuse registry screening.

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

X	**No**. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. *Do not complete Items C-2-c.i – c.iii.*
○	**Yes**. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Complete Items C-2-c.i –c.iii.*

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

Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit

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

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

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:

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

(a) Caregivers, defined as ~~S~~spouses, legal guardians and parents of waiver participants, may be eligible to perform Supported Living 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 caregiver ~~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 Support/Service Plan/Comprehensive Care Plan:

1. Choice of the caregiver ~~legally responsible person~~ to provide waiver services truly reflects the participant's wishes and desires;
2. The provision of services by the caregiver ~~legally responsible person~~ is in the best interests of the participant and his or her family;
3. The provision of services by the caregiver~~legally responsible person~~ is appropriate and based on the participant's identified support needs;
4. The services provided by the caregiver ~~legally responsible person~~ will increase the participant's independence and community integration;
5. There are documented steps in the PCSP 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 caregover~~legally responsible person~~ acting in the capacity of employee no longer be available;
6. The caregiver ~~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.

From a financial perspective, the prior authorization of monthly rate~~hours/~~ and coordination with FMS agencies or providers will be used as a control, ~~in addition to daily/weekly maximum of hours determined to be extraordinary care.~~ In addition, set monthly tier rates will be established using assessment data to determine the need for extraordinary care. State staff members will provide additional oversight and coordinate with Case Managers/Support Coordinators to ensure health and safety objectives are maintained, both for the waiver participant and the caregiver~~spouse~~ rendering care.

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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 caregiver ~~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.

Caregivers~~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.~~ 3.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).
4. Services to the individual promote the health and safety needs of the individual

This benefit/allowance for the delivery of Supported Living Services is limited to parents, guardians, and spouses who~~spouses~~~~family members who~~ would be considered primary caregivers for the waiver participant. Otherwise, it would be anticipated that respite services and other waiver supports would be explored.
The family's assigned FMS agency or provider will be responsible for monitoring that services have been provided in accordance with tier rate, ~~hours used~~, processing monthly summaries~~time sheets~~, and ensuring EVV compliance (where applicable). The Support Coordinator will also review paid claims in addition to working with the family's selected FMS or provider and also review as part of periodic contacts with the family.
The State may make payments to parents, spouses or~~spouses~~~~legally responsible individuals or~~ legal guardians when conditions have been met as described above. The State also allows payments to relatives when the relative is qualified to provide services as specified in Appendix C-3. The State will not pay non-legally responsible caregivers to provide waiver services when they are already being paid by another source to care for the recipient (i.e., foster parents).

On an ongoing basis, the Support Coordinator will verify that services provided are appropriate and furnished in the best interest of the recipient at the time a formal review of the care plan is completed, at least annually or more frequently as necessary to ensure services continue to meet the needs of the waiver participant. Additionally, on an annual basis, a sample review of claims for waiver services rendered to verify the service was authorized and did not exceed the amounts authorized in the care plan.
The State will use the sampling methodology required by CMS when calculating sample sizes. (Currently a 95% confidence interval, 5% margin of error and 50% response distribution). Care plans for those individuals will be compared to actual claims billed and recoupments initiated for those who had utilization exceeded authorized amounts.

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	Payment for services is restricted to Supported Living Services. The amount of ~~hours/~~services is limited to the overall tier level ~~number of hours~~ established in the service plan.

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.*
X	**Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.** Specify the controls that are employed to ensure that payments are made only for services rendered.
	As per Administrative Rule R539-5-5, parents, step-parents, legal guardians and spouses are not permitted to provide waiver services. Relatives, other than those listed above, may provide specified waiver services. The same payment controls are employed as described in Appendix E-1:1. Relatives may not provide services to multiple participants at the same time, but relatives may provide more than one service to a participant with the limitation that the services may not be provided at the same time. For example, a relative may be a provider of both personal care and respite services, but they would not be eligible to bill for both services concurrently. Since parents, step parents, legal guardians and spouses are not permitted to provide waiver services, the State avoids the problem of having those with decision making authority also providing services. For Relatives: Support Coordinators conduct monthly reviews of all services provided before claims are paid. Support Coordinators monitor the use of services as defined in the Care Plan. DSPD conducts random sample audits each year on the SAS programs that focus on service usage and interviews with clients and employees about service utilization. DSPD monitors service utilization each month and notifies the contract monitoring units if there is any indication of fraud or abuse of funds - for more in-depth audits to be completed. The State also allows payments to relatives when the relative is qualified to provide services as specified in Appendix C-3. The State will not pay non-legally responsible caregivers to provide

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	waiver services when they are already being paid by another source to care for the recipient (i.e., foster parents). On an ongoing basis, the Support Coordinator will verify that services provided are appropriate and furnished in the best interest of the recipient at the time a formal review of the care plan is completed, at least annually or more frequently as necessary to ensure services continue to meet the needs of the waiver participant. Additionally, on an annual basis, a sample review of claims for waiver services rendered to verify the service was authorized and did not exceed the amounts authorized in the care plan. The State will use the sampling methodology required by CMS when calculating sample sizes. (Currently a 95% confidence interval, 5% margin of error and 50% response distribution). Care plans for those individuals will be compared to actual claims billed and recoupments initiated for those who had utilization exceeded authorized amounts
○	Other policy. *Specify*:

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

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

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

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

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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.

i. Performance Measures

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

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

Performance Measure:	*Number and percentage of licensed and/or certified providers who meet DHHS provider contract criteria. The numerator is the number of providers in the review for which, upon initial enrollment and annually thereafter meet provider requirements; the denominator is the total number of providers reviewed.*
Data Source *(Select one) (Several options are listed in the on-line application):Other*	
If 'Other' is selected, specify:	
Provider records and Provider Staff interviews	

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

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

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Performance Measure:	*Number and percentage of licensed providers that meet licensure criteria both at initial enrollment and ongoing. The numerator is the number of licensed providers in the review which meet licensure criteria; the denominator is the total number of licensed providers reviewed.*
Data Source *(Select one) (Several options are listed in the on-line application):Other*	
If 'Other' is selected, specify:	
DHS Contract Analyst Certification checklist and DHS Office of Licensing Residential Support Rules checklist	

	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*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =*
	X Other Specify: DHS Office of Licensing	*X Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

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Add another Performance measure (button to prompt another performance measure)

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

i. 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 Self-Administered Services (SAS) providers who have a Self-Administered Services Agreement in place. The numerator is the number of family directed service providers in compliance; the denominator is the total number of family directed service providers reviewed.*		
Data Source *(Select one) (Several options are listed in the on-line application):Other*			
If 'Other' is selected, specify:			
Billing data, Employee files, PCSP and Participant records			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation :*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X Operating Agency	☐ *Monthly*	*X Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	*Representative Sample; Confidence Interval =95% Confidence Level, 5% Margin of Error*
	☐ *Other Specify:*	*X Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*

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		☐ *Other Specify:*		
				☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

Performance Measure:	*Number and percentage of non-licensed/non-certified providers who meet DHHS provider contract criteria. The numerator is the number of providers for which, upon initial enrollment and at least biannually thereafter, a review of their records indicate there are no significant or major findings; the denominator is the total number of providers.*
Data Source *(Select one) (Several options are listed in the on-line application):Other*	
If 'Other' is selected, specify:	
Provider records and Provider staff interviews	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation :*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	*X Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	*Representative Sample; Confidence Interval =95% Confidence Level, 5% Margin of Error*
	X Other	*X Annually*	

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	Specify: DHS			
		☐ Continuously and Ongoing		*☐ Stratified: Describe Group:*
		☐ Other Specify:		
				☐ Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

Add another Performance measure (button to prompt another performance measure)

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.

i. 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 provider agencies who conduct staff training as required. The numerator is the total number of provider agencies in compliance; the denominator is the total number of providers reviewed.*
Data Source *(Select one) (Several options are listed in the on-line application):Other*	
If 'Other' is selected, specify:	

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

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

Performance Measure:	*Number and percentage of ABI Support Coordinators who completed DSPD core curriculum. The numerator is the number of ABI Support Coordinators reviewed who complete the full curriculum as contractually required; the denominator is the total number of ABI Support Coordinators reviewed.*
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify: Other	
DSPD Support Coordinator records	

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

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

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.

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DHHS~~DSPD~~ reviews provider sites to assure that they are safe and in good repair. DHHS ~~DSPD~~ also interviews available direct care staff to determine if they have knowledge of participant goals and can describe progress that is made on each goal. In addition provider staff are interviewed to determine if they received training on a participant's behavior support plan and if they are knowledgeable of problem behaviors and strategies to decrease problem behaviors.

Support coordinators monitor provider staff to assure that staff are able to describe participant goals and progress on the goals. Support coordinators also monitor a sample of SAS employees on a monthly basis. The support coordinators complete a review checklist, which covers employee files, forms, and appropriate training for staff. Time sheets are reviewed to ensure proper billing for services. In most cases, support coordinators meet in person with employees to confirm proper training and work hours. Providers of services for the ABI Waiver must complete all required training as specified in the State Implementation Plan. The USTEPS system tracks the expenditures for each participant and ensures that services remain within the allotted budget.

b. Methods for Remediation/Fixing Individual Problems

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

Individual issues identified that affect the health and welfare of individual recipients are addressed immediately. These issues are addressed in a variety of ways, and may include: a) direct contact for additional information if any, and b) informal discussion or formal (written) notice of adverse findings. The SMA will use discretion in determining notice requirements depending on the findings. Examples of issues requiring intervention by the SMA would include: overpayments; allegations or substantiated violations of health and safety; necessary involvement of APS and/or local law enforcement; or issues involving the State's Medicaid Fraud Control Unit.

To assure the issue has been addressed, DSPD is required to report back to the SMA on the results of their interventions within designated time frames. These time frames are outlined in standard operating procedures or protocols or are stipulated on a case by case basis depending on the nature of a specific issue. A description of issues requiring immediate attention and outcomes are documented through the SMA final report.

Issues that are less immediate are corrected within designated time frames and are also documented through the SMA final review report. When the SMA determines that an issue is resolved, notification is provided and documentation is maintained.

ii Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis	***Responsible Party*** *(check each that applies)*	***Frequency of data aggregation and analysis:***

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

c. Timelines

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

X	**No**
O	**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-3: Participant Services - Waiver Services Specifications

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

Appendix C-4: Additional Limits on Amount of Waiver Services

Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services *(check each that applies).*

X	**Not applicable – The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.**
O	**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; and, (f) how participants are notified of the amount of the limit.

☐	**Limit(s) on Set(s) of Services**. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver. *Furnish the information specified above*.
☐	**Prospective Individual Budget Amount**. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. *Furnish the information specified above*.
☐	**Budget Limits by Level of Support**. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services. *Furnish the information specified above*.
☐	**Other Type of Limit.** The State employs another type of limit. *Describe the limit and furnish the information specified above.*

Appendix C-5: Home and Community-Based Settings

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

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

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

The State completed an analysis of services and the primary settings in which the services are delivered. The following determinations were made:

Settings Presumed to be Compliant:
Indirect Supports (No Setting)

Financial Management Services (3 Providers)

Financial Management Services are provided in support of self–directed or self-administered services (SAS). Services delivered through the SAS method enable the participant maximum flexibility in hiring staff of their choosing. Many Community Supports Waiver services are provided through SAS.

Support Coordination Agency (75 Providers)

Support Coordination Services are services provided to coordinate the array of services the participant receives. Services are provided to the participant and are not dependent on a setting.

Emergency Response Services (5 Providers)

Emergency Response Services are provided in the home to assure the participant's health and safety in a manner that promotes independence.

Specialized Medical Equipment Supplier (5 Providers)
Specialized Medical Equipment Supplies are provided in the home and community to assure the participant's health and safety in a manner that promotes independence.

As part of its Statewide Transition Plan, the State added requirements that all providers are responsible for ongoing monitoring of service settings to ensure compliance with Federal requirements. In addition, State quality assurance monitoring will also include the review of service settings.

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Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	

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

☐	**Registered nurse, licensed to practice in the State**
☐	**Licensed practical or vocational nurse, acting within the scope of practice under State law**
☐	**Licensed physician (M.D. or D.O)**
X	**Case Manager** (qualifications specified in Appendix C-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:*

b. Service Plan Development Safeguards.

Select one:

X	**Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
O	**Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.** The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify*:

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The ABI Waiver support coordinator ensures that the participant, legal representative, primary paid service providers and any others at the invitation of the participant are involved throughout the assessment and planning process. The ABI Waiver support coordinator completes the Comprehensive Brain Injury Assessment (CBIA) with the participant, legal representative, and/or family as respondents, and the results of this are shared with all parties who have been included in this process. A planning meeting is held where the participants are involved in the development of their Person-Centered Profile, which is an element of the Person Centered Support Plan. Participants are also involved in selecting personal goals and making decisions that are related to specific supports in their Action Plan.
The participant or legal representative is asked to invite anyone they wish to participate in the planning process. During the planning process, the participant is given the freedom to select their Support Coordinator and waiver services providers.

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

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

The primary assessment tool conducted to support service plan development is the Comprehensive Brain Injury Assessment (CBIA). Other assessments include, but are not limited to: review of the previous year's assessment, the Person-Centered Profile, Person Centered Planning Tools and educational, psychological, psychiatric, medical and other therapy evaluations as needed. ~~The use of person-centered planning tools is encouraged.~~

a) who develops the plan, who participates in the process, and the timing of the plan;
The ABI Waiver support coordinator has ultimate responsibility to develop the PCSP; however, it is the entire team's responsibility to participate. The team must consist of at least the participant and legal representative, Support Coordinator, ~~primary paid service providers~~ and others as invited by the participant such as the primary paid service providers; at times and locations convenient to both the waiver participant and the other individuals whom the

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participant has invited. The PCSP is reviewed and updated at least once a year with changes made throughout the year as needed based on the participant's needs. Anytime during the plan year the ABI Waiver support coordinator can choose to complete a whole new plan or make modifications (addendums) to the existing plan.

(b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences, strengths, capacities, desired outcomes, risk factors, goals, and health status.
The ABI Waiver utilizes a comprehensive approach to service plan development. The CBIA is the primary assessment tool for the development of the Person Centered Support Plan (PCSP). Other important assessments include, but are not limited to-: the Person-Centered Profile, person-centered planning tools, educational assessments, psychological assessments, psychiatric assessments, medical assessment, other therapy evaluations as needed and the review of the past year.

(c) how the participant is informed of the services that are available under the waiver.
Prior to the initial planning meeting the participant or the participant's representative is given a list of all the services provided on the ABI Waiver including the definition of each service. In addition, the list of ABI services is found on the DSPD web site.

(d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences.
The CBIA is a structured, comprehensive method to document what has been learned about the person throughout the year and directly bridges the gap between assessing and planning. As part of the initial assessment process the CBIA is administered as part of the initial planning meeting and at least annually thereafter, or more often as determined by the Support Coordinator. USTEPS has an edit check to ensure the CBIA will be completed at a minimum of annually. The CBIA is a comprehensive method of gathering information not only for eligibility and level of care determination but also for program and person centered planning. The CBIA facilitates an accurate and in-depth assessment of participant needs. The CBIA identifies and documents participants' needs and focuses on abilities and goals. The CBIA is used to collect data about the participant to identify unmet needs, to determine potential to remain or live in a community based setting and to assist with development of a PCSP that maintains and enhances supports already in place. The CBIA is, for the ABI waiver, the foundation upon which the PCSP is built. Complete and accurate information and recommendations concerning participants' abilities, needs and preferences leads to appropriate program placement and comprehensive person centered service planning assuring the health and welfare of the participant. The CBIA assesses the following areas: Memory and cognition; Activities of daily life; Judgement and self-protection; Control of emotion; Communication; Physical Health; Employment.

The CBIA is also reviewed prior to the annual planning meeting (or whenever the ABI Waiver support coordinator deems necessary) to determine if it continues to accurately reflect the needs of the participant. If additional needs are identified the ABI Waiver support coordinator may add these to the current PCSP. At the annual planning meetings the team discusses any additional information and determines any additional changes that need to be made to the PCSP.

(e) how waiver and other services are coordinated.
The Action Plan lists all the person's supports and services including: Formal/Written Support Strategies, Medicaid State Plan Services, Natural Supports, One-Time and On-Going, Behavior

Supports and Psychotropic Med Plans, Specific Medical, Skill Training, Opportunities, Relationship development, etc.

(f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan.
The Action Plan contains information about specific ABI Waiver services, including details on amount, duration, and frequency. It also includes, supports and services, who is providing the support, date the support will begin and end, and details: including provider requirements, such as, objectives, methods, procedures, data reporting, etc. The Action Plan also includes information related to communication and coordination of services or supports with others. The payment source is also identified. For supports funded by the ABI Waiver the name of the contracted provider, the service code, and the requirement for support strategies and provider monthly summaries are documented

(g) how and when the plan is updated, including when the participant's needs change.
The plan is reviewed and revised as frequently as necessary to address participant's changing needs. A formal review occurs at least annually and is completed during the calendar month in which it is due.

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

The primary tool for assessing risk is the Comprehensive Brain Injury Assessment (CBIA). The CBIA is also used to identify additional health and safety issues. The CBIA includes specific sections on Judgement, including risk of becoming homeless, mental health issues and physical health. The CBIA further helps identify issues of self-protection, possible abuse, neglect and exploitation and helps identify behavior issues. The CBIA measures intensity of "support need". These items are reviewed by the team and addressed in the PCSP as needed in the Action Plan. Back up plans are developed and incorporated into support strategies. Services that address risk are identified and included in the PCSP.

Prior to the annual planning meeting, the ABI Waiver support coordinator will review the CBIA with the participant, family, and provider staff to identify areas of need. These include health and safety areas of need and risk. The ABI Waiver support coordinator also reviews other assessments and the results of the past year's supports. During the planning meeting the team reviews items identified as areas of concern. Decisions are made based on the participant's identified needs and supports and services. Risks are described in support strategies and noted in the Plan Backup section of the PCSP software. They are tracked in Monthly Progress Notes from the service provider. Support strategies and services that address risks are reviewed and followed up on by ABI Waiver support coordinators during visits with participants, families, and providers. Issues are discussed with the ABI Waiver support coordinator's supervisor and other pertinent individuals. DSPD may provide consultation to ABI Waiver support coordinators for the mitigation of risks.

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

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The participant and/or representative are informed of all available qualified providers of waiver services during the PCSP planning meeting.
Each participant or legal representative is given a copy of the booklet, "~~An Introductory~~ Guide to Eligibility and Services—Division of Services for People with Disabilities" and is referred to the website where they can search for a~~that contains~~ list~~s~~ of contracted providers. The USTEPS case management system used to develop the PCSP includes pull down lists of all current providers for each specific waiver service. Support Coordinators will assist in arranging participants' visits with providers if needed to obtain more detailed information. The participant's choice of providers of services is documented on the PCSP.

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

The SMA retains final authority for oversight and approval of the service planning process. Person Centered Support Plans (PCSPs) are reviewed at least every two years by DSPD and at least every five years by the SMA. The specific sample size of each review is selected based on the identified focus of the review and the number of reviews determined to be necessary to evaluate the waiver's performance. If the sample evaluation identifies system-wide service planning problems, an expanded review is initiated by the SMA.

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

○	**Every three months or more frequently when necessary**
○	**Every six months or more frequently when necessary**
X	**Every twelve months or more frequently when necessary**
○	**Other schedule** *Specify the other schedule*:

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

☐	**Medicaid agency**
☐	**Operating agency**
X	**Case manager**
☐	**Other** *Specify:*

Appendix D-2: Service Plan Implementation and Monitoring

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

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

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

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

The Support Coordinator is responsible for ensuring that the PCSP is reviewed and updated as necessary to:
1. Record the participant's progress (or lack of progress)
2. Determine the continued appropriateness and adequacy of the participant's services; and
3. Ensure that the services identified in the PCSP are being delivered and are appropriate for the participant.

Should problems or a change in need be identified by the Support Coordinator, the PCSP will be updated or revised and support strategies modified in order to meet the needs of the individual. Technical assistance will be pursued with the Operating Agency as necessary to resolve care issues.
The Support Coordinator monitors the implementation of the PCSP by doing the following:
1. Monthly face to face visits with the person (While monthly face to face visits is the standard, the Support Coordinator has the discretion to conduct face to faces visits with the individual~~client~~ more frequently or less frequently than once a month. In all cases frequency will be dependent on the assessed needs of the individual~~client~~ and will not exceed 90 days without a face to face visit).
2. Monthly review of progress reports.
3. Recording a monthly case management note within the USTEPS system documenting activities performed in the month and summarizing results/issues/resolution.
4. ~~Working/ meeting with Providers and families of supports to ensure that participants are receiving quality supports in the environment of their choice.~~ Working / meeting with Providers of supports, individuals, and families to ensure individuals are receiving quality supports in the environment of their choice.
5. Evaluating established back-up plans for appropriateness and ability to meet health and safety needs.

PCSPs are reviewed at least every two years by DSPD and at least every five years by the SMA. The sample size for each review will be sufficient to provide a confidence level equal to 95% and a confidence interval equal to five. Records are reviewed for documentation that demonstrates participants have been made aware of all services available on the ABI Waiver and have been offered choice among available providers. Records are also reviewed for compliance with health and welfare standards. This includes the documentation that prevention strategies are developed and implemented (when applicable) when abuse, neglect, or exploitation is identified, verification (during face to face visits) that the safeguards and interventions are in place, notification of incidents to support coordinators has occurred, and documentation that participants have assistance, when needed, to take their medications, and verification that backup plans are effective. Records

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are also reviewed to determine that the PCSP addresses all of the participant's assessed needs, including health needs, safety risks, and personal goals either by the provision of Waiver services or other funding sources (State Plan services, generic services, and natural supports). Significant findings from these reviews will be addressed with DSPD. A plan of correction with specific time frames for completion will be required. The SMA will conduct follow-up reviews as necessary to ensure the plan of correction is implemented and sustained.

b. Monitoring Safeguards. *Select one:*

X	**Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
O	**Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.** The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify*:

Quality Improvement: Service Plan

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

a. **Methods for Discovery: Service Plan Assurance**

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.

i. 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

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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 PCSPs that address all participants' assessed needs including health needs, safety risks and personal goals either by the provision of waiver services or other funding sources including State Plan, generic and natural supports. The numerator is the number of PCSPs in compliance; the denominator is the total number of PCSPs reviewed.*
Data Source *(Select one) (Several options are listed in the on-line application):Other*	
If 'Other' is selected, specify:	
CBIA, SIS, PCSP, Participant records and Participant interviews	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation :*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error*
	☐ Other Specify:	*☐ Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		X Other Specify: Every two years	
			☐ Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

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Specify:	
	☐ Continuously and Ongoing
	X Other *Specify: Every two years*

Performance Measure:	*Number and percentage of participant records that contain documentation of progress on goals identified in the PCSP. The numerator is the number of PCSPs reviewed that identify participant goals and for which there is documentation demonstrating progression of participants on those identified goals; the denominator is the total number of PCSPs reviewed.*

Data Source *(Select one) (Several options are listed in the on-line application):Other*

If 'Other' is selected, specify:

Participant records and PCSP

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation :*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error*
	☐ Other *Specify:*	*☐ Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		X Other *Specify: Every two years*	
			☐ Other Specify:

Add another Data Source for this performance measure

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Responsible Party for data aggregation and analysis	***Frequency of data aggregation and analysis:***

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

b.Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.

i. 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 ~~participant case files containing evidence that~~ PCSPs created which appropriately address the assessed needs/goals of the individual and are agreed upon by the participant/legal representative before waiver services were provided. The numerator is the number of PCSPs which met criteria; ~~reviewed which contain evidence that the PCSP was agreed upon by the participant/legal representative before waiver services were provided;~~ the denominator is the total number of PCSPs reviewed.*
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
Participant records and PCSPs	

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

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	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error*
	☐ Other Specify:	*X Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

Add another Performance measure (button to prompt another performance measure)

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

i. 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

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statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	*Number and percentage of PCSPs reviewed and updated annually, completed during the calendar month in which it is due. The numerator is the number of reviewed PCSPs for which a review shows it was updated annually, completed during the calendar month in which it is due; the denominator is the total number of PCSPs reviewed.*
Data Source *(Select one) (Several options are listed in the on-line application):Other*	
If 'Other' is selected, specify:	
PCSP, Participant records and Participant interviews	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation :*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error*
	☐ Other Specify:	*☐ Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		X Other Specify: Every two years	
			☐ Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

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	☐ *Continuously and Ongoing*
	X Other *Specify: Every two years*

Performance Measure:	*Number and percentage of PCSPs which are updated/revised when warranted by changes in the participant's needs. The numerator is the number of PCSPs which were updated/revised; the denominator is the total number of PCSPs which required updates/revision due to a change in need.*
Data Source *(Select one) (Several options are listed in the on-line application):Other*	
If 'Other' is selected, specify:	
Participant' records and Incident reports	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation :*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	*X Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error*
	☐ *Other* *Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		X Other *Specify: Every two years*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

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

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

i. 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 PCSPs identifying the amount, frequency and duration for each service authorized. The numerator is the total number of PCSPs in the review which clearly identify the amount, frequency and duration for each waiver service authorized; the denominator is the total number of PCSPs reviewed.*		
Data Source *(Select one) (Several options are listed in the on-line application):Other*			
If 'Other' is selected, specify:			
PCSP, Claims Data and Participant interviews			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation :*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error*

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	☐ *Other Specify:*	☐ *Annually*		
		☐ *Continuously and Ongoing*		☐ *Stratified: Describe Group:*
		X Other Specify: Every two years		
				☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

Performance Measure:	*Number and percentage of provider monthly summary reports indicating that services are being delivered in accordance with the PCSP. The numerator is the total number of PCSPs reviewed for which monthly summary reports indicate that services are being delivered in accordance with the PCSP; the denominator is the total number of PCSPs reviewed.*
Data Source *(Select one) (Several options are listed in the on-line application):Other*	
If 'Other' is selected, specify:	
Participant records, PCSP, Provider Monthly reports and Participant interviews	

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

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				Interval = 95% Confidence Level, 5% Margin of Error
	☐ Other Specify:	*☐ Annually*		
		☐ Continuously and Ongoing		*☐ Stratified: Describe Group:*
		X Other Specify: Every two years		
				☐ Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

e. Sub-assurance: Participants are afforded choice between/among waiver services and providers.

i. 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.

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Performance Measure:	*Number and percentage of participants who are made aware of all services available on the ABI Waiver. The numerator is the total number of participants reviewed who were made aware of all services available on the ABI Waiver; the denominator is the total number of participants reviewed.*
Data Source *(Select one) (Several options are listed in the on-line application):Other*	
If 'Other' is selected, specify:	
PCSP, Participant records and Participant interviews	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation :*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error*
	☐ Other Specify:	*☐ Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		X Other Specify: Every two years	
			☐ Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

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	Specify: Every two years

Performance Measure:	*Number and percentage of participants who are offered choice among providers when more than one is available. The numerator is the total number of participants reviewed who are offered choice among providers when more than one is available; the denominator is the total number of participants reviewed.*
Data Source *(Select one) (Several options are listed in the on-line application):Other*	
If 'Other' is selected, specify:	
PCSP, Participant records and Participant interviews	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation :*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error*
	☐ Other Specify:	*☐ Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		X Other Specify: Every two years	
			☐ Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

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	☐ *Continuously and Ongoing*
	X Other *Specify: Every two years*

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

PCSPs are developed based on the Comprehensive Brain Injury Assessment (CBIA) and in consultation with the participant and/or the participant's representative and address health needs, safety risks and personal goals. Documentation in the participant's record contains adequate information to ascertain the progress that a participant has made on goals identified on the service plan. Once an individual is enrolled in the waiver they are to receive the amount of covered services necessary to meet their health and welfare needs and to prevent unnecessary institutionalization.

The CBIA ~~comprehensive assessment~~ is conducted when a participant enters the waiver and a screening is conducted at a minimum every twelve months. If there have been significant changes, the assessment is re-administered. All services are identified on the service plan regardless of funding source. Participants are offered choice of either nursing facility care or ABI Waiver services and choice is documented in USTEPS. Participants are made aware of all services available on the ABI Waiver and are offered choice among providers whenever choice exists. Choice of providers is documented in the participant's record.

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

b. Methods for Remediation/Fixing Individual Problems

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

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

ii. Remediation Data Aggregation

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Remediation-related Data Aggregation and Analysis (including trend identification)	**Responsible Party** *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	X State Medicaid Agency	**☐ Weekly**
	X Operating Agency	**☐ Monthly**
	☐ Sub-State Entity	**☐ Quarterly**
	☐ Other Specify:	**☐ Annually**
		☐ Continuously and Ongoing
		X Other Specify: Every two years

c. Timelines

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

X	**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.

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Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request):*

X	**Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
O	**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):*

O	**Yes. The State requests that this waiver be considered for Independence Plus designation.**
X	**No. Independence Plus designation is not requested.**

Appendix E-1: Overview

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

Self-Administered Services are made available to all waiver enrollees who elect to participate in this method. Support Coordinators provide ongoing oversight of the enrollees' ability to successfully utilize self-administered services. The Financial Management Services (FMS) agency can provide additional assistance and training to participants (employers) regarding methods of interviewing, selecting and hiring employees, legal requirements for retaining and discharging employees, methods of employee supervision, fraud controls and such other topics as required, in the opinion of the FMS agency, to assist employers to effectively self-administer their services. Enrollees who subsequently demonstrate to their support coordinator their incapacity to successfully self-administer their services are transferred to Agency Based Provider Services.

Under Self-Administered Services, individuals and/or their chosen representatives hire individual employees to perform a waiver service/s. The individual and/or their chosen representative are then responsible to perform the functions of supervising, hiring, assuring that employee qualifications are met, scheduling, assuring accuracy of time sheets, etc. of the individual's employees. Individuals and/or their chosen representatives may avail themselves of the assistance offered them through Financial Management Services should they request and/or be assessed as requiring additional support and assistance in carrying out these responsibilities.

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

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perform assigned activities. Appointed decision-makers cannot also be providers of self-administered services.

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

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

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

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

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

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

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

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

X	**Participant – Employer Authority**. As specified in ***Appendix E-2, Item a,*** the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-

	employer of workers. Supports and protections are available for participants who exercise this authority.
○	**Participant – Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
○	**Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

Appendix E: Participant Direction of Services

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

X	**Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
□	**Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
□	**The participant direction opportunities are available to persons in the following other living arrangements** *Specify* these living arrangements:

d. Election of Participant Direction. Election of participant direction is subject to the following policy (s*elect one):*

○	**Waiver is designed to support only individuals who want to direct their services.**
○	**The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
X	**The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.** *Specify the criteria*
	Participant direction is offered to participants. 1. Participants may only choose to direct the covered waiver services listed in E-1(g). 2. Participants must acknowledge the obligation of the State to assure basic health and safety and agree to abide by necessary safeguards negotiated during the risk assessment/service planning process. 3. In the case of an individual who cannot direct his or her own waiver services, another person may be appointed as the decision-maker in accordance with applicable State law. 4. Alternate service delivery methods are available to participants who have are not able to successfully direct their services.

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

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

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Appendix E: Participant Direction of Services

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one)*:

○	**The State does not provide for the direction of waiver services by a representative.**
X	**The State provides for the direction of waiver services by representatives.** Specify the representatives who may direct waiver services: *(check each that applies)*:

X	**Waiver services may be directed by a legal representative of the participant.**
X	**Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Participants with adequate and appropriate information and with the assistance of legal representatives (if necessary), family members, and others in their chosen circle of support, can define, decide, and direct the set of waiver services authorized to be provided under the self-administered services model, that they receive. The informed preferences of the individual waiver recipient will be of primary importance in the decisions relevant to the selection and delivery of supports. As participants exercise greater choice and control over the supports they receive, they also assume relevant responsibility and accept reasonable risk associated with the decision they make. The manner in which the waiver recipient, state agencies and the providers of purchased supports share the responsibilities and risks related to services and supports will be defined in support plans, contracts, and other written agreements.

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

Necessary safeguards that are in place include the requirement that once chosen, the non-legal representative becomes a member of the person's individual support team. In addition to the non-legal representative, the individual support team consists of the participant's support coordinator, provider representatives and any other friends or family members of the participant's choosing. The Operating Agency relies on the decisions made by the individual's support team. If a non-legal representative and the team disagree with a decision made and or a non-legal representative appears to jeopardize a consumer's health and welfare, than the Operating Agency will take steps to resolve the disagreement and will assure the best interests of the participant are maintained. The health and safety of clients are ensured by routinely scheduled face-to-face visits by support coordinators, and by quality monitoring reviews by both the operating agency and the SMA.

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3. *(Check the opportunity or opportunities available for each service)*:

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Appendix E: Participant Direction of Services

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Participant-Directed Waiver Service	Employer Authority	Budget Authority
Homemaker	X	□
Companion Services	X	□
Supported Living	X	□
Chore Service	X	□
Transportation Services (non-medical)	X	□
Respite	X	□

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

X	**Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).* Specify whether governmental and/or private entities furnish these services. *Check each that applies:*	
	□	**Governmental entities**
	X	**Private entities**
○	**No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*	

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. S*elect one*:

X	FMS are covered as the waiver service 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:	
	Not applicable. FMS is not an administrative function.	
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:	

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Appendix E: Participant Direction of Services

	X	**Assists participant in verifying support worker citizenship status**
	X	**Collects and processes timesheets of support workers**
	X	**Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
	X	**Other** *Specify:*

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

1. Verify that the employee completed the following forms

a. Form I-9, including supporting documentation (i.e. copies of driver's license, social security card, passport). If fines are levied against the person for failure to report INS information, the Fiscal Agent shall be responsible for all such fines.

b. Form W-4

2. Obtain a completed and signed Form 2678, Employer Appointment of Agent, from each person receiving services from the Financial Management Services provider, in accordance with IRS Revenue Procedure 70-6.

3. Provide persons with a packet of all required forms when using a Financial Management Services provider, including all tax forms (IRS Forms I-9, W-4 and 2678), payroll schedule, Financial Management Services provider's contact information, and training material for the web-based timesheet.

4. Process and pay DHS/DSPD approved employee timesheets, including generating and issuing paychecks to employees hired by the person.

5. Assume all fiscal responsibilities for withholding and depositing FICA and SUTA/FUTA payments on behalf of the person. Any federal and/or State penalties assessed for failure to withhold the correct amount and/or timely filing and depositing will be paid by the Financial Management Services provider.

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

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

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	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:	
□	**Maintains a separate account for each participant's participant-directed budget**
□	**Tracks and reports participant funds, disbursements and the balance of participant funds**
□	**Processes and pays invoices for goods and services approved in the service plan**
□	**Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
□	**Other services and supports** *Specify*:
Additional functions/activities:	
X	**Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
X	**Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
X	**Provides other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
□	**Other** *Specify:*

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Appendix E: Participant Direction of Services

iv.	**Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.
	Service providers, support coordinators, and others who assist in the development and delivery of supports for people served through the Division of Services for People with Disabilities will be expected to maintain established standards of quality. The State Medicaid Agency and DSPD will assure that high standards are maintained by way of a comprehensive system of quality assurance including: (a) formal surveys of providers for measurement of individual and organizational outcomes, (b) contract compliance reviews, (c) regular observation and evaluation by support coordinators, (d) provider quality assurance systems, (e) consumer/family/legal representative satisfaction measures, (f) performance contracts with and reviews of State agency staff, (g) audits completed by entities external to the agency, and (h) other oversight activities as appropriate. The division improved the accountability of SAS service delivery through standardized mandatory training & manuals for SAS families and support coordinators, development of the Family to Family Network & Peer Mentors, and a formal documentation monitoring tool used by support coordinators to audit SAS employers.

Appendix E: Participant Direction of Services

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

X	**Case Management Activity**. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. *Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*
	In order to provide information and assistance to participants about self-directing their services, the Support Coordinator is responsible to provide the participant/representative with a Self-Administered Services Support Book. The support coordinator reviews the information in the Support Book with the participant/participant family and is available to answer any questions and provide assistance as needed. The support coordinator is responsible to assess whether the information provided is sufficient to meet the needs of the individual. If the assessment of the situation shows that the participant/representative requires additional training – such as hiring, scheduling, or training of employees, the support coordinator will contact the Financial Management Services agency to provide more detailed training on how to self-direct services. The support coordinator monitors payments, reviews actual expenditure in comparison with the PCSP and budget, contacts the waiver participant or their representative if any concerns arise, and assists in resolution of billing problems.
X	**Waiver Service Coverage**. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-1/C-3 (check each that applies):

	Participant-Directed Waiver Service	**Information and Assistance Provided through this Waiver Service Coverage**
	(list of services from Appendix C-1/C-3)	□
	Financial Management Services	X

□	**Administrative Activity**. Information and assistance in support of participant direction are furnished as an administrative activity. *Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and (e) the entity or entities responsible for assessing performance:*

k. Independent Advocacy *(select one).*

X	**No. Arrangements have not been made for independent advocacy.**
O	**Yes**. Independent advocacy is available to participants who direct their services.

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	Describe the nature of this independent advocacy and how participants may access this advocacy:

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

DSPD will issue an Invitation for Service Offering (ISO) to all providers found qualified and available to render the services which the individual has elected to receive from an agency-based provider and will then enter into a contract for the provision of those services from the provider selected by the individual and their person-centered planning team. Health and welfare and continuity of services are assured during the transition process because the consumer continues to receive services under the self-administered services method until the transfer to the agency-based provider method is made.

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

All participants in the Waiver program are considered, de facto, to be eligible for self-administration. Only after a participant has repeatedly demonstrated an incapacity for self-administration or problems with fraud or malfeasance have been identified would involuntary termination of self-administered services occur. Prior to that occurrence however, the State offers participants who are struggling with self-administering their services repeated assistance rendered by support coordinators and/or through Financial Management Services to assist the participant to acquire the skills necessary for self-administration. Only after the failure of all these efforts will the State involuntarily terminate self-administered services for a participant.

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

Health and welfare and continuity of services are assured during the transition process because the consumer continues to receive services under the self-administered services method until the transfer to the agency-based provider method is made.

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

Prior to enrolling in self-administered services, the participant/representative is informed of their responsibilities and the rules that must be followed in order to participate. The individual is provided with a Self-Administered Services Support Book which outlines the rules for participating in self-administered services. In addition, the participant/representative is required to sign a self-administered services agreement which outlines the conditions which the participant must comply with in order to use the self-administered services method.

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

Table E-1-n

	Employer Authority Only	**Budget Authority Only or Budget Authority in Combination with Employer Authority**
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	16	
Year 2	17	
Year 3	18	
Year 4 (only appears if applicable based on Item 1-C**)**	19	
Year 5 (only appears if applicable based on Item 1-C**)**	20	

Appendix E: Participant Direction of Services

Appendix E-2: Opportunities for Participant-Direction

a. Participant – Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *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:
X	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

X	**Recruit staff**
□	**Refer staff to agency for hiring (co-employer)**
□	**Select staff from worker registry**
X	**Hire staff (common law employer)**
X	**Verify staff qualifications**
X	**Obtain criminal history and/or background investigation of staff** Specify how the costs of such investigations are compensated:
	The operating agency (DSPD) is responsible to pay any fees associated with background investigations.
X	**Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
X	**Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
X	**Determine staff wages and benefits subject to applicable State limits**

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X	**Schedule staff**
X	**Orient and instruct staff in duties**
X	**Supervise staff**
X	**Evaluate staff performance**
X	**Verify time worked by staff and approve time sheets**
X	**Discharge staff (common law employer)**
□	**Discharge staff from providing services (co-employer)**
□	**Other** Specify:

b. Participant – Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *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:

ii. Participant-Directed Budget. Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

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

iv. Participant Exercise of Budget Flexibility. *Select one:*

○	**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 participantdirected 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:

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.

Notice of Agency Action and Hearing Rights ~~RIGHTS TO A FAIR HEARING DOCUMENTATION~~

An individual and the individual's legal representative will receive a written Notice of Agency Action, Form 522 and a Hearing Request Form 490S from a DSPD administrative program manager, if the individual is denied a choice of institutional or waiver program, found ineligible for the waiver program, or denied access to the provider of choice for a covered waiver service or experiences a denial, reduction, suspension, or termination in waiver services in accordance with R539-2-5. In instances in which an individual is found to be ineligible for entrance to the waiver, they may request an informal ~~administrative fair~~ hearing from the Department of Health and Human Services, which is dispositive. Services are not afforded during this period of pendency.

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

The Notice of Agency Action and the completed Hearing Request Form ~~s and the opportunity to request a fair hearing documentation is~~ are kept in the individual's USTEPS electronic profile. ~~case record/file and at the Operating Agency – State Office.~~

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

When DSPD receives a Hearing Request Form (490S), and the individual opted to use the Division dispute resolution process, ~~a two-step resolution process begins with:~~
~~1. The Division staff explaining the regulations on which the action is based and attempt to resolve the disagreement.~~
~~2. If resolution is not reached,~~ the Division staff arranges a dispute resolution~~Review~~ meeting between the individual and/or their legal representative and the Director or the Director's designee.

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

If the dispute resolution ~~two-step resolution~~ process is not able to resolve the problem, the individual may request an informal hearing with an administrative law judge or hearing officer with the Department of Health and Human Services, Office of Administrative Hearings.

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

~~DSPD Policy 1.11 Conflict Resolution requires the Ssupport Ccoordinator to provide information to waiver participants on the conflict resolution process and on how to contact the Division. The Division reviews all complaints submitted either orally or written and any relevant information submitted with the complaint. The Division will take appropriate action to resolve the dispute and~~

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~~respond to all parties concerned.~~ If the parties are unable to resolve the dispute either party may appeal to the Division Director or the Director's designee.

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

DSPD Policy 1.11 Conflict Resolution requires the Support Coordinator to provide information to waiver participants on the conflict resolution process and on how to contact the Division. The Division reviews all complaints submitted either orally or written and any relevant information submitted with the complaint.

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Appendix F-3: State Grievance/Complaint System

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

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

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

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

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

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

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

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

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

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

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Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

X	**Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
☐	**No. This Appendix does not apply** (*do not complete Items b through e).* *If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.*

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents, and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

State Medicaid Agency (DHHS) Critical Event or Incident Reporting Requirements:

The SMA requires that DHHS/DSPD report critical events/incidents within 24 hours of the event that occurs either to or by a participant. Reportable incidents or events include: an allegation or confirmation of abuse, neglect, or exploitation; a loss or impairment of the function of a bodily member, organ. or mental faculty or significant disfigurement; a death related to an adverse event; a death of a minor; , a medication error resulting in a telephone call to or a consultation with a poison control center, an emergency department visit, an urgent care visit, or hospitalization;, missing persons, human rights violations such as unauthorized use of restraints, criminal activities that are performed by or perpetrated on waiver participants (including sexual abuse), any significant criminal activity; events that compromise the participant's working or living environment that put a participant(s) at risk, and events that are anticipated to receive media, legislative, or other public scrutiny. The SMA and OA determine who will be responsible for the oversight of the investigation based on the severity/type of incident.

Operating Agency (DSPD) Critical Event or Incident Reporting Requirements:

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

1. Actual or suspected incidents of abuse, neglect, exploitation or maltreatment per the DHHS/DSPD Code of Conduct and Utah Code Annotated Sections 62-A-3-301 through 321 (mandatory reporting to Adult Protective Services)
2. Drug or alcohol misuse
3. Medication overdose or error requiring medical intervention
4. Missing person
5. Evidence of a seizure in person with no seizure diagnosis
6. Significant property destruction ($500.00 or more)
7. Physical injury requiring medical intervention
8. Law enforcement involvement
9. Emergency hospitalizations

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

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

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

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

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

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

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

The following situations are incidents that require the filing of a report:
1. Actual or suspected incidents of abuse, neglect, exploitation, or maltreatment per the DHHS/DSPD Code of Conduct and Utah Code §§ 62-A-3-301 through 321, which can be found at http:// le.utah.gov/code/TITLE62A/htm/62A03_030100.htm for adults; and, Utah Code §§ 62-4a-401 through 412 for children, which can be found at http://le.utah.gov/code/TITLE62A/htm/62A04a040100.htm.
2. Drug or alcohol abuse, medication overdoses or errors reasonably requiring medical intervention,
3. Missing person,
4. Evidence of seizure in a person with no existing seizure diagnosis,
5. Significant property destruction (damage totaling $500.00 or more). Property damage shall be covered by the Contractor's insurance unless it is agreed upon by the person's team that the person shall pay for damages,
6. Physical injury reasonably requiring a medical intervention,
7. Law enforcement involvement,
8. Any use of manual restraint, mechanical restraints, exclusionary time-out or time-out rooms as defined in Utah Administrative Code, Rule R539-4, and level II emergency interventions not outlined in the person's behavioral plan (e.g., response cost, overcorrection). http://rules.utah.gov/publicat/code/r539/r539.htm
9. Any other instances the Contractor determines should be reported.

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

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

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

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

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

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

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

Training for Support Coordinators:
Within the first week of employment a Support Coordinator receives the "Support Coordinator Manual. This manual educates and trains a Support Coordinator of Legal Advocacy Programs and Policies, Child Protective Services, Adult Protective Services, as well as Abuse and Neglect reporting. According to Division's Staff Directive 1.18 "Division Support Coordination Training Requirements" states that by the end of the first year of employment, the Support Coordinator will complete more intensive training in the following areas:…one of them being Abuse, Neglect, and Exploitation."

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

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

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

Paragraph C., reads as follows:
In the second and subsequent years of employment, the Contractor's staff shall complete a minimum of 12 hours of training each year. The Contractor operating licensed facilities shall train staff in behavior management each year per Utah Administrative Code, Rule, DHHS, Office of Licensing (OL) (which may be referred to as DHHS/OL) Rule R501-2-7. http://rules.utah.gov/publicat/code/r501/r501-02.htm#T7

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

Responsibility of the State Medicaid Agency

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

Responsibility of the Operating Agency

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

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

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

In instances where the incident may have involved contracted Supported Coordinators, State staff would conduct the review/investigation of the incident. In instances where the allegation/incident involved conduct by the Operating Agency, the SMA would conduct the investigation.

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

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

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

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

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

During annual chart reviews, State staff reviews for instances where log notes may have indicated a reportable event occurred. In addition, the State has begun efforts to analyze claim/encounter data to review for necessary reports following inpatient stays. Claims data is consulted ad hoc during investigations when believed to be helpful to the investigation or to determine validity in allegations such as waste/fraud/abuse of Medicaid funds or in ANE cases.

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

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:
X	**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).

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

R539-3-10. Prohibited Procedures.
(1) The following procedures are prohibited for Division staff and Providers, including staff hired for Self-Administered Services, in all circumstances in supporting Persons receiving Division funding:
(a) Physical punishment, such as slapping, hitting, and pinching.
(b) Demeaning speech to a Person that ridicules or is abusive.
(c) Locked confinement in a room. [definition of seclusion]
(d) Denial or restriction of access to assistive technology devices, except where removal prevents injury to self, others, or property as outlined in Sections R539-3-6 and R539-4-7.
(e) Withholding or denial of meals, or other supports for biological needs, as a consequence or punishment for problems.
(f) Any Level II or Level III Intervention, as defined in R539-4-3(n) and R539-4-3(o), used as coercion, as convenience to staff, or in retaliation.
(g) Any procedure in violation of R495-876, R512-202, R510-302, 62A-3-301 thru 62A-3-321, and 62A-4a- 402 thru 62A-4a-412 prohibiting abuse.

R539-4-4. Levels of Behavior Interventions.
(2) All Behavior Support Plans shall be implemented only after the Person or Guardian gives consent and the Behavior Support Plan is approved by the Team.
(3) All Behavior Support Plans shall incorporate Positive Behavior Supports with the least intrusive, effective treatment designed to assist the Person in acquiring and maintaining skills, and preventing problems.
(4) Behavior Support Plans must:
(a) Be based on a Functional Behavior Assessment.

(b) Focus on prevention and teach replacement behaviors.
(c) Include planned responses to problems.
(d) Outline a data collection system for evaluating the effectiveness of the plan.
(5) All Provider staff involved in implementing procedures outlined in the Behavior Support Plan shall be trained and demonstrate competency prior to implementing the plan.
(a) Completion of training shall be documented by the Provider.
(b) The Behavior Support Plan shall be available to all staff involved in implementing or supervising the plan.
(8) Level II Interventions may be used in pre-approved Behavior Support Plans or emergency situations. [Includes manual restraint].
(9) Level III Interventions may only be used in pre-approved Behavior Support Plans. [Includes mechanical restraint and seclusion (time-out room)].
(10) Behavior Support Plans that utilize Level II or Level III Interventions shall be implemented only after Positive Behavior Supports, including Level I Interventions, are fully implemented and shown to be ineffective. A rationale on the necessity for the use of intrusive procedures shall be included in the Behavior Support Plan.
(11) Time-out Rooms shall be designed to protect Persons from hazardous conditions, including sharp corners and objects, uncovered light fixtures, and unprotected electrical outlets. The rooms shall have adequate lighting and ventilation.
(a) Doors to the Time-out Room may be held shut by Provider staff, but not locked at any time.
(b) Persons shall remain in Time-out Rooms no more than 2 hours per occurrence.
(c) Provider staff shall monitor Persons in a Time-out Room visually and auditorially on a continual basis. Staff shall document ongoing observation of the Person while in the Time-out Room at least every fifteen minutes.
(12) Time-out Rooms shall be used only upon the occurrence of problems previously identified in the Behavior Support Plan.
(a) Persons shall be placed in the Time-out Room immediately following a previously identified problem. Time delays are not allowed.
(b) Persons shall not be transported to another location for placement in a Time-out Room.
(c) Behavior Support Plans must outline specific release criteria that may include time and behavior components. Time asleep must count toward time-release criteria.
(13) Mechanical restraints shall ensure the Person's safety in breathing, circulation, and prevent skin irritation.
(a) Persons shall be placed in Mechanical Restraints immediately following the identified problem. Time delays are not allowed.
(b) Persons shall not be transported to another location for Mechanical Restraints.
(14) Mechanical Restraints shall be used only upon the occurrence of problems previously identified in the Behavior Support Plan.
(a) Behavior Support Plans must outline specific release criteria that may include time and behavior components. Time asleep must count toward time-release criteria. The plan shall also specify maximum time limits for single application and multiple use.
(b) Behavior Support Plans shall include specific requirements for monitoring the Person, before, during, and after application of the restraint to ensure health and safety.
(c) Provider staff shall document their observation of the Person as specified in the Behavior Support Plan.
(15) Manual restraints shall ensure the Person's safety in breathing and circulation. Manual restraint procedures are limited to the Mandt System (Mandt), the Professional Assault Response Training (PART), or Supports Options and Actions for Respect (SOAR) training

programs. Procedures not outlined in the programs listed above may only be used if pre-approved by the State Behavior Review Committee.
(16) Behavior Support Plans that include Manual Restraints shall provide information on the method of restraint, release criteria, and time limitations on use.

R539-4-5. Review and Approval Process.
(1) The Behavior Peer Review Committee shall review and approve the Behavior Support Plan annually. The plan may be implemented prior to the Behavior Peer Review Committee's review; however the review and approval must be completed within 60 calendar days of implementation.
(2) The Behavior Peer Review Committee's review and approval process shall include the following:
(a) A confirmation that appropriate Positive Behavior Supports, including Level I Interventions, were fully implemented and revised as needed prior to the implementation of Level II or Level III Interventions.
(b) Ensure the technical adequacy of the Functional Behavior Assessment and Behavior Support Plan based on principles from the fields of Positive Behavior Supports and applied behavior analysis.
(c) Ensure plans are in place to attempt reducing the use of intrusive interventions.
(d) Ensure that staff training and plan implementation are adequate.
(3) The Provider Human Rights Committee shall approve Behavior Support Plans with Level II and Level III Interventions annually. Review and approval shall focus on rights issues, including consent and justification for the use of intrusive interventions.
(4) The State Behavior Review Committee must consist of at least three members, including representatives from the Division, Provider, and an independent professional having a recognized expertise in Positive Behavior Supports. The Committee shall review and approve the following:
(a) Behavior Support Plans that include Time-out Rooms, Mechanical Restraints or Highly Noxious Stimuli.
(b) Behavior Support Plans that include forms of Manual Restraint or Exclusionary Time-out used for long-term behavior change and not used in response to an emergency situation.
(c) Behavior Support Plans that include manual restraint not outlined in Mandt, PART or SOAR training programs.
(5) The Committee shall determine the time-frame for follow-up review.
(6) Behavior Support Plans shall be submitted to the Division's state office for temporary approval prior to implementation pending the State Behavior Review Committee's review of the plan.
(7) Families participating in Self-Administered Services may seek State Behavior Review Committee recommendations, if desired.

R539-4-6. Emergency Behavior Interventions.
(1) Emergency Behavior Interventions may be necessary to prevent clear and imminent threat of injury or property destruction during emergency situations.
(2) Level I Interventions shall be used first in emergency situations, if possible.
(3) The least intrusive Level II Interventions shall be used in emergency situations. The length of time in which the intervention is implemented shall be limited to the minimum amount of time required to resolve the immediate emergency situation.
(4) Each use of Emergency Behavior Interventions and a complete Emergency Behavior Intervention Review shall be documented by the Provider on Division Form 1-8 and forwarded to the Division, as outlined in the Provider's Service Contract with the Division.

(a) The Emergency Behavior Intervention Review shall be conducted by the Provider supervisor or specialist and staff involved with the Emergency Behavior Intervention. The review shall include the following:
(i) The circumstances leading up to and following the problem.
(ii) If the Emergency Behavior Intervention was justified.
(iii) Recommendations for how to prevent future occurrences, if applicable.
(5) The Person's Support Coordinator shall review Form 1-8 received from Providers and document the follow-up action.
(6) If Emergency Behavior Interventions are used three times, or for a total of 25 minutes, within 30 calendar days, the Team shall meet within ten business days of the date the above criteria are met to review the interventions and determine if:
(a) A Behavior Support Plan is needed;
(b) Level II or III Interventions are required in the Behavior Support Plan;
(c) Technical assistance is needed;
(d) Arrangements should be made with other agencies to prevent or respond to future crisis situations; or
(e) Other solutions can be identified to prevent future use of Emergency Behavior Interventions.
(7) The Provider's Human Rights Committee shall review each use of Emergency Behavior Interventions.

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

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

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

The SMA actively participates in the immediate oversight of Level 1 incidents and quarterly review of Level 2 incidents and has a standing member on the OA's Human Rights Council.

b. Use of Restrictive Interventions

☐	**The State does not permit or prohibits the use of restrictive interventions** Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:
X	**The use of restrictive interventions is permitted during the course of the delivery of waiver services.** Complete Items G-2-b-i and G-2-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.

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

R539-3-10. Prohibited Procedures.
(1) The following procedures are prohibited for Division staff and Providers, including staff hired for Self-Administered Services, in all circumstances in supporting Persons receiving Division funding:
(a) Physical punishment, such as slapping, hitting, and pinching.
(b) Demeaning speech to a Person that ridicules or is abusive.
(c) Locked confinement in a room. [definition of seclusion]
(d) Denial or restriction of access to assistive technology devices, except where removal prevents injury to self, others, or property as outlined in Sections R539-3-6 and R539-4-7.
(e) Withholding or denial of meals, or other supports for biological needs, as a consequence or punishment for problems.
(f) Any Level II or Level III Intervention, as defined in R539-4-3(n) and R539-4-3(o), used as coercion, as convenience to staff, or in retaliation.
(g) Any procedure in violation of R495-876, R512-202, R510-302, 62A-3-301 thru 62A-3-321, and 62A-4a- 402 thru 62A-4a-412 prohibiting abuse.

R539-4-4. Levels of Behavior Interventions.
(2) All Behavior Support Plans shall be implemented only after the Person or Guardian gives consent and the Behavior Support Plan is approved by the Team.
(3) All Behavior Support Plans shall incorporate Positive Behavior Supports with the least intrusive, effective treatment designed to assist the Person in acquiring and maintaining skills, and preventing problems.
(4) Behavior Support Plans must:
(a) Be based on a Functional Behavior Assessment.
(b) Focus on prevention and teach replacement behaviors.
(c) Include planned responses to problems.
(d) Outline a data collection system for evaluating the effectiveness of the plan.
(5) All Provider staff involved in implementing procedures outlined in the Behavior Support Plan shall be trained and demonstrate competency prior to implementing the plan.
(a) Completion of training shall be documented by the Provider.
(b) The Behavior Support Plan shall be available to all staff involved in implementing or supervising the plan.
(8) Level II Interventions may be used in pre-approved Behavior Support Plans or emergency situations. [Includes manual restraint].
(9) Level III Interventions may only be used in pre-approved Behavior Support Plans. [Includes mechanical restraint and seclusion (time-out room)].
(10) Behavior Support Plans that utilize Level II or Level III Interventions shall be implemented only after Positive Behavior Supports, including Level I Interventions, are fully implemented and shown to be ineffective. A rationale on the necessity for the use of intrusive procedures shall be included in the Behavior Support Plan.

(11) Time-out Rooms shall be designed to protect Persons from hazardous conditions, including sharp corners and objects, uncovered light fixtures, and unprotected electrical outlets. The rooms shall have adequate lighting and ventilation.
(a) Doors to the Time-out Room may be held shut by Provider staff, but not locked at any time.
(b) Persons shall remain in Time-out Rooms no more than 2 hours per occurrence.
(c) Provider staff shall monitor Persons in a Time-out Room visually and auditorially on a continual basis. Staff shall document ongoing observation of the Person while in the Time-out Room at least every fifteen minutes.
(12) Time-out Rooms shall be used only upon the occurrence of problems previously identified in the Behavior Support Plan.
(a) Persons shall be placed in the Time-out Room immediately following a previously identified problem. Time delays are not allowed.
(b) Persons shall not be transported to another location for placement in a Time-out Room.
(c) Behavior Support Plans must outline specific release criteria that may include time and behavior components. Time asleep must count toward time-release criteria.
(13) Mechanical restraints shall ensure the Person's safety in breathing, circulation, and prevent skin irritation.
(a) Persons shall be placed in Mechanical Restraints immediately following the identified problem. Time delays are not allowed.
(b) Persons shall not be transported to another location for Mechanical Restraints.
(14) Mechanical Restraints shall be used only upon the occurrence of problems previously identified in the Behavior Support Plan.
(a) Behavior Support Plans must outline specific release criteria that may include time and behavior components. Time asleep must count toward time-release criteria. The plan shall also specify maximum time limits for single application and multiple use.
(b) Behavior Support Plans shall include specific requirements for monitoring the Person, before, during, and after application of the restraint to ensure health and safety.
(c) Provider staff shall document their observation of the Person as specified in the Behavior Support Plan.
(15) Manual restraints shall ensure the Person's safety in breathing and circulation. Manual restraint procedures are limited to the Mandt System (Mandt), the Professional Assault Response Training (PART), or Supports Options and Actions for Respect (SOAR) training programs. Procedures not outlined in the programs listed above may only be used if pre-approved by the State Behavior Review Committee.
(16) Behavior Support Plans that include Manual Restraints shall provide information on the method of restraint, release criteria, and time limitations on use.

R539-4-5. Review and Approval Process.
(1) The Behavior Peer Review Committee shall review and approve the Behavior Support Plan annually. The plan may be implemented prior to the Behavior Peer Review Committee's review; however the review and approval must be completed within 60 calendar days of implementation.
(2) The Behavior Peer Review Committee's review and approval process shall include the following:
(a) A confirmation that appropriate Positive Behavior Supports, including Level I Interventions, were fully implemented and revised as needed prior to the implementation of Level II or Level III Interventions.

(b) Ensure the technical adequacy of the Functional Behavior Assessment and Behavior Support Plan based on principles from the fields of Positive Behavior Supports and applied behavior analysis.
(c) Ensure plans are in place to attempt reducing the use of intrusive interventions.
(d) Ensure that staff training and plan implementation are adequate.
(3) The Provider Human Rights Committee shall approve Behavior Support Plans with Level II and Level III Interventions annually. Review and approval shall focus on rights issues, including consent and justification for the use of intrusive interventions.
(4) The State Behavior Review Committee must consist of at least three members, including representatives from the Division, Provider, and an independent professional having a recognized expertise in Positive Behavior Supports. The Committee shall review and approve the following:
(a) Behavior Support Plans that include Time-out Rooms, Mechanical Restraints or Highly Noxious Stimuli.
(b) Behavior Support Plans that include forms of Manual Restraint or Exclusionary Time-out used for long-term behavior change and not used in response to an emergency situation.
(c) Behavior Support Plans that include manual restraint not outlined in Mandt, PART or SOAR training programs.
(5) The Committee shall determine the time-frame for follow-up review.
(6) Behavior Support Plans shall be submitted to the Division's state office for temporary approval prior to implementation pending the State Behavior Review Committee's review of the plan.
(7) Families participating in Self-Administered Services may seek State Behavior Review Committee recommendations, if desired.

R539-4-6. Emergency Behavior Interventions.
(1) Emergency Behavior Interventions may be necessary to prevent clear and imminent threat of injury or property destruction during emergency situations.
(2) Level I Interventions shall be used first in emergency situations, if possible.
(3) The least intrusive Level II Interventions shall be used in emergency situations. The length of time in which the intervention is implemented shall be limited to the minimum amount of time required to resolve the immediate emergency situation.
(4) Each use of Emergency Behavior Interventions and a complete Emergency Behavior Intervention Review shall be documented by the Provider on Division Form 1-8 and forwarded to the Division, as outlined in the Provider's Service Contract with the Division.
(a) The Emergency Behavior Intervention Review shall be conducted by the Provider supervisor or specialist and staff involved with the Emergency Behavior Intervention. The review shall include the following:
(i) The circumstances leading up to and following the problem.
(ii) If the Emergency Behavior Intervention was justified.
(iii) Recommendations for how to prevent future occurrences, if applicable.
(5) The Person's Support Coordinator shall review Form 1-8 received from Providers and document the follow-up action.
(6) If Emergency Behavior Interventions are used three times, or for a total of 25 minutes, within 30 calendar days, the Team shall meet within ten business days of the date the above criteria are met to review the interventions and determine if:
(a) A Behavior Support Plan is needed;
(b) Level II or III Interventions are required in the Behavior Support Plan;
(c) Technical assistance is needed;

(d) Arrangements should be made with other agencies to prevent or respond to future crisis situations; or
(e) Other solutions can be identified to prevent future use of Emergency Behavior Interventions.
(7) The Provider's Human Rights Committee shall review each use of Emergency Behavior Interventions.

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

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

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

The SMA actively participates in the immediate oversight of Level 1 incidents and quarterly review of Level 2 incidents and has a standing member on the OA's Human Rights Council.

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:

X	**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 in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Utah Administrative Rules describe the use of seclusion and the safeguards in place to protect participants when seclusion is used, including:

R539-3-10. Prohibited Procedures.
(1) The following procedures are prohibited for Division staff and Providers, including staff hired for Self-Administered Services, in all circumstances in supporting Persons receiving Division funding:
(a) Physical punishment, such as slapping, hitting, and pinching.
(b) Demeaning speech to a Person that ridicules or is abusive.
(c) Locked confinement in a room. [definition of seclusion]
(d) Denial or restriction of access to assistive technology devices, except where removal prevents injury to self, others, or property as outlined in Sections R539-3-6 and R539-4-7.
(e) Withholding or denial of meals, or other supports for biological needs, as a consequence or punishment for problems.
(f) Any Level II or Level III Intervention, as defined in R539-4-3(n) and R539-4-3(o), used as coercion, as convenience to staff, or in retaliation.
(g) Any procedure in violation of R495-876, R512-202, R510-302, 62A-3-301 thru 62A-3-321, and 62A-4a- 402 thru 62A-4a-412 prohibiting abuse.
R539-4-4. Levels of Behavior Interventions.
(2) All Behavior Support Plans shall be implemented only after the Person or Guardian gives consent and the Behavior Support Plan is approved by the Team.
(3) All Behavior Support Plans shall incorporate Positive Behavior Supports with the least intrusive, effective treatment designed to assist the Person in acquiring and maintaining skills, and preventing problems.
(4) Behavior Support Plans must:
(a) Be based on a Functional Behavior Assessment.
(b) Focus on prevention and teach replacement behaviors.
(c) Include planned responses to problems.
(d) Outline a data collection system for evaluating the effectiveness of the plan.
(5) All Provider staff involved in implementing procedures outlined in the Behavior Support Plan shall be trained and demonstrate competency prior to implementing the plan.
(a) Completion of training shall be documented by the Provider.
(b) The Behavior Support Plan shall be available to all staff involved in implementing or supervising the plan.
(8) Level II Interventions may be used in pre-approved Behavior Support Plans or emergency situations. [Includes manual restraint].

(9) Level III Interventions may only be used in pre-approved Behavior Support Plans. [Includes mechanical restraint and seclusion (time-out room)].
(10) Behavior Support Plans that utilize Level II or Level III Interventions shall be implemented only after Positive Behavior Supports, including Level I Interventions, are fully implemented and shown to be ineffective. A rationale on the necessity for the use of intrusive procedures shall be included in the Behavior Support Plan.
(11) Time-out Rooms shall be designed to protect Persons from hazardous conditions, including sharp corners and objects, uncovered light fixtures, and unprotected electrical outlets. The rooms shall have adequate lighting and ventilation.
(a) Doors to the Time-out Room may be held shut by Provider staff, but not locked at any time.
(b) Persons shall remain in Time-out Rooms no more than 2 hours per occurrence.
(c) Provider staff shall monitor Persons in a Time-out Room visually and auditorially on a continual basis. Staff shall document ongoing observation of the Person while in the Time-out Room at least every fifteen minutes.
(12) Time-out Rooms shall be used only upon the occurrence of problems previously identified in the Behavior Support Plan.
(a) Persons shall be placed in the Time-out Room immediately following a previously identified problem. Time delays are not allowed.
(b) Persons shall not be transported to another location for placement in a Time-out Room.
(c) Behavior Support Plans must outline specific release criteria that may include time and behavior components. Time asleep must count toward time-release criteria.
(13) Mechanical restraints shall ensure the Person's safety in breathing, circulation, and prevent skin irritation.
(a) Persons shall be placed in Mechanical Restraints immediately following the identified problem. Time delays are not allowed.
(b) Persons shall not be transported to another location for Mechanical Restraints.
(14) Mechanical Restraints shall be used only upon the occurrence of problems previously identified in the Behavior Support Plan.
(a) Behavior Support Plans must outline specific release criteria that may include time and behavior components. Time asleep must count toward time-release criteria. The plan shall also specify maximum time limits for single application and multiple use.
(b) Behavior Support Plans shall include specific requirements for monitoring the Person, before, during, and after application of the restraint to ensure health and safety.
(c) Provider staff shall document their observation of the Person as specified in the Behavior Support Plan.
(15) Manual restraints shall ensure the Person's safety in breathing and circulation. Manual restraint procedures are limited to the Mandt System (Mandt), the Professional Assault Response Training (PART), or Supports Options and Actions for Respect (SOAR) training programs. Procedures not outlined in the programs

listed above may only be used if pre-approved by the State Behavior Review Committee.
(16) Behavior Support Plans that include Manual Restraints shall provide information on the method of restraint, release criteria, and time limitations on use.

R539-4-5. Review and Approval Process.
(1) The Behavior Peer Review Committee shall review and approve the Behavior Support Plan annually. The plan may be implemented prior to the Behavior Peer Review Committee's review; however the review and approval must be completed within 60 calendar days of implementation.
(2) The Behavior Peer Review Committee's review and approval process shall include the following:
(a) A confirmation that appropriate Positive Behavior Supports, including Level I Interventions, were fully implemented and revised as needed prior to the implementation of Level II or Level III Interventions.
(b) Ensure the technical adequacy of the Functional Behavior Assessment and Behavior Support Plan based on principles from the fields of Positive Behavior Supports and applied behavior analysis.
(c) Ensure plans are in place to attempt reducing the use of intrusive interventions.
(d) Ensure that staff training and plan implementation are adequate.
(3) The Provider Human Rights Committee shall approve Behavior Support Plans with Level II and Level III Interventions annually. Review and approval shall focus on rights issues, including consent and justification for the use of intrusive interventions.
(4) The State Behavior Review Committee must consist of at least three members, including representatives from the Division, Provider, and an independent professional having a recognized expertise in Positive Behavior Supports. The Committee shall review and approve the following:
(a) Behavior Support Plans that include Time-out Rooms, Mechanical Restraints or Highly Noxious Stimuli.
(b) Behavior Support Plans that include forms of Manual Restraint or Exclusionary Time-out used for long-term behavior change and not used in response to an emergency situation.
(c) Behavior Support Plans that include manual restraint not outlined in Mandt, PART, SOAR, Safety Care, or CPI training programs.
(5) The Committee shall determine the time-frame for follow-up review.
(6) Behavior Support Plans shall be submitted to the Division's state office for temporary approval prior to implementation pending the State Behavior Review Committee's review of the plan.
(7) Families participating in Self-Administered Services may seek State Behavior Review Committee recommendations, if desired.

R539-4-6. Emergency Behavior Interventions.
(1) Emergency Behavior Interventions may be necessary to prevent clear and imminent threat of injury or property destruction during emergency situations.
(2) Level I Interventions shall be used first in emergency situations, if possible.

(3) The least intrusive Level II Interventions shall be used in emergency situations. The length of time in which the intervention is implemented shall be limited to the minimum amount of time required to resolve the immediate emergency situation.
(4) Each use of Emergency Behavior Interventions and a complete Emergency Behavior Intervention Review shall be documented by the Provider on Division Form 1-8 and forwarded to the Division, as outlined in the Provider's Service Contract with the Division.
(a) The Emergency Behavior Intervention Review shall be conducted by the Provider supervisor or specialist and staff involved with the Emergency Behavior Intervention. The review shall include the following:
(i) The circumstances leading up to and following the problem.
(ii) If the Emergency Behavior Intervention was justified.
(iii) Recommendations for how to prevent future occurrences, if applicable.
(5) The Person's Support Coordinator shall review Form 1-8 received from Providers and document the follow-up action.
(6) If Emergency Behavior Interventions are used three times, or for a total of 25 minutes, within 30 calendar days, the Team shall meet within ten business days of the date the above criteria are met to review the interventions and determine if:
(a) A Behavior Support Plan is needed;
(b) Level II or III Interventions are required in the Behavior Support Plan;
(c) Technical assistance is needed;
(d) Arrangements should be made with other agencies to prevent or respond to future crisis situations; or
(e) Other solutions can be identified to prevent future use of Emergency Behavior Interventions.
(7) The Provider's Human Rights Committee shall review each use of Emergency Behavior Interventions.

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

The SMA monitors the use of seclusion during formal reviews and also when reviewing critical incident notifications. The SMA reviews participant records and conducts interviews with providers and participants to determine if all incidents of seclusion have been reported and appropriately administered. Behavior Support Plans are also reviewed to determine if the use of seclusion has been appropriately addressed in the plan including safeguards that address the health and welfare of the participant and that the Human Rights Committee has appropriately reviewed and approved the use of seclusion. The formal reviews are conducted, at a minimum, every five years. The sample size for each review will be sufficient to provide a confidence level equal to 95% and a confidence interval equal to five. The SMA has established a Critical Incident/Event Notification system that requires the operating agency to notify the SMA of any serious incidents. The SMA reviews, on an ongoing basis, 100% of the use of seclusion that is reported as part of critical incident notifications.

The operating agency has the day- to- day responsibility to assure that appropriate procedures are followed regarding the implementation of the use of seclusion. All uses of time-out rooms are recorded on incident reports and are reviewed at least monthly by support coordinators. The Provider Human Rights Committee reviews all emergency seclusion use. All programmatic use of time-out rooms is reviewed and approved annually by the participant's PCSP team, Provider Behavior Peer Review, and Provider Human Rights Committee. All programmatic use of time-out rooms is also summarized in provider's Behavior Consultation Service Progress Notes and reviewed at least monthly by Support Coordinators.

The SMA actively participates in the immediate oversight of Level 1 incidents and quarterly review of Level 2 incidents and has a standing member on the OA's Human Rights Council.

Appendix G-3: Medication Management and Administration

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

a. Applicability. Select one:

☐	**No**. **This Appendix is not applicable** *(do not complete the remaining items)*
X	**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.

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

Methods for Conducting Monitoring:
1. Providers are required to train all applicable staff in medication assistance procedures. Training records are maintained to verify compliance. Providers are required to perform quality assurance activities and improvements which may include medication record reviews.
2. DHHS/DSPD certifies new providers before contracting for services. Medication training and competency is part of the certification process. DHHS/DSPD also conducts annual contract reviews to verify provider compliance with medication training and competency. The DSPD Quality Assurance Team conducts ad hoc monitoring of providers to ensure competency. Psychotropic medications, which require a Psychotropic Medication Plan, are monitored through the DSPD Human Rights Committee. The committee determines appropriateness of the Psychotropic Medication Plan, and reviews any human rights restrictions.
3. The SMA conducts Quality Assurance Reviews which include Performance Measures to monitor provider compliance with medication management, including psychotropic medications. When adverse practices are discovered, a remediation is cited in the review which requires DHHS/DSPD to provide a plan of correction.

Frequency of Monitoring:

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

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

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

Methods used to ensure participant medications are managed appropriately
(a.) the identification of potentially harmful practices:
- Providers perform ongoing monitoring of self-directed self-administrated medication management by showing compliance with the contractual agreement of staff medication competencies.
- DSPD places a contractual obligation on its providers who participate in the supervised self-directed self-administration of waiver enrollee medications to utilize "blister-pack" medication packaging from licensed pharmacies whenever possible. The licensed pharmacy plays a role in monitoring medications for potentially harmful practices.
- Periodic monitoring of participant health and welfare is performed by the support coordinator.
- DHHS/DSPD contract analyst reviews staff medication competencies annually.
- DHHS/DSPD Quality Assurance compiles and analyzes incident report data that includes medication errors.
- The SMA conducts Quality Assurance Reviews which include medication performance measures.

(b.) The method for following up on potentially harmful practices
- Notification of incidents (including medication errors) is required per contractual agreement to be submitted by the Provider to the DSPD support coordinator within 24 hours. A written incident report must be submitted within 5 days.
- Each participant's record must contain a list of possible reactions and precautions for medications.

• The Provider must notify a licensed health care professional when medication errors occur. • Medication errors must be incorporated into the QA process for that provider. • Training is provided per Provider Contract on: types of errors to report, who to report errors to and how errors are followed up. (c.) The State agency that is responsible for follow up and oversight. • Providers are contractually obligated to furnish incident reports to DHHS/DSPD regarding medication errors and these reports are reviewed by both the DHHS Office of Licensing as well as the Division Leadership Team. • The SMA receives an annual Incident Report Summary from DSPD which include an analysis of medication errors by Providers.

c. Medication Administration by Waiver Providers

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

☐	Not applicable (*do not complete the remaining items*)
X	**Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

X	**Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).** *Complete the following three items:*
	(a) Specify State agency (or agencies) to which errors are reported:
	All medication errors are reported to the Division of Services for People with Disabilities Medication errors considered to be critical incidents are reported to the SMA.
	(b) Specify the types of medication errors that providers are required to *record:*
	Providers must record medication error including: wrong dose, wrong time, wrong route, and wrong medication or missed medication.
	(c) Specify the types of medication errors that providers must *report* to the State:
	Any Medication error that occurs will be reported on an incident report form and will be reported to the support coordinator and the provider director or designee, The employee must notify the support coordinator and representative within 24 hours of the development of any apparent medical need for the person Medication overdoses or medication errors reasonably requiring medical intervention much be reported to the DHS Office of Licensing by the provider within 24 hours
☐	**Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.** Specify the types of medication errors that providers are required to record:

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

DSPD compiles an annual incident report which includes medication errors reported by providers. DHHS/DSPD Contract Analyst reviews each provider on an annual basis, identifies problems with medication management and requires follow-up remediation actions and quality improvement activities if the problem is systemic. DHHS/DSPD performs Ad Hoc reviews that may identify medication management problems, which require follow-up by the provider and incorporation into their quality assurance program. The SMA receives the findings from the above monitoring activities on an on-going basis and as an annual report.

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

Quality Improvement: Health and Welfare

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

a. **Methods for Discovery: Health and Welfare**
The State 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.)*

i. **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 suspected abuse, neglect, exploitation and unexpected death incidents referred to Adult Protective Services and/or law enforcement as required by State law. The numerator is the total number of incidents reported correctly; the denominator is the total number of reported incidents reviewed involving suspected abuse, neglect, exploitation, and/or unexpected death*
Data Source *(Select one) (Several options are listed in the on-line application):Other*	
If 'Other' is selected, specify:	
DSPD records, Participant records, Incident reports, DSPD Annual Incident report	

State:	
Effective Date	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation :*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error*
	☐ Other Specify:	*X Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify	
			☐ Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

Performance Measure:	*Number and percentage of incidents involving abuse, neglect, exploitation and unexpected death of waiver participants where recommended actions to protect health and welfare were implemented. The numerator is the total number of reported incidents where recommended actions to protect health and welfare were implemented; the denominator is the total number of incidents requiring safeguards.*
Data Source *(Select one) (Several options are listed in the on-line application):Other*	

State:	
Effective Date	

If 'Other' is selected, specify:			
Incident reports			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation :*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error*
	☐ Other Specify:	*X Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

Performance Measure:	*Number and percentage of waiver participant deaths for which the Department of Human Services' Fatality Review Committee process was followed. The numerator is the total number of waiver participant deaths for which the Department of Human Services' Fatality Review Committee*

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	process was followed; the denominator is the total number of waiver participant deaths.
Data Source *(Select one) (Several options are listed in the on-line application):Other*	
If 'Other' is selected, specify:	
Participant records and Annual report	

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

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

State:	
Effective Date	

Performance Measure:	*Number and percentage of abuse, neglect, exploitation and unexpected death incidents reported to the Division of Services for People with Disabilities within 24 hours of the discovery of the occurrence. The numerator is the total number of abuse, neglect, exploitation and unexpected death incidents reviewed that were reported to the Division of Services for People with Disabilities within 24 hours of the discovery of the occurrence; the denominator is the total number of abuse, neglect, exploitation and unexpected death incidents reviewed.*
Data Source *(Select one) (Several options are listed in the on-line application):Other*	
If 'Other' is selected, specify:	
Participant records, Incident reports, Provider interviews and Provider records	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation :*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error*
	☐ Other Specify:	*☐ Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		X Other Specify: Every two years	
			☐ Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

State:	
Effective Date	

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

Performance Measure:	*Number and percentage of abuse, neglect, exploitation and unexpected death incidents for which providers submit an incident report within 5 business days of the discovery of an incident. The numerator is the total number of incidents reviewed for which providers submit an incident report within 5 business days of the discovery of the incident; the denominator is the total number of abuse, neglect, exploitation and unexpected death incidents reviewed.*

Data Source *(Select one) (Several options are listed in the on-line application):Other*

If 'Other' is selected, specify:

Participant records and incident reports

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation :*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	☐ *Weekly*	☐ *100% Review*
	X Operating Agency	☐ *Monthly*	*X Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	*X Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error*
	☐ *Other Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		X Other Specify: Every two years	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

State:	
Effective Date	

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

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.

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.

Add another Data Source for this performance measure

Data Aggregation and Analysis

State:	
Effective Date	

Add another Data Source for this performance measure

Data Aggregation and Analysis

Performance Measure:	*Number and percentage of critical incident trends identified for systemic intervention that were implemented. The numerator is the number of trends where systemic intervention was implemented; the denominator is the total number of critical incident trends.*		
Data Source *(Select one) (Several options are listed in the on-line application):Other*			
If 'Other' is selected, specify:			
Participant records, Participant Service plans, Participant interviews and Provider interviews			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*

	☐ *Sub-State Entity*	☐ *Quarterly*		*X Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error*
	☐ *Other Specify:*	*X Annually*		
		☐ *Continuously and Ongoing*		☐ *Stratified: Describe Group:*
		☐ *Other Specify:*		
				☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

c. Sub-assurance: The State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

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

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

Performance Measure:	*Number and percentage of incidents identifying unauthorized use of restrictive interventions (including restraints and seclusion) that were*

State:	
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	appropriately reported, investigated and for which recommended follow-up was completed. The numerator is the total number of incidents reviewed identifying the use of unauthorized restrictive interventions which were appropriately reported investigated and for which recommended follow-up was completed; the denominator is the total number of incidents reviewed that identified the use of unauthorized restrictive interventions(including restraints and seclusion).

Data Source *(Select one) (Several options are listed in the on-line application):Other*

If 'Other' is selected, specify:

Participant records and Incident reports

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation :*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error*
	☐ Other Specify:	*X Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify: Every two years	
			☐ Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

State:	
Effective Date	

	☐ *Other Specify:*

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.

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.

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

Referrals are made to Adult Protective Services and/or law enforcement according to State laws. Prevention strategies are developed and implemented, when abuse, neglect, or exploitation are reported. Health and welfare needs are addressed and steps are taken to resolve concerns in a timely manner and are documented in the record. In most cases face to face visits are conducted to verify that concerns are resolved. When a critical incident occurs at a provider location, the provider must notify the support coordinator within twenty-four hours of the discovery of the occurrence. In addition, when an incident occurs at a provider location, providers must document the details of the incident on Form 1-8 and submit this form to the Support Coordinator within five business days of the discovery of the incident. The SMA Quality Assurance Team conducts monitoring when notified byDSPD of a level one critical incident or event.

DSPD conducts reviews of each provider every other year to assure and evaluate the provider's Quality Improvement Plan, which includes incident reporting and Human Rights Plans. When a fatality occurs, the Fatality Review Committee reviews the death and submits a written report to the DSPD director. If follow up is required, DSPD and the Director submit a report commenting on the findings and recommendations to the Fatality Review Committee within 15 working days. This report includes an action plan to implement recommended improvements. The DSPD Director is responsible for ensuring the recommendations are implemented.

The OA conducts an annual review of the ABI program for each of the five waiver years. At a minimum one comprehensive review will be conducted during this five year cycle. The other annual reviews will be focused reviews. The criteria for the focused reviews will be determined from DSPD and SMA review findings as well as other issues that develop during the review year.

b. Methods for Remediation/Fixing Individual Problems

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

Individual issues identified that affect the health and welfare of individual participants are addressed immediately. These issues are addressed in a variety of ways, and may include: a) direct contact for additional information if any, and b) informal discussion or formal (written) notice of adverse findings. The SMA will use discretion in determining notice requirements depending on the findings. Examples of issues requiring intervention by the SMA would include: overpayments; allegations or substantiated violations of health and safety; necessary involvement of APS and/or local law enforcement; or issues involving the State's Medicaid Fraud Control Unit or Office of Inspector General.

To assure the issue has been addressed, \DSPD is required to report back to the SMA on the results of their interventions within designated time frames. These time frames are outlined in standard operating procedures or protocols or are stipulated on a case by case basis depending on the nature of a specific issue. A description of issues requiring immediate attention and outcomes are documented through the SMA final report.

Issues that are less immediate are corrected within designated time frames and are also documented through the SMA final review report. When the SMA determines that an issue is resolved, notification is provided and documentation is maintained.

ii. Remediation Data Aggregation

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

c. Timelines

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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.

X	**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.

State:	
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Appendix H: Quality Improvement Strategy

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

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

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

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

State:	
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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;
- 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 QIS* and revise it as necessary and appropriate.

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

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

H.1 Systems Improvement

a. **System Improvements**

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

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

ii. System Improvement Activities

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

b. **System Design Changes**

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The SMA will establish a Quality Improvement Committee consisting of the SMA Quality Assurance Team, DHHS and DSPD among others. The team will meet to assess the results of the systems design changes. The success of the systems changes will be based on criteria that must be met to determine that the change has been accomplished and also criteria that will determine that the systems change has been sustained or will be sustained. The Quality Improvement Committee will determine the sustainability criteria. Results of system design changes will be communicated to participants and families, providers, agencies and others through the Medicaid Information Bulletin, ~~the ABI Quarterly Newsletter,~~ the DSPD web site, and DSPD Advisory Council~~Board Meeting~~s. The Quality Improvement Committee utilizes data from quarterly and/or annual quality improvement reports to review findings and inform the development of any necessary Quality Improvement Plans. 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. All members of the Quality Improvement Committee can support the development of strategies to improve outcomes; action items are assigned to appropriate agency representatives in the accountability tracker to ensure research is conducted and strategies are fully developed in accordance with Committee timelines and expectations. The Committee assesses the effectiveness of system improvements through the review of quality improvement reports at a minimum of quarterly, more frequently as necessary, or in accordance with the Quality Improvement Plan for any performance measure with a rate of compliance below 86%.

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

The Quality Improvement Strategy is a dynamic document that is continuously evaluated each year by the SMA's quality management team. The team evaluates the data collection process and makes changes as necessary to allow for accurate data collection and analysis. In addition the Quality Improvement Committee will evaluate the QIS after the third year of the waiver operation. This committee will meet to discuss the elements of the QIS for each assurance, the findings relative to each performance measure and the contributions of all parties that conduct quality assurance of the ABI waiver. Improvements to the QIS will be made at this time and submitted in the following waiver renewal application.

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Appendix I: Financial Accountability

APPENDIX I-1: Financial Integrity and Accountability

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

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

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

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

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

In accordance with DSPD's lead role and designated responsibilities, monies allocated for services for persons with disabilities are appropriated by the State Legislature to DSPD which in turn contracts with public and private providers for the delivery of services. To assure the proper accounting for State funds, DSPD enters into a written State contract with each provider. This State-specific requirement applies regardless of whether:

1) the State funds are used for State-funds only programs or are used to draw down FFP as part of a 1915(c) HCBS Waiver program, or
2) the target population includes Medicaid-eligible citizens. The State contract is the sole responsibility of, and is managed by, DSPD's parent agency, the Department of Health and Human Services.

In the case where a portion of the annual Legislative appropriation is designated for use as State matching funds for the Medicaid 1915(c) HCBS Waiver described herein, DSPD certifies to the State Medicaid Agency, through an interagency agreement, that the State funds will be transferred to the

State:	
Effective Date	

State Medicaid Agency in the amount necessary to reimburse the State match portion of projected Medicaid expenditures paid through the MMIS system for waiver services.

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

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

STATE MEDICAID AGENCY ROLE AND PROVIDER CONTRACT REQUIREMENT

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

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

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

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

Each month the support coordinator reviews the billing statement and a monthly budget report ~~generated by the DSPD Financial Analyst~~.in the USTEPS Provider Interface (UPI) system

INTERAGENCY AGREEMENT FOR OPERATIONS AND ADMINISTRATION OF THE HCBS WAIVER

An ~~interagency~~ agreement between the State Medicaid Agency and DSPD sets forth the respective responsibilities for the administration and operation of this waiver. The agreement delineates the State Medicaid Agency's overall responsibility to provide management and oversight of the waiver including review and approval of all waiver related rules and policies to ensure compliance with Medicaid HCBS Waiver rules and regulations. The agreement also delineates

DSPD's roles in relation to the statutory responsibilities to develop the State's program for persons with disabilities. The nature of the agreement enhances provider access to the Medicaid program and quality assurance of services as well as defines the fiscal relationship between the two agencies.

The major components of the agreement are:

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

Quality Improvement: Financial Accountability

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

a. **Methods for Discovery: Financial Accountability 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.)*

a.i. 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

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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 paid claims in a representative sample for services identified on a participant's service plan which in total do not exceed the participant's annual budget. The numerator is the total number of paid claims made for waiver services which were in compliance; the denominator is the total number of paid claims in the review sample.*
Data Source *(Select one) (Several options are listed in the on-line application): Other*	
If 'Other' is selected, specify:	
Participant Claims Data, PCSP, Participant Budgets, and Provider Records	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation :*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error*
	☐ Other Specify:	*X Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

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Specify:	
	☐ Continuously and Ongoing
	X Other *Specify: Every two years.*

Performance Measure:	*Number and percentage of paid claims in a representative sample for services that use approved waiver codes and rates. The numerator is the total number of paid claims in the review sample for services that use approved waiver codes and rates; the denominator is the total number of paid claims in the review sample.*

Data Source *(Select one) (Several options are listed in the on-line application):Other*

If 'Other' is selected, specify:

Participant Claims Data; PCSP; Participant Budgets

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation :*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error*
	☐ Other *Specify:*	*X Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other *Specify:*	
			☐ Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

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

Performance Measure:	*Number and percentage of provider claims submitted and processed through the CAPS in a representative sample match the DSPD claims submitted and processed through ~~the~~ PRISM ~~MMIS~~. The numerator is the total number of provider claims in compliance; the denominator is the total number of provider claims submitted and processed through CAPS in the review sample.*
Data Source *(Select one) (Several options are listed in the on-line application):Other*	
If 'Other' is selected, specify:	
CAPS claims payment history report; MMIS claims payment history report.	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation :*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error*
	☐ Other Specify:	*X Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

Performance Measure:	*Number and percentage of recoupments in a representative sample identified and processed correctly through PRISM~~MMIS~~ with an audit trail of the claim paid in error and overpayments are returned to the federal government within required time-frames. The numerator is the total number of recoupments in compliance; the denominator is the total number of recoupments identified in the review sample.*
Data Source *(Select one) (Several options are listed in the on-line application):*	
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)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	☐ Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error*
	☐ Other Specify:	*X Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

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Add another Data Source for this performance measure

Data Aggregation and Analysis

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

b. Sub-assurance: The State provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

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

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

Performance Measure:	*Number and percentage of maximum allowable rates (MARs) for covered Waiver services which are consistent with the approved rate methodology. The numerator is the total number of MARs which are consistent with the approved rate methodology; the denominator is the total number of MARs for covered waiver services.*
Data Source *(Select one) (Several options are listed in the on-line application):Other*	
If 'Other' is selected, specify:	
Participant Claims Data; PCSP; Participant Budgets	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation :*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*

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

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

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

The SMA conducts an annual review of the ABI program for each of the five Waiver years. Due to available resources, at a minimum one comprehensive review will be conducted during this five year cycle. The comprehensive review will include participant and provider interviews. The other annual reviews will be focused reviews. The criteria for the focused reviews will be determined from DSPD and SMA review findings as well as other issues that develop during the review year. The sample size for each review will be sufficient to provide a confidence level equal to 95% and a confidence interval equal to 5.

~~Contract analysts from DSPD~~ Support coordinators will monitor monthly usage of approved services to ensure that billed services are within the participant's budget. Adjustments will be made to the service

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plan and budgets when warranted by changes in participant needs. The Utah Systems for Tracking Eligibility, Planning, and Services (USTEPS) will assist with preventing overpayments that are over an individual's budget by providing reports to support coordinators to review when claims are ~~significantly~~ under or over budget.

b. Methods for Remediation/Fixing Individual Problems

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

Recoupment of Funds:

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

The recoupment of funds will proceed as follows:

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

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	***Responsible Party*** *(check each that applies)*	***Frequency of data aggregation and analysis:*** *(check each that applies)*
	X State Medicaid Agency	**☐ Weekly**
	X Operating Agency	**☐ Monthly**
	☐ Sub-State Entity	**☐ Quarterly**
	☐ Other Specify:	**☐ Annually**
		☐ Continuously and Ongoing

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		X Other Specify: OA: At a minimum every two years. SMA: At a minimum every five years.

c. **Timelines**

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

X	**No**
O	**Yes**

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

APPENDIX I-2: Rates, Billing and Claims

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

There are four principal methods used in setting the DHHS~~DHS~~ Maximum Allowable Rate level. Each method is designed to determine a fair market rate. Four different methodologies are in place to accommodate the different market factors that exist for different types of services. With all new services and any inflationary increases or decreases to existing service rates, the SMA reviews and approves all proposed rates prior to the rates being loaded into ~~the MMIS~~PRISM.

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

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

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

2. Component Cost Analysis

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

3. Comparative Analysis

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

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agency or program, the existing rate may be used to provide consistency of payments in the provider community, if the companion agency rate is considered to be in line with the market.

4. Community Price Survey

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

The State solicited public comment during the drafting of the waiver renewal application. The State Medicaid Agency and the Division of Services for People with Disabilities completed the initial draft application November, 2013. The revised draft was submitted to a broad network of consumers, advocates, providers and Tribal Governments and the Medical Care Advisory Committee (MCAC). The entities were sent an electronic copy of the application and were asked to disseminate copies broadly. Entities had 30 days in which to submit comments or questions about all aspects of the ABI Waiver Application.

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

The method used to establish the rate for each waiver service is provided below, along with information regarding how the service is reimbursed to the provider:

ABI Waiver Support Coordination - Comparative Analysis - Fixed/Predetermined
Day Supports - Comparative Analysis - Fixed/Predetermined
Homemaker - Comparative Analysis - Fixed/Predetermined
Residential Habilitation - Comparative Analysis - Varies by client based upon their acuity/supervision needs
Respite - Comparative Analysis - Fixed/Predetermined
Supported Employment- Comparative Analysis - Fixed/Predetermined (payment for 1:1 service and small group use the same methodology but adjust for staffing ratios)

Financial Management Services - Comparative Analysis - Fixed/Predetermined
Behavior Consultation I - Comparative Analysis - Fixed/Predetermined
Behavior Consultation II - Comparative Analysis - Fixed/Predetermined
Behavior Consultation Service III - Comparative Analysis - Fixed/Predetermined
Chore Services - Comparative Analysis - Fixed/Predetermined
Companion Services - Comparative Analysis - Fixed/Predetermined
Environmental Adaptations – Home - Community Price Survey - Based on Episode
Environmental Adaptations – Vehicle - Community Price Survey - Based on Episode
Extended Living Supports - Comparative Analysis - Fixed/Predetermined
Living Start-Up Costs - Comparative Analysis - Fixed/Predetermined
Personal Budget Assistance - Comparative Analysis - Fixed/Predetermined
Personal Emergency Response System - Existing Market Survey - Fixed/Predetermined
Professional Medication Monitoring - Comparative Analysis - Fixed/Predetermined
Specialized Medical Equipment/Supplies/Assistive Technology - Purchase - Community Price Survey - Fixed/Predetermined

Specialized Medical Equipment/Supplies/Assistive Technology- Monthly Fee - Community Price Survey - Fixed/Predetermined
Supported Living - Comparative Analysis - Fixed/Predetermined
Transportation Services (non-medical) - Comparative Analysis - Fixed/Predetermined
Massage Therapy - Comparative Analysis - Fixed/Predetermined

The difference in rate payment between agency and self-direction is primarily the anticipated amount used for administration/overhead, otherwise the methodologies remain similar.

The State has compared service requirements and reimbursement to several surrounding states including: Wyoming, Nevada, North Dakota, Oregon, Idaho, Montana, Colorado, Arizona, New Mexico, and Montana. The State has used this methodology as nearby states may have similar challenges with respect to urban/rural service delivery; similar labor markets; service descriptions/qualifications; etc. The State has used this method in order to validate whether payment rates established fall within reason after accounting for differences which may exist in provider qualifications (ex. Requirement service is delivered by a Registered Nurse); how reimbursement is made (daily, hourly, episodic); cost of living; etc.

The State reviews rates at least once each waiver cycle and has enlisted the assistance of a CPA firm to assist in administering a cost survey to providers. The second year of this project is nearing its end at which point the SMA and OA intend to review the data provided and determine if any rate rebasing may be required.

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

For Providers who Voluntarily Reassign Payment to DHHS ~~DHS~~/DSPD:

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

For individuals self-directing their self-administered services, the participant submits their staff time sheet(s) to the FMS Agent. The FMS Agent pays the claim(s) and submits a bill to DHHS ~~DHS~~/DSPD on form 520.DHHS ~~DHS~~/DSPD pays the FMS Agent then submits billing claim to Division of Integrated Health~~DOH~~ for reimbursement.

Providers who voluntarily reassign payment to DHHS ~~DHS~~/DSPD have three options for submitting a request for payment:

1. Upload a data file containing the payment data.
2. Manually enter the payment directly into the system.
3. Deliver a paper invoice to DSPD for hand entry into the system.

All three options fall into the same process where the payment data in the initial submission is automatically validated against the service code's prescribed rate/units in the Person Centered Support Plan (PCSP) budget. The process is:

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Step 1: The payment is submitted for initial processing.

a. The payment passes the validation process:
    i. The payment is automatically sent on to the support coordinator for review.
b. The payment fails validation and is put in "Error" status where the provider must choose from one of three options to resolve the problem:
    i. Delete the payment;
    ii. Resubmit the payment with corrected data; or
    iii. Send the payment to the support coordinator with a note attached to it explaining what needs to be done to resolve the problem.

Step 2: Payments that pass the initial submission process are automatically delivered to the support coordinator for review where they must take one of the following actions.

a. Approve the payment
    i. The validation process re-runs against the payment at the moment the support coordinator approves it. If the payment passes, it is forwarded on to Step 3. If it fails, it remains assigned to the support coordinator for further review / action
b. Deny the payment
c. If the payment is in error status even though it was legitimately delivered, then the support coordinator can review the service code's prescription in the PCSP budget. If a change in the plan is appropriate, it can be made. Then, the payment can be approved.

Step 3: Payments that pass the support coordinator's approval (i.e. Step 2) are automatically delivered to the DSPD payment technician for review where they must take one of the following actions.

a. Approve the payment
    i. The validation process re-runs against the payment at the moment the tech approves it. If the payment passes, it is automatically delivered to CAPS (the DHHS~~DHS~~ payment system). If it fails, it remains assigned to the tech for further review / action.
b. Deny the payment
c. If the payment is in error status even though it was legitimately delivered, then the payment technician must consult with the support coordinator to review the service code's prescription in the PCSP budget. If a change in the plan is appropriate, it can be made. Then, the payment can be approved.

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

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

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If the services listed on the billing prior authorization form are not consistent with the PCSP or budget, billing for services will not be authorized by the Operating Agency. The Operating Agency will submit the denial notice to the provider that will include an explanation of why the prior authorization was denied. Once the Operating Agency has approved the billing prior authorization forms, the provider will then submit claims directly throughthought the States'PRISM MMIS. The Acquired Brain Injury Waiver only pays for Non-Medical transportation and only when in accordance with the written plan of care. No waiver expenditures are paid for by DWS and they are not a waiver provider.

c. Certifying Public Expenditures *(select one)*:

X	**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.*)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

1. A participant's Medicaid eligibility is determined by the Department of Workforce Services (DWS) or the Bureau of Eligibility Services within the Department of Health and Human Services ~~Health~~. The information is entered into the electronic Resource and Eligibility Product (eREP). eREP is an on-line, rules-based eligibility system which automates Medicaid eligibility decisions, benefits amounts, participants' notices and administrative reports. eREP interfaces with other governmental agencies such as~~,~~ Social Security, Unemployment Insurance, and the Internal Revenue Service. The system is a Federally-Approved Management Information System (FAMIS). In Utah, eRep is used by DWS employees to determine eligibility and issue benefits for several public assistance programs including Mediciad, food stamps and various other financial assistance programs. ~~the following programs are accessed through eREP: Aid to Families with Dependent Children (AFDC), Medicaid, Food Stamps, and two state-administered programs – General Assistance and the Primary Care Network (PCN).~~ PRISM~~The Medicaid Management Information System (MMIS)~~ accesses eREP to ensure the participant is Medicaid eligible before payment of claims is made.

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

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

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

APPENDIX I-3: Payment

a. Method of payments — PRISMMMIS *(select one)*:

○	**Payments for all waiver services are made through the approvedthean approved system, PRISMMedicaid Management Information System (MMIS).**
○	**Payments for some, but not all, waiver services are made through the an approved system, PRISMMMIS.** Specify: (a) the waiver services that are not paid through the approvedthean approved system, PRISM MMIS; (b) the process for making such payments and the entity that processes payments; (c) how an audit trail is maintained for all state and federal funds expended outside thePRISM MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.
X	**Payments for waiver services are not made through thean approved system, PRISM 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 thePRISM MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64: a) The Waiver services that are not paid through the an approved system, PRISMMMIS - Payment for all Waiver services are made through the approved systemthean approved Medicaid Management Information System (PRISMMMIS) eventually, but for providers who voluntarily reassign payment to the Department of Health and Human Services (DHHS), initially payments for Waiver services are paid to providers through the Department of Health and Human Services (DHHS), Contract, Approval and Provider System (CAPS). (b) The process for making such payments and the entity that processes payments- Waiver service providers bill the DHHS using Form 520 a paper claim that is entered into the CAPS system. The CAPS system has edits in place that will deny payment for reasons such as exceeding the maximum allowable number of approved units or maximum allowable rates, etc. Providers are reimbursed by DHHS with either a paper check or an electronic funds transfer as per the provider's preference. DHHS then submits a filetape of all claims paid through the CAPS to the SMA. The claims are then entered into the PRISMMMIS for payment. The SMA makes payment to DHHS through an Intergovernmental Transfer of Funds (IGT).Internal exchange transaction (IET) Each claim is individually identifiable at the level of the participant, provider, HCPCS and units of service paid. (c) How an audit trail is maintained for all state and federal funds expended outside the PRISMMMIS- The audit trail outside the PRISMMMIS is in CAPS. (d) The basis for the draw of federal funds and claiming of these expenditures on the CMS-64- As stated previously all Waiver service payments are eventually made through an approved Medicaid Management Information System (MMIS)system, PRISM, and this is the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.

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	CAPS along with supporting documentation and claim information processed through PRISM~~MMIS~~ provide audit support. Plans of care including specifications of amount, frequency and duration of prescribed services are documented in CAPS by case managers and result in payment authorizations in CAPS. Payment authorizations result in the generation of provider billings. Provider claims are accompanied by eligibility codes that detail whether services qualify for FFP. Claims for services rendered under Medicaid eligibility are then ported to PRISM~~MMIS~~ where recipient and provider eligibility are verified and claims that are determined to be eligible for FFP result in reimbursement to DHHS/DSPD. Individual claim information is documented in PRISM ~~MMIS~~. Utah DI~~O~~H/DSPD IGT Process 1. The Division of Integrated Health (DIH)~~Department of Health (DOH)~~ estimates the state seed amount for the quarter. 2. The DI~~O~~H sends the IGT request to the Department Human Services (DHHS) for the estimated amount. 3. DHHS processes the IGT request. 4. DHHS approves the request. 5. DI~~O~~H receives the funds before the start of the quarter. 6. At the end of the quarter, DI~~O~~H determines the actual seed amount based on the paid claims. 7. The DI~~O~~H sends the IE~~G~~T request to the Department of Human Services (DHHS) for the actual paid amount. 8. DHHS approves the IE~~G~~T request and DI~~O~~H receives the funds. 9. DI~~O~~H refunds the estimated amount to DHHS via an IE~~G~~T. Utah DSPD/UTA IGT Process UTA is initially paid out of CAPS. On a quarterly basis DSPD will invoice UTA for the seed portion of the expense. ~~Quarterly IGT's will occur prior to the start of the quarter. UTA will not receive payment for any services in that quarter until the quarterly IGT has been made to DSPD~~. This guarantees that the provider will not recycle the Federal share of the payment.
○	**Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.** Describe how payments are made to the managed care entity or entities:

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

☐	**The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
X	**The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
X	**The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.** Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and

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	the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:
	The DHHS/DSPD serves as the governmental entity that pays for Waiver claims for providers who voluntarily reassign payment to DHHS and DHHS will pay for all services provided by the Waiver when they are delivered by qualified providers according to the service plan. The DSPD obtains all of the claims for payment for services delivered directly from contract providers on the form 520. It reviews the claims for accuracy and all approved claims are paid directly to the providers by DSPD. The DSPD then submits billing claims to the DIOH for reimbursement. The DSPD has internal controls in place to assure providers paid through the CAPS system receive payment that is equal to the payment DSPD receives from DIOH including a comparison of DIOH's ~~MMIS~~ PRISM Reference File rates with DSPD's CAPS rates for the same service, as per the DIOH rate sheet provided each year. A comparison of MMIS HCPCS code/rate information with corresponding CAPS service code/rate information is implemented and documented via screen prints on a copy of a rate chart spreadsheet. This is completed before the beginning of each fiscal year when rates are generally adjusted, but a periodic review of CAPS to PRISM~~MMIS~~ rates is completed throughout the year. Post rate adjustment billing detail is reviewed closely to ensure the agreed rates are correct on the claims submitted for reimbursement, as is the claims reimbursement detail. The SMA will perform an annual post payment review of claims that are paid to providers through the CAPS. The review will verify that the rates paid to providers through the CAPS are equal to the rates paid to DSPD through the PRISM~~MMIS~~.
☐	**Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.** Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

X	**No. The State does not make supplemental or enhanced payments for waiver services.**
O	**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.

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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.*
X	**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. *Complete item I-3-e.*
	STATE LEVEL SOURCE(S) OF THE NON-FEDERAL SHARE OF COMPUTABLE WAIVER COSTS a. The Department of Health and Human Service is the source of the non-federal share that is appropriated to a state agency. The underlying source of the non-federal share is state general funds. b. The mechanism that is used to transfer the funds to the Medicaid Agency is an Intergovernmental Transfer (IGT). The IGT is made to the Medicaid Agency prior to any federal funds being drawn. LOCAL GOVERNMENT OR OTHER SOURCE(S) OF THE NON-FEDERAL SHARE OF COMPUTABLE WAIVER COSTS a. The Utah Transit Authority (UTA), a Utah public transit district, is the local governmental source of the non-federal share of computable waiver costs. b. The source of the funding from UTA is local sales and use taxes. The funds are publicly approved sales tax revenues levied by the cities and counties within UTA's service district. The taxes are collected quarterly from businesses from the sale of retail goods. The sales tax revenues are given to the transit authority for the operation of a local public transportation agency. c. The mechanism that is used to transfer funds from the UTA to the Department of Health and Human Services is an IGT. After receiving funds from the UTA, the Department of Human Services will transfer the funds to the Medicaid Agency through an IGT. The reason the funds are transferred to the Department of Health and -Human Services rather than to the Medicaid Agency directly is that, in the event UTA chooses to discontinue providing the non-federal share of computable waiver costs, the Department of Health and Human Services would become responsible to provide the non-federal share. The IGT is made to the Medicaid Agency prior to any federal funds being drawn.

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*:

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X	**The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
○	**The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
○	**The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.** Describe the recoupment process:

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

X	**Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
○	**Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.** Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

○	**No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
X	**Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).** Specify the governmental agency (or agencies) to which reassignment may be made.
	The Department of Health and Human Services is the governmental agency to which reassignment is made.

ii. Organized Health Care Delivery System. *Select one:*

X	**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

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	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. *Select one:*

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

APPENDIX I-4: Non-Federal Matching Funds

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

☐	**Appropriation of State Tax Revenues to the State Medicaid agency**
X	**Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.** If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency ~~or Fiscal Agent, such as~~ through a revenue transfer~~n Intergovernmental Transfer (IGT)~~, ~~including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:~~
	The Division of Services for People with Disabilities (DSPD) which resides within the Department of Health and Human Services receives the appropriated funds. DSPD transfers the funds to the State Medicaid Agency via a revenue~~an revenue~~ transfer~~ Intergovernmental Transfer (IGT~~). This prepayment transfer is based on estimates for the upcoming quarter and takes place approximately 15 days before each new quarter. At the end of each quarter, the State Medicaid Agency will perform a reconciliation of the actual state match obligation and the prepaid amount. State Tax Revenues (general funds) are appropriated directly to the Department of Health and Human Services by the legislature. The Division of Services for People with Disabilities (DSPD) which resides within the Department of Health and Human Services receives the appropriated funds. DSPD transfers the funds to the State Medicaid Agency via a revenue~~an revenue~~ transfer~~Intergovernmental Transfer (IGT)~~. This prepayment transfer is based on estimates for the upcoming quarter and takes place approximately 15 days before each new quarter. At the end of each quarter, the State Medicaid Agency will perform a reconciliation of the actual state match obligation and the prepaid amount.
☐	**Other State Level Source(s) of Funds.** Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select one:*

○	**Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
X	**Applicable** *Check each that applies:*

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	☐	**Appropriation of Local Government Revenues.** Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:
	X	**Other Local Government Level Source(s) of Funds.** Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:
		The source of the funding from UTA is local sales and use taxes. The funds are publicly approved sales tax revenues levied by the cities and counties within UTA's service district. The taxes are collected quarterly from businesses from the sale of retail goods. The sales tax revenues are given to the transit authority for the operation of a local public transportation agency.

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

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

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

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

○	**No services under this waiver are furnished in residential settings other than the private residence of the individual.**
X	**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:

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

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

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

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

X	**No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
○	**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:

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

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

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

i. Co-Pay Arrangement

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

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

ii Participants Subject to Co-pay Charges for Waiver Services.

Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded

iii. Amount of Co-Pay Charges for Waiver Services. The following table lists the waiver services defined in C-1/C-3 for which a charge is made, the amount of the charge, and the basis for determining the charge.

Waiver Service	Charge	
	Amount	**Basis**

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iv. Cumulative Maximum Charges.

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

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

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

Appendix 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-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care *(specify)*:			Nursing Home				
Col. 1	**Col. 2**	**Col. 3**	**Col. 4**	**Col. 5**	**Col. 6**	**Col. 7**	**Col. 8**
Year	**Factor D**	**Factor D′**	**Total: D+D′**	**Factor G**	**Factor G′**	**Total: G+G′**	**Difference (Column 7 less Column 4)**
1	$52,721.55	$3,305.91	$56,027.46	$69,036.32	$7,220.38	$76,256.70	$20,229.24
2	$52,721.55	$3,372.03	$56,093.58	$70,417.05	$7,364.78	$77,781.83	$21,688.25
3	$52,721.55	$3,439.47	$56,161.02	$71,825.39	$7,512.08	$79,337.47	$23,176.45
4	$52,721.55	$3,508.26	$56,229.81	$73,261.90	$7,662.32	$80,924.22	$24,694.41
5	$52,721.55	$3,578.43	$56,299.98	$74,727.14	$7,815.57	$82,542.71	$26,242.73

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Appendix J-2: Derivation of Estimates

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

Table J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
		Nursing Home	
Year 1	164~~142~~	142	
Year 2	164~~142~~	142	
Year 3	164~~142~~	142	
Year 4 (only appears if applicable based on Item 1-C)	164~~142~~	142	
Year 5 (only appears if applicable based on Item 1-C)	164~~142~~	142	

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) = 338 days
- Used the average annual LOS counts for the past fiscal years

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

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

- All calculations are based off the actual amounts for FY2023~~FY2016-FY2018~~
- Unduplicated client counts were increased and the number of users for each service was raised proportional to the change in enrollment.
- Price per unit was increased 2% to account for ~~FY19~~FY2025-FY2029
- Units Per User is the average units per user for ~~FY2016-2018~~ FY2025-FY2029 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

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~~- Estimates for massage therapy were based on utilization from the Community Supports Waiver~~

~~Throughout the previous waiver cycle, the State observed an approximate 2% increase in rates in most services on the ABI waiver. In addition, during the 2019 session, and at the time the financial estimates were drafted for the SIP prior to public comment, provider associations were requesting funds that would have led to an approximate 2% increase leading into WY1 of this renewal. This amount was not carried through waiver years 2-5 as the State intends to monitor and amend the SIP as appropriations are determined.~~

- Beginning SFY22, Support Coordination rates were increased by 12.2% following a direct funding appropriation by the State Legislature. (WY3-5 estimates updated).

-In WY4, services with a direct labor component were increased by 19.54% as a result of legislative appropriation.

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 ~~FY2016-2018~~FY2023
- Average cost per enrollee was increased by 2% for each subsequent year consistent with the mandatory inflation in the State's contracts with the ACOs and the consumer price index for medical services.
- The state utilizes PRISM~~the MMIS~~ Categories of Service and Provider Type functionality to account for and exclude the costs of prescribed drugs from D'

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

- All calculations are based off the actual amounts for FY2023~~FY2016-2018~~
- Per diem amounts calculated and multiplied by waiver LOS for comparison
- 2% increase added for FY2024~~FY2019~~ and each subsequent year consistent with the mandatory inflation in the State's contracts with the ACOs and the consumer price index for medical services.

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:

- All calculations are based off the actual amounts for~~r~~FY2023~~FY2016-2018~~
- Per diem amounts calculated and multiplied by waiver LOS for comparison
- 2% increase added forFY2024~~FY2019~~ and each subsequent year consistent with the mandatory inflation in the State's contracts with the ACOs and the consumer price index for medical services.
- The state utilizes PRISM~~the MMIS~~ Categories of Service and Provider Type functionality to account for and exclude the costs of prescribed drugs from G'

The State believes that due to the needs of this waiver population being more habilitative in nature, the supports offered through the waiver comprise the majority of the individual's need. While the immediate care which may have surrounded the qualifying condition may have been

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costly, this population does not have extensive ongoing medical need. The care provided through the waiver offers stability for participants, preventing the need for more acute care needs typically paid through the State Plan.

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
ABI Waiver Support Coordination	**manage components**
Day Supports	**manage components**
Homemaker	**manage components**
Residential Habilitation	**manage components**
Respite	**manage components**
Supported Employment	**manage components**
Financial Management Services	**manage components**
Behavior Consultation I	**manage components**
Behavior Consultation II	**manage components**
Behavior Consultation Service III	**manage components**
Chore Services	**manage components**
Companion Services	**manage components**
Environmental Adaptations - Home	**manage components**
Environmental Adaptations - Vehicle	**manage components**
Extended Living Supports	**manage components**
Living Start-Up Costs	**manage components**
Massage Therapy	**manage components**
Personal Budget Assistance	**manage components**
Personal Emergency Response System	**manage components**
Professional Medication Monitoring	**manage components**
Specialized Medical Equipment/Supplies/Assistive Technology - Purchase	**manage components**

Specialized Medical Equipment/Supplies/Assistive Technology-Monthly Fee	**manage components**

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

X	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
O	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

i. Estimate of Factor D – Non-Concurrent Waiver. Complete the following table for each waiver year. 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	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
ABI Waiver Support Coordination	Monthly	142	12	$212.12	$361,452.48
Day Supports - 15 minute	15 Minute	11	2744	$10.92	$329,609.28
Day Supports - daily (6 hr avg)	Daily	49	188	$83.92	$773,071.04
Homemaker Services	15 Minute	2	300	$5.37	$3,222.00
Residential Habilitation - Facility Based	Daily	47	298	$205.36	$2,876,272.16
Residential Habilitation - Host Home/Professional Parent	Daily	11	257	$166.25	$469,988.75
Respite - Room and Board Included - Daily (6 hrs +)	Daily	1	20	$99.96	$1,999.20
Respite Care - Unskilled 15 Minute	15 Minute	8	1304	$3.70	$38,598.40
Respite Care - 6+ hrs	Daily	2	7	$89.05	$1,246.70
Supported Employment - 15 Minute	15 Minute	23	844	$10.92	$211,979.04
Supported Employment - Daily	Daily	7	172	$44.90	$54,059.60
Financial Management Services	Monthly	32	9	$97.14	$27,976.32
Behavior Consultation Services I	15 Minute	6	126	$6.99	$5,284.44
Behavior Consultation Services II	15 Minute	32	145	$11.95	$55,448.00
Behavior Consultation Services III	15 Minute	18	186	$18.30	$61,268.40
Chore Services	15 Minute	3	140	$5.37	$2,255.40
Companion Services - Daily (6 hrs +)	Daily	1	5	$121.80	$609.00
Companion Services - 15 minute	15 Minute	2	1594	$5.08	$16,195.04

State:	
Effective Date	

Waiver Year: Year 1					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Environmental Adaptations - Home	Per Episode	1	1	$1,338.65	$1,338.65
Environmental Adaptations - Vehicle	Per Episode	1	1	$3,240.85	$3,240.85
Extended Living Supports	15 Minute	7	725	$5.04	$25,578.00
Living Start-Up Costs	Per Episode	1	1	$362.41	$362.41
Personal Budget Assistance - 15 minute	15 Minute	13	66	$7.38	$6,332.04
Personal Budget Assistance - Daily (6 hrs +)	Daily	48	22	$14.76	$15,586.56
Personal Emergency Response System - Purchase	Per Episode	2	1	$204.37	$408.74
Personal Emergency Response System - monthly	Monthly	7	9	$31.26	$1,969.38
Personal Emergency Response System - installation	Per Episode	2	1	$36.48	$72.96
Professional Medication Monitoring - RN	Per Episode	22	56	$9.70	$11,950.40
Professional Medication Monitoring - LPN	Per Episode	6	91	$6.71	$3,663.66
Specialized Medical Equipment/Supplies/Assistive Technology - Purchase	Per Episode	3	3	$307.91	$2,771.19
Specialized Medical Equipment/Supplies/Assistive Technology - Monthly Fee	Monthly	1	5	$24.32	$121.60
Supported Living	15 Minute	85	2987	$7.38	$1,873,745.10
Non-Medical Transportation - Daily (Flat rate for all trips needed)	Daily	52	182	$15.05	$142,433.20
Non-Medical Transportation - UTA Bus Pass Purchase	Per Episode	17	10	$117.30	$19,941.00
Non-Medical Transportation - Mileage	Per Mile	2	600	$0.43	$516.00
Non-Medical Transportation - Per Trip (UTA)	Per Episode	10	185	$6.43	$11,895.50
Massage Therapy	15 Minute	33	151	$14.85	$73,997.55
GRAND TOTAL:					$7,486,460.04
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					164 ~~142~~

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Appendix J-2: 6

State:	
Effective Date	

Waiver Year: Year 1					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
FACTOR D (Divide grand total by number of participants)					$52,721.55
AVERAGE LENGTH OF STAY ON THE WAIVER					338

State:	
Effective Date	

Waiver Year: Year 2					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
ABI Waiver Support Coordination	Monthly	142	12	$212.12	$361,452.48
Day Supports - 15 minute	15 Minute	11	2744	$10.92	$329,609.28
Day Supports - daily (6 hr avg)	Daily	49	188	$83.92	$773,071.04
Homemaker Services	15 Minute	2	300	$5.37	$3,222.00
Residential Habilitation - Facility Based	Daily	47	298	$205.36	$2,876,272.16
Residential Habilitation - Host Home/Professional Parent	Daily	11	257	$166.25	$469,988.75
Respite - Room and Board Included - Daily (6 hrs +)	Daily	1	20	$99.96	$1,999.20
Respite Care - Unskilled 15 Minute	15 Minute	8	1304	$3.70	$38,598.40
Respite Care - 6+ hrs	Daily	2	7	$89.05	$1,246.70
Supported Employment - 15 Minute	15 Minute	23	844	$10.92	$211,979.04
Supported Employment - Daily	Daily	7	172	$44.90	$54,059.60
Financial Management Services	Monthly	32	9	$97.14	$27,976.32
Behavior Consultation Services I	15 Minute	6	126	$6.99	$5,284.44
Behavior Consultation Services II	15 Minute	32	145	$11.95	$55,448.00
Behavior Consultation Services III	15 Minute	18	186	$18.30	$61,268.40
Chore Services	15 Minute	3	140	$5.37	$2,255.40
Companion Services - Daily (6 hrs +)	Daily	1	5	$121.80	$609.00
Companion Services - 15 minute	15 Minute	2	1594	$5.08	$16,195.04
Environmental Adaptations - Home	Per Episode	1	1	$1,338.65	$1,338.65
Environmental Adaptations - Vehicle	Per Episode	1	1	$3,240.85	$3,240.85
Extended Living Supports	15 Minute	7	725	$5.04	$25,578.00
Living Start-Up Costs	Per Episode	1	1	$362.41	$362.41

State:	
Effective Date	

Waiver Year: Year 2					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Personal Budget Assistance - 15 minute	15 Minute	13	66	$7.38	$6,332.04
Personal Budget Assistance - Daily (6 hrs +)	Daily	48	22	$14.76	$15,586.56
Personal Emergency Response System - Purchase	Per Episode	2	1	$204.37	$408.74
Personal Emergency Response System - monthly	Monthly	7	9	$31.26	$1,969.38
Personal Emergency Response System - installation	Per Episode	2	1	$36.48	$72.96
Professional Medication Monitoring - RN	Per Episode	22	56	$9.70	$11,950.40
Professional Medication Monitoring - LPN	Per Episode	6	91	$6.71	$3,663.66
Specialized Medical Equipment/Supplies/Assistive Technology - Purchase	Per Episode	3	3	$307.91	$2,771.19
Specialized Medical Equipment/Supplies/Assistive Technology - Monthly Fee	Monthly	1	5	$24.32	$121.60
Supported Living	15 Minute	85	2987	$7.38	$1,873,745.10
Non-Medical Transportation - Daily (Flat rate for all trips needed)	Daily	52	182	$15.05	$142,433.20
Non-Medical Transportation - UTA Bus Pass Purchase	Per Episode	17	10	$117.30	$19,941.00
Non-Medical Transportation - Mileage	Per Mile	2	600	$0.43	$516.00
Non-Medical Transportation - Per Trip (UTA)	Per Episode	10	185	$6.43	$11,895.50
Massage Therapy	15 Minute	33	151	$14.85	$73,997.55
GRAND TOTAL:					$7,486,460.04
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					142

State:	
Effective Date	

Waiver Year: Year 2					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
FACTOR D (Divide grand total by number of participants)					$52,721.55
AVERAGE LENGTH OF STAY ON THE WAIVER					338

State:	
Effective Date	

Waiver Year: Year 3					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
ABI Waiver Support Coordination	Monthly	142	12	$212.12	$361,452.48
Day Supports - 15 minute	15 Minute	11	2744	$10.92	$329,609.28
Day Supports - daily (6 hr avg)	Daily	49	188	$83.92	$773,071.04
Homemaker Services	15 Minute	2	300	$5.37	$3,222.00
Residential Habilitation - Facility Based	Daily	47	298	$205.36	$2,876,272.16
Residential Habilitation - Host Home/Professional Parent	Daily	11	257	$166.25	$469,988.75
Respite - Room and Board Included - Daily (6 hrs +)	Daily	1	20	$99.96	$1,999.20
Respite Care - Unskilled 15 Minute	15 Minute	8	1304	$3.70	$38,598.40
Respite Care - 6+ hrs	Daily	2	7	$89.05	$1,246.70
Supported Employment - 15 Minute	15 Minute	23	844	$10.92	$211,979.04
Supported Employment - Daily	Daily	7	172	$44.90	$54,059.60
Financial Management Services	Monthly	32	9	$97.14	$27,976.32
Behavior Consultation Services I	15 Minute	6	126	$6.99	$5,284.44
Behavior Consultation Services II	15 Minute	32	145	$11.95	$55,448.00
Behavior Consultation Services III	15 Minute	18	186	$18.30	$61,268.40
Chore Services	15 Minute	3	140	$5.37	$2,255.40
Companion Services - Daily (6 hrs +)	Daily	1	5	$121.80	$609.00
Companion Services - 15 minute	15 Minute	2	1594	$5.08	$16,195.04
Environmental Adaptations - Home	Per Episode	1	1	$1,338.65	$1,338.65
Environmental Adaptations - Vehicle	Per Episode	1	1	$3,240.85	$3,240.85
Extended Living Supports	15 Minute	7	725	$5.04	$25,578.00
Living Start-Up Costs	Per Episode	1	1	$362.41	$362.41
Personal Budget Assistance - 15 minute	15 Minute	13	66	$7.38	$6,332.04
Personal Budget Assistance - Daily (6 hrs +)	Daily	48	22	$14.76	$15,586.56
Personal Emergency Response System - Purchase	Per Episode	2	1	$204.37	$408.74
Personal Emergency Response System - monthly	Monthly	7	9	$31.26	$1,969.38
Personal Emergency Response System - installation	Per Episode	2	1	$36.48	$72.96
Professional Medication Monitoring - RN	Per Episode	22	56	$9.70	$11,950.40
Professional Medication Monitoring - LPN	Per Episode	6	91	$6.71	$3,663.66
Specialized Medical Equipment/Supplies/Assistive Technology - Purchase	Per Episode	3	3	$307.91	$2,771.19

State:	
Effective Date	

Waiver Year: Year 3					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Specialized Medical Equipment/Supplies/Assistive Technology - Monthly Fee	Monthly	1	5	$24.32	$121.60
Supported Living	15 Minute	85	2987	$7.38	$1,873,745.10
Non-Medical Transportation - Daily (Flat rate for all trips needed)	Daily	52	182	$15.05	$142,433.20
Non-Medical Transportation - UTA Bus Pass Purchase	Per Episode	17	10	$117.30	$19,941.00
Non-Medical Transportation - Mileage	Per Mile	2	600	$0.43	$516.00
Non-Medical Transportation - Per Trip (UTA)	Per Episode	10	185	$6.43	$11,895.50
Massage Therapy	15 Minute	33	151	$14.85	$73,997.55
GRAND TOTAL:					$7,486,460.04
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					142
FACTOR D (Divide grand total by number of participants)					$52,721.55
AVERAGE LENGTH OF STAY ON THE WAIVER					338

State:	
Effective Date	

Waiver Year: Year 4 *(only appears if applicable based on Item 1-C)*					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
ABI Waiver Support Coordination ~~ABI Waiver Support Coordination~~	Monthly~~Monthly~~	142~~142~~	12~~12~~	$237.96 ~~$212.12~~	$405,483.84 ~~$361,452.48~~
Day Supports - 15 minute ~~Day Supports - 15 minute~~	15 Minute~~15 Minute~~	11~~11~~	2744~~2744~~	$13.05 ~~$10.92~~	$393,901.20 ~~$329,609.28~~
Day Supports - daily (6 hr avg)~~Day Supports - daily (6 hr avg)~~	Daily~~Daily~~	49~~49~~	188~~188~~	$100.32 ~~$83.92~~	$924,147.84 ~~$773,071.04~~
Homemaker Services~~Homemaker Services~~	15 Minute~~15 Minute~~	2~~2~~	300~~300~~	$6.42 ~~$5.37~~	$3,852.00 ~~$3,222.00~~
Residential Habilitation - Facility Based~~Residential Habilitation - Facility Based~~	Daily~~Daily~~	47~~47~~	298~~298~~	$245.49 ~~$205.36~~	$3,438,332.94 ~~$2,876,272.16~~
Residential Habilitation - Host Home/Professional Parent~~Residential Habilitation - Host Home/Professional Parent~~	Daily~~Daily~~	11~~11~~	257~~257~~	$198.74 ~~$166.25~~	$561,837.98 ~~$469,988.75~~
Respite - Room and Board Included - Daily (6 hrs +)~~Respite - Room and Board Included - Daily (6 hrs +)~~	Daily~~Daily~~	1~~1~~	20~~20~~	$119.49 ~~$99.96~~	$2,389.80 ~~$1,999.20~~
Respite Care - Unskilled 15 Minute~~Respite Care - Unskilled 15 Minute~~	15 Minute~~15 Minute~~	8~~8~~	1304~~1304~~	$4.42 ~~$3.70~~	$46,109.44 ~~$38,598.40~~
Respite Care - 6+ hrs~~Respite Care - 6+ hrs~~	Daily~~Daily~~	2~~2~~	7~~7~~	$106.45 ~~$89.05~~	$1,490.30 ~~$1,246.70~~
Supported Employment - 15 Minute~~Supported Employment - 15 Minute~~	15 Minute~~15 Minute~~	23~~23~~	844~~844~~	$13.05 ~~$10.92~~	$253,326.60 ~~$211,979.04~~
Supported Employment - Daily ~~Supported Employment - Daily~~	Daily~~Daily~~	7~~7~~	172~~172~~	$53.67 ~~$44.90~~	$64,618.68 ~~$54,059.60~~
Financial Management Services ~~Financial Management Services~~	Monthly~~Monthly~~	32~~32~~	9~~9~~	$97.14 ~~$97.14~~	$27,976.32 ~~$27,976.32~~
Behavior Consultation Services I ~~Behavior Consultation Services I~~	15 Minute~~15 Minute~~	6~~6~~	126~~126~~	$8.36 ~~$6.99~~	$6,320.16 ~~$5,284.44~~
Behavior Consultation Services II ~~Behavior Consultation Services II~~	15 Minute~~15 Minute~~	32~~32~~	145~~145~~	$14.29 ~~$11.95~~	$66,305.60 ~~$55,448.00~~
Behavior Consultation Services III~~Behavior Consultation Services III~~	15 Minute~~15 Minute~~	18~~18~~	186~~186~~	$21.88 ~~$18.30~~	$73,254.24 ~~$61,268.40~~
Consumer Preparation Services~~Chore Services~~	15 Minute~~15 Minute~~	1~~3~~	1~~40~~	$5.87 ~~$5.37~~	$5.87 ~~$2,255.40~~
Chore Services~~Companion Services - Daily (6 hrs +)~~	15 Minute~~Daily~~	3~~1~~	140~~5~~	$6.42 ~~$121.80~~	$2,696.40 ~~$609.00~~
Companion Services - Daily (6 hrs +)~~Companion Services - 15 minute~~	Daily~~15 Minute~~	1~~2~~	5~~1594~~	$145.60 ~~$5.08~~	$728.00 ~~$16,195.04~~
Companion Services - 15 minute~~Environmental Adaptations - Home~~	15 Minute~~Per Episode~~	2~~1~~	1594~~1~~	$6.07 ~~$1,338.65~~	$19,351.16 ~~$1,338.65~~

State:	
Effective Date	

Waiver Year: Year 4 *(only appears if applicable based on Item 1-C)*					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Environmental Adaptations - Home ~~Environmental Adaptations - Vehicle~~	Per Episode~~Per Episode~~	1~~1~~	1~~1~~	$1,338.65 ~~$3,240.85~~	$1,338.65 ~~$3,240.85~~
Environmental Adaptations - Vehicle ~~Extended Living Supports~~	Per Episode~~15 Minute~~	1~~7~~	1~~725~~	$3,240.85 ~~$5.04~~	$3,240.85 ~~$25,578.00~~
Extended Living Supports ~~Living Start-Up Costs~~	15 Minute~~Per Episode~~	7~~1~~	725~~1~~	$6.02 ~~$362.41~~	$30,551.50 ~~$362.41~~
Living Start-Up Costs ~~Personal Budget Assistance - 15 minute~~	Per Episode~~15 Minute~~	1~~13~~	1~~66~~	$362.41 ~~$7.38~~	$362.41 ~~$6,332.04~~
Personal Budget Assistance - 15 minute~~Personal Budget Assistance - Daily (6 hrs +)~~	15 Minute~~Daily~~	13~~48~~	66~~22~~	$8.82 ~~$14.76~~	$7,567.56 ~~$15,586.56~~
Personal Budget Assistance - Daily (6 hrs +)~~Personal Emergency Response System - Purchase~~	Daily~~Per Episode~~	48~~2~~	22~~1~~	$17.64 ~~$204.37~~	$18,627.84 ~~$408.74~~
Personal Emergency Response System - Purchase~~Personal Emergency Response System - monthly~~	Per Episode~~Monthly~~	2~~7~~	1~~9~~	$204.37 ~~$31.26~~	$408.74 ~~$1,969.38~~
Personal Emergency Response System - monthly~~Personal Emergency Response System - installation~~	Monthly~~Per Episode~~	7~~2~~	9~~1~~	$31.26 ~~$36.48~~	$1,969.38 ~~$72.96~~
Personal Emergency Response System - installation~~Professional Medication Monitoring - RN~~	Per Episode~~Per Episode~~	2~~22~~	1~~56~~	$36.48 ~~$9.70~~	$72.96 ~~$11,950.40~~
Professional Medication Monitoring - RN~~Professional Medication Monitoring - LPN~~	Per Episode~~Per Episode~~	22~~6~~	569~~1~~	$11.60 ~~$6.71~~	$14,291.20 ~~$3,663.66~~
Professional Medication Monitoring - LPN~~Specialized Medical Equipment/Supplies/Assistive Technology - Purchase~~	Per Episode~~Per Episode~~	6~~3~~	9~~13~~	$8.02 ~~$307.91~~	$4,378.92 ~~$2,771.19~~
Specialized Medical Equipment/Supplies/Assistive Technology - Purchase ~~Specialized Medical Equipment/Supplies/Assistive Technology - Monthly Fee~~	Per Episode~~Monthly~~	3~~1~~	3~~5~~	$307.91 ~~$24.32~~	$2,771.19 ~~$121.60~~
Specialized Medical Equipment/Supplies/Assistive Technology - Monthly Fee ~~Supported Living~~	Monthly~~15 Minute~~	1~~85~~	5~~2987~~	$24.32 ~~$7.38~~	$121.60 ~~$1,873,745.10~~
Supported Living ~~Non-Medical Transportation - Daily (Flat rate for all trips needed)~~	15 Minute~~Daily~~	85~~52~~	2987~~182~~	$8.82 ~~$15.05~~	$2,239,353.90 ~~$142,433.20~~
Non-Medical Transportation - Daily (Flat rate for all trips needed)~~Non-~~	Daily~~Per Episode~~	52~~17~~	1821~~0~~	$15.05 ~~$117.30~~	$142,433.20 ~~$19,941.00~~

State:	
Effective Date	

Waiver Year: Year 4 *(only appears if applicable based on Item 1-C)*					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
~~Medical Transportation - UTA Bus Pass Purchase~~					
Non-Medical Transportation - UTA Bus Pass Purchase~~Non-Medical Transportation - Mileage~~	Per Episode~~Per Mile~~	17~~2~~	10~~600~~	$117.30 ~~$0.43~~	$19,941.00 ~~$516.00~~
Non-Medical Transportation - Mileage~~Non-Medical Transportation - Per Trip (UTA)~~	Per Mile~~Per Episode~~	2~~10~~	600~~185~~	$0.43 ~~$6.43~~	$516.00 ~~$11,895.50~~
Non-Medical Transportation - Per Trip (UTA)~~Massage Therapy~~	Per Episode~~15 Minute~~	10~~33~~	185~~151~~	$6.43 ~~$14.85~~	$11,895.50 ~~$73,997.55~~
Massage Therapy	15 Minute	33	151	$17.75	$88,448.25
GRAND TOTAL:					$8,880,419.02 ~~$7,486,460.04~~
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					142~~142~~
FACTOR D (Divide grand total by number of participants)					$62,538.16 ~~$52,721.55~~
AVERAGE LENGTH OF STAY ON THE WAIVER					338~~338~~

State:	
Effective Date	

Waiver Year: Year 5 *(only appears if applicable based on Item 1-C)*					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
ABI Waiver Support Coordination ~~ABI Waiver Support Coordination~~	Monthly~~Monthly~~	142~~142~~	12~~12~~	$237.96 ~~$212.12~~	$405,483.84 ~~$361,452.48~~
Day Supports - 15 minute ~~Day Supports - 15 minute~~	15 Minute~~15 Minute~~	11~~11~~	2744~~2744~~	$13.05 ~~$10.92~~	$393,901.20 ~~$329,609.28~~
Day Supports - daily (6 hr avg)~~Day Supports - daily (6 hr avg)~~	Daily~~Daily~~	49~~49~~	188~~188~~	$100.32 ~~$83.92~~	$924,147.84 ~~$773,071.04~~
Homemaker Services~~Homemaker Services~~	15 Minute~~15 Minute~~	2~~2~~	300~~300~~	$6.42 ~~$5.37~~	$3,852.00 ~~$3,222.00~~
Residential Habilitation - Facility Based~~Residential Habilitation - Facility Based~~	Daily~~Daily~~	47~~47~~	298~~298~~	$245.49 ~~$205.36~~	$3,438,332.94 ~~$2,876,272.16~~
Residential Habilitation - Host Home/Professional Parent~~Residential Habilitation - Host Home/Professional Parent~~	Daily~~Daily~~	11~~11~~	257~~257~~	$198.74 ~~$166.25~~	$561,837.98 ~~$469,988.75~~
Respite - Room and Board Included - Daily (6 hrs +)~~Respite - Room and Board Included - Daily (6 hrs +)~~	Daily~~Daily~~	1~~1~~	20~~20~~	$119.49 ~~$99.96~~	$2,389.80 ~~$1,999.20~~
Respite Care - Unskilled 15 Minute~~Respite Care - Unskilled 15 Minute~~	15 Minute~~15 Minute~~	8~~8~~	1304~~1304~~	$4.42 ~~$3.70~~	$46,109.44 ~~$38,598.40~~
Respite Care - 6+ hrs~~Respite Care - 6+ hrs~~	Daily~~Daily~~	2~~2~~	7~~7~~	$106.45 ~~$89.05~~	$1,490.30 ~~$1,246.70~~
Supported Employment - 15 Minute~~Supported Employment - 15 Minute~~	15 Minute~~15 Minute~~	23~~23~~	844~~844~~	$13.05 ~~$10.92~~	$253,326.60 ~~$211,979.04~~
Supported Employment - Daily ~~Supported Employment - Daily~~	Daily~~Daily~~	7~~7~~	172~~172~~	$53.67 ~~$44.90~~	$64,618.68 ~~$54,059.60~~
Financial Management Services ~~Financial Management Services~~	Monthly~~Monthly~~	32~~32~~	9~~9~~	$97.14 ~~$97.14~~	$27,976.32 ~~$27,976.32~~
Behavior Consultation Services I ~~Behavior Consultation Services I~~	15 Minute~~15 Minute~~	6~~6~~	126~~126~~	$8.36 ~~$6.99~~	$6,320.16 ~~$5,284.44~~
Behavior Consultation Services II ~~Behavior Consultation Services II~~	15 Minute~~15 Minute~~	32~~32~~	145~~145~~	$14.29 ~~$11.95~~	$66,305.60 ~~$55,448.00~~
Behavior Consultation Services III~~Behavior Consultation Services III~~	15 Minute~~15 Minute~~	18~~18~~	186~~186~~	$21.88 ~~$18.30~~	$73,254.24 ~~$61,268.40~~
Consumer Preparation Services~~Chore Services~~	15 Minute~~15 Minute~~	1~~3~~	1~~40~~	$5.87 ~~$5.37~~	$5.87 ~~$2,255.40~~
Chore Services~~Companion Services - Daily (6 hrs +)~~	15 Minute~~Daily~~	3~~1~~	140~~5~~	$6.42 ~~$121.80~~	$2,696.40 ~~$609.00~~
Companion Services - Daily (6 hrs +)~~Companion Services - 15 minute~~	Daily~~15 Minute~~	1~~2~~	5~~1594~~	$145.60 ~~$5.08~~	$728.00 ~~$16,195.04~~
Companion Services - 15 minute~~Environmental Adaptations - Home~~	15 Minute~~Per Episode~~	2~~1~~	1594~~1~~	$6.07 ~~$1,338.65~~	$19,351.16 ~~$1,338.65~~

State:	
Effective Date	

Waiver Year: Year 5 *(only appears if applicable based on Item 1-C)*					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Environmental Adaptations - Home ~~Environmental Adaptations - Vehicle~~	Per Episode~~Per Episode~~	1~~1~~	1~~1~~	$1,338.65 ~~$3,240.85~~	$1,338.65 ~~$3,240.85~~
Environmental Adaptations - Vehicle ~~Extended Living Supports~~	Per Episode~~15 Minute~~	1~~7~~	1~~725~~	$3,240.85 ~~$5.04~~	$3,240.85 ~~$25,578.00~~
Extended Living Supports ~~Living Start-Up Costs~~	15 Minute~~Per Episode~~	7~~1~~	725~~1~~	$6.02 ~~$362.41~~	$30,551.50 ~~$362.41~~
Living Start-Up Costs ~~Personal Budget Assistance - 15 minute~~	Per Episode~~15 Minute~~	1~~13~~	1~~66~~	$362.41 ~~$7.38~~	$362.41 ~~$6,332.04~~
Personal Budget Assistance - 15 minute~~Personal Budget Assistance - Daily (6 hrs +)~~	15 Minute~~Daily~~	13~~48~~	66~~22~~	$8.82 ~~$14.76~~	$7,567.56 ~~$15,586.56~~
Personal Budget Assistance - Daily (6 hrs +)~~Personal Emergency Response System - Purchase~~	Daily~~Per Episode~~	48~~2~~	22~~1~~	$17.64 ~~$204.37~~	$18,627.84 ~~$408.74~~
Personal Emergency Response System - Purchase~~Personal Emergency Response System - monthly~~	Per Episode~~Monthly~~	2~~7~~	1~~9~~	$204.37 ~~$31.26~~	$408.74 ~~$1,969.38~~
Personal Emergency Response System - monthly~~Personal Emergency Response System - installation~~	Monthly~~Per Episode~~	7~~2~~	9~~1~~	$31.26 ~~$36.48~~	$1,969.38 ~~$72.96~~
Personal Emergency Response System - installation~~Professional Medication Monitoring - RN~~	Per Episode~~Per Episode~~	2~~22~~	1~~56~~	$36.48 ~~$9.70~~	$72.96 ~~$11,950.40~~
Professional Medication Monitoring - RN~~Professional Medication Monitoring - LPN~~	Per Episode~~Per Episode~~	22~~6~~	569~~1~~	$11.60 ~~$6.71~~	$14,291.20 ~~$3,663.66~~
Professional Medication Monitoring - LPN~~Specialized Medical Equipment/Supplies/Assistive Technology - Purchase~~	Per Episode~~Per Episode~~	6~~3~~	91~~3~~	$8.02 ~~$307.91~~	$4,378.92 ~~$2,771.19~~
Specialized Medical Equipment/Supplies/Assistive Technology - Purchase ~~Specialized Medical Equipment/Supplies/Assistive Technology - Monthly Fee~~	Per Episode~~Monthly~~	3~~1~~	3~~5~~	$307.91 ~~$24.32~~	$2,771.19 ~~$121.60~~
Specialized Medical Equipment/Supplies/Assistive Technology - Monthly Fee ~~Supported Living~~	Monthly~~15 Minute~~	1~~85~~	5~~2987~~	$24.32 ~~$7.38~~	$121.60 ~~$1,873,745.10~~
Supported Living ~~Non-Medical Transportation - Daily (Flat rate for all trips needed)~~	15 Minute~~Daily~~	85~~52~~	2987~~182~~	$8.82 ~~$15.05~~	$2,239,353.90 ~~$142,433.20~~
Non-Medical Transportation - Daily (Flat rate for all trips needed)~~Non-~~	Daily~~Per Episode~~	52~~17~~	1821~~0~~	$15.05 ~~$117.30~~	$142,433.20 ~~$19,941.00~~

State:	
Effective Date	

Waiver Year: Year 5 *(only appears if applicable based on Item 1-C)*					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
~~Medical Transportation - UTA Bus Pass Purchase~~					
Non-Medical Transportation - UTA Bus Pass Purchase~~Non-Medical Transportation - Mileage~~	Per Episode~~Per Mile~~	17~~2~~	10~~600~~	$117.30 ~~$0.43~~	$19,941.00 ~~$516.00~~
Non-Medical Transportation - Mileage~~Non-Medical Transportation - Per Trip (UTA)~~	Per Mile~~Per Episode~~	2~~10~~	600~~185~~	$0.43 ~~$6.43~~	$516.00 ~~$11,895.50~~
Non-Medical Transportation - Per Trip (UTA)~~Massage Therapy~~	Per Episode~~15 Minute~~	10~~33~~	185~~151~~	$6.43 ~~$14.85~~	$11,895.50 ~~$73,997.55~~
Massage Therapy	15 Minute	33	151	$17.75	$88,448.25
GRAND TOTAL:					$8,880,419.02 ~~$7,486,460.04~~
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					142~~142~~
FACTOR D (Divide grand total by number of participants)					$62,538.16 ~~$52,721.55~~
AVERAGE LENGTH OF STAY ON THE WAIVER					338~~338~~

State:	
Effective Date	

ii. Estimate of Factor D – Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. 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	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

State:	
Effective Date	

Waiver Year: Year 2						
Waiver Service / Component	Col. 1 **Check if included in capitation**	Col. 2 **Unit**	Col. 3 **# Users**	Col. 4 **Avg. Units Per User**	Col. 5 **Avg. Cost/ Unit**	Col. 6 **Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

State:	
Effective Date	

Waiver Year: Year 3						
Waiver Service / Component	Col. 1 **Check if included in capitation**	Col. 2 **Unit**	Col. 3 **# Users**	Col. 4 **Avg. Units Per User**	Col. 5 **Avg. Cost/ Unit**	Col. 6 **Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

State:	
Effective Date	

Waiver Year: Year 4 (only appears if applicable based on Item 1-C)						
Waiver Service / Component	Col. 1 **Check if included in capitation**	Col. 2 **Unit**	Col. 3 **# Users**	Col. 4 **Avg. Units Per User**	Col. 5 **Avg. Cost/ Unit**	Col. 6 **Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

State:	
Effective Date	

Waiver Year: Year 5 (only appears if applicable based on Item 1-C)						
Waiver Service / Component	Col. 1 **Check if included in capitation**	Col. 2 **Unit**	Col. 3 **# Users**	Col. 4 **Avg. Units Per User**	Col. 5 **Avg. Cost/ Unit**	Col. 6 **Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

State:	
Effective Date	