Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.6

Includes Changes Implemented through January 2019

Submitted by:

Submission Date:	

CMS Receipt Date *(CMS Use)*	

State:	
Effective Date	

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

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The 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*): Limited Supports 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:		
	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:** 7/1/2021

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:
		Medicaid participants classified as meeting the Intensive Skilled level of care are not eligible for this waiver.
	○	**Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**
X	**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 Limited Supports Waiver (LSW) is to offer supportive services to individuals who live in their own home. Waiver services are intended to assist participants to live as independently and productively as possible while living in their community.

The Department of Health, Division of Medicaid and Health Financing is the Administrative Agency for this waiver, and the Department of Human Services, Division of Services for People with Disabilities (DSPD) is the operating agency. The functions of both of these agencies are specified in Appendix A of this application. DSPD utilizes an array of service providers in the community that comprise the direct service workforce for this population.

The LSW offers both provider-managed and participant-directed service delivery methods.

3. Components of the Waiver Request

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

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

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

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

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

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

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

5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

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

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

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

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services.

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

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

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

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

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State

Plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. **Habilitation Services**. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education 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:

During 2019, the State held five focus groups that solicited stakeholder input about service design. Focus groups explored how families use services, community integration, day activities, and remote support. Each focus group was followed with a survey sent out to participants, people waiting for services, and families. The State used the information gathered to inform the qualities and details of services on the LSW. In July 2020, the State held three stakeholder input sessions to gather feedback on the design of LSW services.

Beginning in January 2021, and for 30 days thereafter, a copy of the draft State Implementation Plan (SIP) was posted online at **https://medicaid.utah.gov/ltc**. Public comment was accepted by mail, fax and online submission. In addition, the State presented information on the waiver application to the Utah Indian Health Advisory Board (UIHAB) on November 13, 2020. The UIHAB represents all federally recognized Tribal Governments within the State. Additionally, a summary of the SIP was presented to the Medical Care Advisory Committee (MCAC) on November 19, 2020. Information on the application was published in the newspaper with instructions on how a copy of the implementation plan could be requested and how comment may be submitted. Hard copies were also made available at the Department of Health.

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, Bureau of Long Term Services and Supports				
Agency:	Utah Department of Health, Division of Medicaid and Health Financing				
Address :	288 N. 1460 W.				
Address 2:	PO Box 143101				
City:	Salt Lake City				
State:					
Zip:	84114-3101				
Phone:	(801) 538-6090	**Ext :**		☐	**TTY**
Fax:	(801) 538-6412				
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:	Department of Human Services, Division of Services for People with Disabilities
Address:	195 N. 1950 W.
Address 2:	
City:	Salt Lake City

State:	Utah				
Zip :	84116				
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:	Checketts				
First Name:	Nate				
Title:	Director				
Agency:	Division of Medicaid and Health Financing				
Address:	288 N 1460 W				
Address 2:					
City:	Salt Lake City				
State:	Utah				
Zip:	84114				
Phone:	801-538-6043	**Ext:**		☐	**TTY**
Fax:	801-538-6860				
E-mail:	nchecketts@utah.gov				

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Not applicable.

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

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

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

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

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

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

The State assures the LSW is compliant with 42 CFR 441.301(c)(4)-(5), and associated CMS guidance upon the waiver's effective date.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

○	The waiver is operated by the State Medicaid agency. Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one)*:		
	○	The Medical Assistance Unit *(specify the unit name) (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:		
	Utah Department of Human Services (DHS), Division of Services for People with Disabilities (DSPD)		
X	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 DHS 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 DHS'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. Home and Community Based Services (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 DHS Quality Management Team. If ongoing or formal annual reviews conducted by the Quality Management Team reveal concerns with compliance DHS is required to develop plans of correction within specific time frames to correct the problems. The DHS Quality Management Team conducts follow up activities to ensure that corrections are sustaining. The SMA evaluates all performance measure reviews and approves any necessary Quality Improvement Plans (QIP). This evaluation occurs annually and should a QIP be developed, the SMA provides representation at all meetings and reviews progress on affected measures.

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

○	**Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).** Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*
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**
○	**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	☒	☒	☐	☐
Waiver enrollment managed against approved limits	☒	☒	☐	☐
Waiver expenditures managed against approved levels	☒	☒	☐	☐
Level of care evaluation	☒	☒	☐	☐
Review of Participant service plans	☒	☒	☐	☐
Prior authorization of waiver services	☒	☒	☐	☐
Utilization management	☒	☒	☐	☐
Qualified provider enrollment	☒	☒	☐	☐
Execution of Medicaid provider agreements	☒	☐	☐	☐

Establishment of a Statewide rate methodology	☒	☒	☐	☐
Rules, policies, procedures and information development governing the waiver program	☒	☒	☐	☐
Quality assurance and quality improvement activities	☒	☒	☐	☐

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.

Performance Measure:	***Number and percentage of applicants denied access to the waiver following the initial LoC eval who were provided timely notice of appeal rights. Numerator is the total # of applicants who were denied waiver access after the initial LoC and received a timely notice of appeal rights at least 10 days before the date of action; denominator is the total # of applicants denied waiver access after the initial LoC***
Data Source (Select one) (Several options are listed in the on-line application):	

If 'Other' is selected, specify:			
DSPD application denial records and Participant records			
	Responsible Party for data collection/generation (check each that applies)	***Frequency of data collection/generation: (check each that applies)***	***Sampling Approach (check each that applies)***
	¨ State Medicaid Agency	***¨ Weekly***	***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 cases given 30 days notice for reductions/terminations or 10 days notice for denials; D = total # of cases requiring notification*		
Data Source (Select one) (Several options are listed in the on-line application):			
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 =*
	¨ Other Specify:	*¨ Annually*	*95% Confidence Level, 5% Margin of Error*
		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 newly enrolled waiver providers with a Medicaid provider agreement that has been approved prior to receiving reimbursement for waiver services. Numerator is the total # of newly enrolled waiver providers with approved Medicaid provider agreements in place prior to receiving reimbursement; denominator is the total # of newly enrolled waiver providers receiving reimbursement.***
Data Source (Select one) (Several options are listed in the on-line application):	
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:*	*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	*x Weekly*
x Operating Agency	¨ *Monthly*
¨ *Sub-State Entity*	¨ *Quarterly*
¨ *Other Specify:*	*x Annually*
	¨ *Continuously and Ongoing*
	¨ *Other Specify:*

Performance Measure:	***Number and percentage of documents/rules/policies/procedures submitted and approved by the SMA using the Document Submittal Protocol prior to implementation. The numerator is the total # of documents/rules/policies/procedures that were appropriately submitted by the OA; the denominator includes any documents that were required to be submitted to the SMA for review prior to implementation.***		
Data Source (Select one) (Several options are listed in the on-line application):			
If 'Other' is selected, specify:			
SMA/OA records			
	Responsible Party for data collection/generation (check each that applies)	***Frequency of data collection/generation: (check each that applies)***	***Sampling Approach (check each that applies)***
	x State Medicaid Agency	***¨ Weekly***	***x 100% Review***
	x Operating Agency	***¨ Monthly***	***¨ Less than 100% Review***
	¨ Sub-State Entity	***¨ Quarterly***	***¨ Representative Sample; Confidence Interval =***
	¨ Other Specify:	***¨ Annually***	
		x Continuously and Ongoing	***¨ Stratified: Describe 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 enrolled in the waiver in accordance with the State Implementation Plan (SIP). Numerator is the number of participants enrolled in the waiver in accordance with the SIP; Denominator is the total number of enrolled waiver participants.***
Data Source (Select one) (Several options are listed in the on-line application):	
If 'Other' is selected, specify:	

Level of Care Documents; Log Notes;			
	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***
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.*

The SMA demonstrates ultimate administrative authority and responsibility for the operation of the Limited Supports Waiver (LSW) program through numerous activities including the issuance of LSW provider agreement approvals as well as the review of the following: applicants denied entry to the LSW to determine if timely appeal rights were provided and 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 to determine if timely notice of appeal rights were provided. The SMA also conducts quarterly meetings with staff from DHS, monitors compliance with the interagency MOU, reviews policy/procedures as necessary prior to implementation, conducts annual quality assurance reviews of the LSW program and provides technical assistance to DSPD and other entities within the State that affect the operation of the waiver program.

In Addition, waiver participants, members of the public, and stakeholders may submit concerns to SMA or OA, both of which have representatives designated to respond to concerns.

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 Adult Protective Services (APS) and/or local law enforcement; or issues involving the State's Medicaid Fraud Control Unit or Office of Inspector General.

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**
○	**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		☒

	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
X	**Intellectual Disability or Developmental Disability, or Both**				
	X	Autism	0		x
	X	Developmental Disability	0		x
	X	Mental Retardation	0		x
☐	**Mental Illness** *(check each that applies)*				
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

Waiver services are limited to individuals with the following condition(s)
1. Must have a diagnosis of intellectual disability as per 42CFR483.102(b)(3) or a condition closely related to intellectual disability as per 42CFR435.1010, or have an acquired brain injury.

2. In addition, individuals served in this waiver program must also demonstrate substantial functional limitations in three or more areas of major life activity as described in R414-502-8.

3. Conditions closely related to intellectual disabilities do not include individuals whose functional limitations are due solely to mental illness, substance abuse, personality disorder, hearing impairment, visual impairment, learning disabilities, behavior disorders, physical problems, borderline intellectual functioning, communication or language disorders, aging process, terminal illnesses, or developmental disabilities that do not result in an intellectual impairment.

4. Acquired brain injury is defined as being related to an injury 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.

5. 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.

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

7. Individuals must score between 36 and 136 on the Comprehensive Brain Injury Assessment (CBIA) form as outlined in Administrative Rule R539-1-8 (1)(c), UAC.

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:

○	**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*.		
X	**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*.		
	In FY2018, DSPD conducted a study on methods for managing its waiting list for HCBS, and put a proposal together for how to address the increasing numbers of individuals with disabilities applying for services. DSPD explored several options, and ultimately determined a limited supports waiver would be the most cost effective way to address the needs of individuals currently waiting for services, as well as the thousands of individuals who are, at this point, unknown to the disability service delivery system. Based on a variety of factors, DSPD determined that a cost limit of $16,400 (total funds) would be sufficient to serve the majority of individuals who are in need of disability supports. The University of Minnesota Residential Information Systems Project Annual Report: Status and Trends Through 2016 was used to estimate the prevalence of individuals Statewide who are in need of disability services. The		

current expenditures of individuals on the Community Support Waiver (CSW), who would be able to have their health and safety needs met by this waiver were assessed and factored into the cost limit on this waiver. Additionally, multiple focus groups were held with families, individuals in services, providers, and Support Coordinators to determine what services would be most beneficial to include on this waiver. In the appropriation from the Utah State Legislature, a targeted rate increase was given to selected services which providers and families identified as some of the most critical services to individuals with disabilities. The cost limit also includes a cost of living adjustment of 2% compounding each year for 5 years.

The cost limit specified by the State is *(select one)*:

x **The following dollar amount**: Specify dollar amount: $16,400

The dollar amount *(select one)*:

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

Years 2-5: the previous year's individual cost limit is multiplied by 1.02 to obtain the new year's individual cost limit.

○ **May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**

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

○ **Other:**
Specify:

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:

Individuals are expected to live in their own home or with their family; and have available services and supports from other sources, that in combination with waiver services, are sufficient to assure their health and safety within the individual cost limit.

The OA will use the person-centered planning process to determine the level of service need and develop a budget. A Support Coordinator will conduct a face-to-face in person meeting with the individual in order to develop the person-centered service plan; and review, update, or complete any needed documents and assessments. If the health and welfare of the participant cannot be assured within the cost limit in combination with other resources, the applicant will be denied enrollment.

If enrollment in the waiver is denied, the individual will be given notification of the opportunity for a Fair Hearing to appeal the denial. If a CSW slot is not available, the person can continue to wait for the CSW and be considered for enrollment in the same manner as all other applicants. Information about other available resources will also be provided.

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.**
x	**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:
	The OA may approve up to $10,000 annually to address emergencies, temporary changes in need, and one-time equipment purchases. The OA may also approve up to $10,000 annually to address an individual's ongoing support needs. In all cases, the approval requires an annual authorization or re-authorization of funds to address the person's needs. The Support Coordinator will submit a request to the waiver manager through USTEPS that indicates the amount, the assessed need, what the amount purchases, and how the request meets established criteria. The request will be submitted by the Support Coordinator through USTEPS to the waiver manager for review. If an individual's needs exceed the individual cost limit and the enhanced funding, they may be disenrolled from the LSW.
☐	**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	40
Year 2	40
Year 3	40
Year 4 (only appears if applicable based on Item 1-C)	40
Year 5 (only appears if applicable based on Item 1-C)	40

X	**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	

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

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

x	**Not applicable**. **The State does not reserve capacity.**		
○	**The State reserves capacity for the following purpose(s).** Purpose(s) the State reserves capacity for:		
	Table B-3-c		
		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.**
○	**The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an *intra-year* limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

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

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

If a person is eligible for more than one of the Utah's HCBS waivers the SMA and DSPD will educate the individual about their choices and will advise the individual about which of the waivers will likely best meet their needs.

UT Admin Code R539-1-8 describes the entrance of individuals to the program:

(1) Matching federal funds may be available through a limited support waiver that provides an array of home and community-based services for a person with an intellectual disability or related condition, or brain injury.
(a) A person must meet financial eligibility for Medicaid benefits as determined by the Department of Workforce Services.
(b) A person must meet a waiver level of care as determined by the division.
(2) Within an appropriation from the Legislature, as described in Section 62A-5-102, the division determines waiver enrollment.
(a) The division shall offer enrollment in order of time spent waiting.
(b) The division shall identify a person through:
(i) an adjusted critical needs score at or below the person's age group threshold; and
(ii) no immediate need for out-of-home residential support services.
(c) The adjusted critical need score equals the person's total critical need score minus the time spent waiting component.
(d) A person shall be enrolled in a limited support waiver only if the person's assessed need can be safely met within the individual budget limit.
(4) Pursuant to Section R414-510, if the Department of Health determines that sufficient funding is available, an eligible individual may receive a waiver service by transitioning out of an ICF into a limited support waiver.
(5) Pursuant to Section R414-502, the Department of Health may find a person meeting nursing facility level of care eligible for funding through a limited support waiver.
(6) Any person offered enrollment in a Medicaid waiver may choose not to participate. If an eligible person chooses not to participate in a waiver, the person shall receive only the State funded portion of their assessed need as described in Section R539-1-9.

DSPD will use an adjusted critical needs score to identify individuals eligible for the LSW. The adjusted critical needs score is the Critical Needs Assessment score calculated without the time spent waiting component. Time spent waiting will be used to determine order of enrollment.

Entrants to the waiver are selected based on the following information:

- applicants with an adjusted critical needs score at or below their age group threshold; and
- screened in advance to confirm the services and supports offered by the LSW would be sufficient to meet health and safety needs.

A clinical file review found that adults most likely to benefit from the LSW had a Needs Assessment Questionnaire (NAQ) score at or below 25. This score was translated for other age groups by identifying the relative number of standard deviations from the mean. At the time of analysis (August 2020), adults with a score of 25 were found to be .916 standard deviations below the mean. Applying this same formula (.916 standard deviations below the mean for that age group), the following thresholds for each age group were calculated:

- Children (age 0-14): 40.9
- Transition Age Youth (age 14-22): 34.2
- Adults (age 22 or older): 25.0

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
☐	☐	☐	☐	☐

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		

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

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

○	§1634 State
x	SSI Criteria State
○	209(b) State

2. Miller Trust State.

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

x	No
○	Yes

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

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)			
☐	Low income families with children as provided in §1931 of the Act		
x	SSI recipients		
☐	Aged, blind or disabled in 209(b) States who are eligible under 42 CFR §435.121		
x	Optional State supplement recipients		
x	Optional categorically needy aged and/or disabled individuals who have income at: *(select one)*		
	x	100% of the Federal poverty level (FPL)	
	○	%	of FPL, which is lower than 100% of FPL 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 1634(c)/1634(d) 1619(b)

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*:		

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.

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 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.

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. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
x	The following standard included under the State Plan *(Select one):*			
	○	**SSI standard**		
	○	**Optional State supplement standard**		
	○	**Medically needy income standard**		
	x	**The special income level for institutionalized persons** *(select one):*		
		x	**300% of the SSI Federal Benefit Rate (FBR)**	
		○	%	**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. <u>Allowance for the spouse only</u> (*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:** 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)*:			
x	**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:

x	**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 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		
○	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 §435.735:

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

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

Select one:

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

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

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. <u>Allowance for the needs of the waiver participant</u> (*select one*):

○	The following standard included under the State Plan *(Select one):*			
	○	**SSI standard**		
	○	**Optional State supplement standard**		
	○	**Medically needy income standard**		
	○	**The special income level for institutionalized persons** *(select one):*		
		○	**300% of the SSI Federal Benefit Rate (FBR)**	
		○	%	**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. <u>Allowance for the spouse only</u> (*select one*):

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

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

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

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

iii. <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*:

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. <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 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. <u>Allowance for the spouse only</u> (*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. <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:

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. <u>Allowance for the personal needs of the waiver participant</u> *(select one)***:**			
○	**SSI Standard**		
○	**Optional State supplement standard**		
○	**Medically needy income standard**		
x	**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:			
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:

x	**Not applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
○	**The State does not establish reasonable limits.**
○	**The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

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.

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

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

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

iii. <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*:

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. <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 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. <u>Allowance for the spouse only</u> (*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. <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*:

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. <u>Allowance for the personal needs of the waiver participant</u> *(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.**
○	**The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

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

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

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

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

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

○	**Directly by the Medicaid agency**
x	**By the operating agency specified in Appendix A**
○	**By a government agency under contract with the Medicaid agency.** *Specify the entity*:
○	**Other** *Specify*:

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

Support Coordinator – Certified by DSPD

Qualified Support Coordinators shall meet the qualifications in Option 1, Option 2, or Option 3.

Option 1:

- Possess at least a Bachelor's degree in nursing, behavioral science, or a human services related field such as social work, sociology, special education, rehabilitation counseling, or psychology; and
- at least one year of experience working directly with persons with intellectual disabilities, other developmental disabilities, or acquired brain injuries.

Option 2:
Experience:

- Have five years of professional experience working directly with people with disabilities.
- Must be supervised by a QIDP/ABISC

Option 3:
Experience and Education:

- Have a combination of experience and education totaling five years of professional experience working directly with people with disabilities and college credits in sociology, psychology, human development, special education, or other related social services.
- Must be supervised by a QIDP/ABISC

Support Coordinators must also demonstrate competency related to the planning and delivery of health services to the waiver population through successful completion of a training program approved by the State Medicaid Agency. At a minimum, the program includes certifications in assessment, Acquired Brain Injury Certification, and training on supporting individuals with intellectual or developmental disabilities and related conditions, acquired brain injuries requirements, self-directed and agency services, employment, person-centered planning, eligibility and level of care requirements, medication, critical incidents, mandatory reporting for abuse, neglect, exploitation; fatalities, Medicaid eligibility, human rights, housing, the Health Insurance Portability and Accountability Act, and the Settings Rule. The training program must be completed prior to acting as a Support Coordinator.

Support Coordinators must also complete at least 30 hours of training annually.

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

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

Utah Administrative Rule 414-502-8 defines the State's level of care criteria for intermediate care facilities for persons with intellectual disabilities. The rule defines that a participant must:
(1) Have a diagnosis of intellectual disability (42 CFR 483.102(b)(3) or a condition closely related to intellectual disability (42 CFR 435.1010) and
(2) For people seven years old and older, have documented substantial functional limitations in at least three areas of major life activity (self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency applicable to those 18 and older). Children under the age of seven years old are considered "at risk" for substantial functional limitations due to simply having a diagnosis as described in item (1). Separate documentation to indicate substantial functional limitations in at least three areas of major life activity is not required until a child turns seven years of age.

A variety of histories and evaluations are required for determination of level of care:
(1) Assessments that document functional limitations in three of the major areas of life activity. Assessments may include psychological evaluations, adaptive testing, State assessments such as the Utah Comprehensive Assessment of Needs and Strengths (UCANS) or the Needs Assessment Questionnaire, and other available documentation.
(2) Social History and/or Social Summary which has been completed by the applicant or for the applicant no longer than one year prior to the date of application.
(3) Psychological evaluation completed within five years of application to the waiver. The evaluation requirement may be waived if the individual has resided in any Utah ICF/ID continuously for more than five years prior to the date of original waiver eligibility determination.
(4) Medical Nursing Evaluation which has been completed by a physician or registered nurse no longer than one year prior to the date of original eligibility determination. (This information is only required for cases in which the person has specific medical conditions that are complex and/or may require additional services to meet the individual's specific medical needs.
(5) Documentation of the developmental disability or related condition as evidenced by the psychological assessment or other medical documentation.
(6) For individuals residing in any Utah ICF/ID who transition directly from the ICF/ID to waiver services, original level of care certification and eligibility documentation from the ICF/ID may be considered to determine waiver eligibility.

Utah Administrative Rule 414-502 defines the State's level of care for nursing facility care. The rule defines that a participant 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 Brain Injury Waiver is the Comprehensive Brain Injury Assessment (CBIA). The applicant must score between 36 - 136 on this assessment.

The level of care determination screen in USTEPS documents the level of care determination. The Support Coordinator must certify the individual meets all of the following requirements:

1. Has Intellectual Disability as defined in 42CFR483.102(b)(3)
2. A Support Coordinator has documented that the individual meets the level of care requirements specified in R414-502-8: Criteria for ICF/ID and;
3. The individual is determined to require the level of care furnished in an ICF/ID.

OR

1. Individual scores between 36 and 136 on the Comprehensive Brain Injury Assessment(CBIA).

2. Individual has an Acquired Brain Injury defined as being injury related and neurological in nature.
3. The individual must require care above the level of room and board as documented by at least two of the following criteria (check all that apply).

-Due to the diagnosed medical condition, the applicant requires at least substantial physical assistance with activities of daily living above the level of verbal prompting, supervising, or setting up.
-The attending physician had determined that the applicant's level of dysfunction in orientation to person, place, or time requires nursing facility; or
-The medical condition and intensity of services indicate that the care needs of the applicant cannot be safely met in a less structured setting and alternatives have been explored and are not feasible.

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

○	**The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
X	**A different instrument is used to determine the level of care for the waiver than for institutional care under the State Plan.** Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.
	The primary instrument/methodology to determine level of care in intermediate care facilities is the same as for those receiving institutional care through the State Plan.

	The primary instrument used to determine level of care in nursing facilities is the Minimum Data Set (MDS) assessment. Because this nursing facility level of care assessment was designed to determine the needs of individuals residing in facility based settings, for waiver nursing facility level of care, 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 nursing facility level of care 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. The assessment used to determine intellectual/developmental disability level of care is the same for the waiver and institutional care.

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

A thorough review of available documentation and assessments is conducted initially and annually by specially trained operating agency intake and eligibility personnel who are Support Coordinator's. State Support Coordinators determine the initial level of care for new enrollees; other State eligibility personnel certify ongoing level of care for waiver participants. All State staff responsible for initial or ongoing level of care evaluations are trained on level of care requirements including the diagnosis of an intellectual or developmental disability, related condition, or brain injury; the criteria for an Intermediate Care Facility for Persons with Intellectual Disability including substantial functional limitations in three or more of the seven areas of major life activity; substantial functional limitations in three or more of the seven areas of major life activity for brain injury; criteria for nursing facility level of care; and determining when but for the provision of waiver services the individual would otherwise require placement in an ICF/ID or a nursing facility to receive needed services. On the level of care determination screen in USTEPS, the Support Coordinator must certify the individual meets all of the respective requirements using assessments including adaptive testing and psychological evaluations, medical records, or other documentation that is available to inform their decision. If these personnel determine that the individual meets eligibility criteria for enrollment in a Home and Community Based Services waiver including the LSW, that determination is entered in the Level of Care determination screen in the USTEPS system and is electronically signed by the Support Coordinator making that decision, which certifies the initial and annual level of care determinations.

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:
	For ID/RC, every 12 months or more often as needed. To determine whether the participant has an ongoing need for ICF/ID level of care, the Participant's level of care is screened at the time a substantial change in the participant's health status occurs. A substantial change includes evaluating health status at the conclusion of an inpatient stay in a medical institution. A full level of care reevaluation is conducted whenever indicated by a health status change screening and at a minimum within 12 consecutive months of the last recorded level of care determination. For ABI, 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. Health Status changes would speak to any change is physical or mental health which has a direct impact on re-evaluating items specifically listed in Level of Care and Functional Limitations

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

X	**The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
○	**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 DSPD, provides an automated tickler "to do" message to be sent to the Support Coordinator at the beginning of the month in which a reevaluation is due. In addition to the tickler reminder for Support Coordinators, State staff use a USTEPS report to identify all level of care evaluations that will be required for the month, and to confirm their completion before the start of the next month. A report with customized date parameters can be generated at any time to obtain the most current information.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are

maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Electronically retrievable documentation of all evaluations and reevaluations are maintained within the USTEPS system for a minimum of three years as required.

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

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:*

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 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):*			
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*	*XLess than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =*
	☐ Other Specify:	*X Annually*	*95% Confidence Level, 5% Margin of Error*
		☐ 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 initial Level of Care evaluations performed by a State Support Coordinator certified by DSPD as a qualified Support Coordinator. The numerator is the number of initial Level of Care evaluations which were performed by a certified 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):*			
If 'Other' is selected, specify:			
Participant records, USTEPS			
	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*	☐ *100% Review*
	X Operating Agency	☐ *Monthly*	*XLess than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	*X Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	*X Annually*	*95% Confidence Level, 5% Margin of Error*
		☐ *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:*

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 Support Coordinator and that evaluation is documented in USTEPS. DSPD reviews monthly reports to verify that ongoing ICF/ID or NF level of care evaluations are completed within designated timeframes.

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 regarding the accuracy of level of care determination for waiver participants are addressed and corrected immediately by DSPD to assure that all participants meet ICF/ID or SNF 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 annual Final 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.

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

c. Timelines

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

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.

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 form 818. Freedom of choice procedures:

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

In addition, during the intake process individuals will be given a 2-sided Informational Fact Sheet (Form IFS-10) which describes the eligibility criteria and services available through both the waiver program and through ICF/IDs or NFs, including contact information for DSPD Intake and for each of the ICF/IDs or NFs throughout the State. The information given to an individual is determined by their eligible diagnosis.

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 person centered 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.
d. The individual's health and safety needs can be met within their allotted service budget.

3. Once the individual has chosen home and community-based waiver services, the choice has been documented by the Support Coordinator, and the individual has received a copy of the Guide and the Informational Fact Sheet, subsequent review of choice of program will only be required at the time a substantial change in the enrollee's condition results in a change in the Person Centered Support Plan. Health Status changes would speak to any change in physical or mental health which

has a direct impact on re-evaluating items specifically listed in Level of Care and Functional Limitations. It is, however, the individual's option to choose institutional (ICF/ID or 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 person centered 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 person centered support plan.

5. The operating agency will provide in writing, an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to beneficiaries who are not given the choice of home or community-based services as an alternative to the institutional care specified for this request, who are denied the waiver service(s) and/or waiver provider(s) of their choice, who are found ineligible for the waiver program or who have been notified of actions to suspend, reduce and/or terminate services.

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

The Operating Agency maintains the Freedom of Choice Forms 818 and 818b electronically in USTEPS for a minimum of three years as required.

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 participants who have limited English proficiency. Individuals participating in the LSW are entitled to the same access to an interpreter to assist in making appointments for qualified procedures and during those visits. Providers must notify participants that interpretive services are available at no charge. The SMA and OA encourage participants to use professional services rather than relying on a family member or friends though the final choice is theirs. Using an interpretive service provider ensures confidentiality as well as the quality of language translation. Waiver participants may be referred to Medicaid interpretive services by providers, their Support Coordinator, and/or State staff from the OA or SMA.

Information regarding access to Medicaid Translation Services is included in the Medicaid Member Guide distributed to all Utah Medicaid participants. Waiver participants 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

Additionally, the DHS provides contracted interpretive services for limited English proficiency persons throughout the waiver entrance process. State staff explore the individual's preference, if any, for a type of language assistance service.

Bilingual State staff support individuals directly when available and desired by the individual. When interpreting, State staff must meet the following requirements:

-Demonstrate proficiency in and ability to communicate information accurately in both English and in the other language and identify and employ the appropriate mode of interpreting (e.g., consecutive, simultaneous, summarization, or sight translation);

-To the extent necessary for communication between the recipient or its staff and the LEP person, have knowledge in both languages of any specialized terms or concepts peculiar to the recipient's program or activity and of any particularized vocabulary and phraseology used by the LEP person;

-Understand and follow confidentiality and impartiality rules to the same extent as the recipient employee for whom they are interpreting and/or to the extent their position requires;

-Understand and adhere to their role as interpreters without deviating into other roles--such as counselor or advisor--where such deviation would be inappropriate

Appendix C: Participant Services

Appendix C-1/C-3: Summary of Services Covered and Services Specifications

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

Statutory Services *(check each that applies)*		
Service	Included	Alternate Service Title (if any)
Case Management	☐	
Homemaker	☐	
Home Health Aide	☐	
Personal Care	☐	
Adult Day Health	☐	
Habilitation	☐	
Residential Habilitation	☐	
Day Habilitation	x	Integrated Community Learning
Prevocational Services	x	
Supported Employment	x	
Education	☐	
Respite	☐	

Day Treatment	☐	
Partial Hospitalization	☐	
Psychosocial Rehabilitation	☐	
Clinic Services	☐	
Live-in Caregiver (42 CFR §441.303(f)(8))	☐	

Other Services *(select one)*
Not applicable
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute *(list each service by title)*:
Applied Behavioral Analysis Therapy (Non-Autism/or ASD Support for Non-EPSDT Eligible Individuals)
Attendant Care
Behavioral Services
Environmental Adaptations - Home
Environmental Adaptations - Vehicle
Individual and Family Peer Support
Individual Goods and Services
Remote Support Equipment - Installation
Remote Support Equipment - Periodic Fee
Specialized Medical Equipment/Supplies/Assistive Technology - Periodic Fee
Specialized Medical Equipment/Supplies/Assistive Technology - Purchase

Transportation Services (non-medical)

Extended State Plan Services *(select one)*

Not applicable

The following extended State Plan services are provided *(list each extended State Plan service by service title)*:

Supports for Participant Direction *(check each that applies))*

The waiver provides for participant direction of services as specified in Appendix E. The waiver includes Information and Assistance in Support of Participant Direction, Financial Management Services or other supports for participant direction as waiver services.

The waiver provides for participant direction of services as specified in Appendix E. Some or all of the supports for participant direction are provided as administrative activities and are described in Appendix E.

Not applicable

Support	Included	Alternate Service Title (if any)
Information and Assistance in Support of Participant Direction	x	Individual and Family Peer Support
Financial Management Services	x	

Other Supports for Participant Direction *(list each support by service title)*:

C-1/C-3: Service Specification

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

Service Specification - Integrated Community Learning	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Service Definition (Scope)**:**	
Integrated Community Learning (ICL) provides a person with general skill building, and opportunities to identify and build interests. The service has a focus on developing opportunities and skills that can further the person's chosen goals and enable community integrated employment. ICL can be provided individually and in groups up to 3 people. When the service is provided in a group, the interests, preferences, abilities, and goals of each person must be addressed. ICL includes supports, activities and opportunities for a person to engage and participate in regularly scheduled, daytime, nighttime or weekend community activities. Activities are chosen by the person and support their employment goals, community integration, involvement and exploration. Activities intend to build and strengthen communication and social relationships so that the person can engage in a meaningful life in the community.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	

ICL cannot be provided in the person's residence, the provider's residence, or a segregated facility-based setting. Integrated community learning services rendered under the waiver cannot be available under a program funded by either the Rehabilitation Act of 1973, or the Individuals with Disabilities Education Act.

Transportation may not be billed for separately and is included in the rate paid.

Participants receiving Integrated Community Learning may receive Attendant Care, Prevocational Services, and employment-related services as long as these services are neither provided nor billed for at times when the participant is receiving Integrated Community Learning services.

In total, the supports and services authorized in an individual's PCSP in the LSW may not exceed the Individual Cost Limit established in Appendix B-2.

Service Delivery Method *(check each that applies)*:	x	Participant-directed as specified in Appendix E		x	Provider managed
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	x	Relative	☐ Legal Guardian

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	x	Agency. List the types of agencies:
			Agency-based - Integrated Community Learning	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
	Current business license	Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	Under State contract with DHS/DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Enrolled as a Medicaid provider. 30 days-

		Workplace Supports Training	• Emergency Procedures; when to call 911, incident reporting, when to call doctor/hospital, orientation to seizure disorder, notification process for lost client; prevention of choking (if applicable to client), first aid. • Catastrophic Emergency/Crisis Procedures • Positive behavior supports • Legal rights of persons with disabilities • Abuse, Neglect, Exploitation prevention and reporting • DHS/DSPD Code of Conduct • Confidentiality • Orientation to persons with ID.RC or ABI • Medication Training • Prevention of communicable diseases • Knowledge of person supporting • Protective Service Reporting • Client specific medication training • Client specific medical/dietary/eating needs • Age appropriate community inclusion/natural supports • Client specific preferences/routines • Client specific functional limitations/disabling conditions 90 days- • CPR Certification 6 months- • Behavior Crisis Intervention • Mandt, SOAR, PART • DHS/DSPD rules, philosophy, mission, beliefs • Contractor Policy, philosophy, mission • Key elements of ADA (Americans with Disabilities Act) • Fraud (Federal/Utah false claim act, UT whistle blower act) • PCSP Development

			• Supporting clients preferred recreational/leisure activities • Supporting clients preferred work activities 2nd year- • 12 hour minimum additional training • Behavior Training (if supporting in a licensed site) Additional Requirements: • Annual review of Driver license, personal auto insurance, and driving record of all staff that transport clients (annual review) • Criminal Background Check completion (annual review) • Signed DHS and DSPD Code of Conduct (annual review) • Conflict of Interest disclosure (annual review) • Office of Inspector General Exclusion List (annual review) • Contractors Emergency Management and Business Continuity Plan (annual review)

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Division of Services for People with Disabilities	**Annually**

Service Specification - Prevocational Services	
HCBS Taxonomy	
Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope)**:**

Prevocational Services support people who are interested in learning more about and exploring employment opportunities, which will improve their employment readiness by offering opportunities for choice and critical thinking. Prevocational Services include experiential activities that help identify a person's specific interests and aptitudes leading toward informed choice to work or not; and activities to determine skills, interests, or behavior of the person before employment or for the re-placement of employment. This may include volunteer work or internships.

Prevocational Services use the pathways to employment framework which allows individuals to configure a variety of supportive services available during the day to achieve community integrated employment. Individually tailored services target employment readiness through improvement of general soft skills and acquisition of task-related skills. Individuals navigate these pathways based on their own interests, goals, and experiences. The optimal outcome of this service and associated goals is competitive integrated employment for the individual.

Attendant care, personal care/assistance is a component of prevocational services, but may not comprise the entirety of the service.

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

Prevocational Services are time-limited to a maximum of 24 months unless modified in the person-centered support plan. Documentation will be maintained that prevocational services rendered under the waiver are not available under a program funded by either the Rehabilitation Act of 1973, or the Individuals with Disabilities Education Act. Services may not be primarily directed at teaching specific skills to perform a particular job unless those skills are being taught in relation to, or in preparation for, an obtained or actively sought after Competitive Integrated Employment position. Individuals participating in prevocational services may be compensated in accordance with applicable Federal laws and regulations and the optimal outcome of the provision of prevocational services is permanent integrated employment at or above the minimum wage in the community.

Transportation may not be billed for separately and is included in the rate paid.

Participants receiving Prevocational Services may receive Attendant Care, Integrated Community Learning, and employment-related services as long as these services are neither provided nor billed for at times when the participant is receiving Prevocational Services.

In total, the supports and services authorized in an individual's PCSP in the LSW may not exceed the Individual Cost Limit established in Appendix B-2.

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

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

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	x	Agency. List the types of agencies:
			Prevocational Provider	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
	Current Business license	Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Workplace Supports Training	Under State contract with DHS/DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Enrolled as a Medicaid provider. 30 days- • Emergency Procedures; when to call 911, incident reporting, when to call doctor/hospital, orientation to seizure disorder, notification process for lost client; prevention of choking (if applicable to client), first aid. • Catastrophic Emergency/Crisis Procedures

			• Positive behavior supports • Legal rights of persons with disabilities • Abuse, Neglect, Exploitation prevention and reporting • DHS/DSPD Code of Conduct • Confidentiality • Orientation to persons with ID.RC or ABI • Medication Training • Prevention of communicable diseases • Knowledge of person supporting • Protective Service Reporting • Client specific medication training • Client specific medical/dietary/eating needs • Age appropriate community inclusion/natural supports • Client specific preferences/routines • Client specific functional limitations/disabling conditions 90 days- • CPR Certification 6 months- • Behavior Crisis Intervention • Mandt, SOAR, PART • ACRE • DHS/DSPD rules, philosophy, mission, beliefs • Contractor Policy, philosophy, mission • Key elements of ADA (Americans with Disabilities Act) • Fraud (Federal/Utah false claim act, UT whistle blower act) • PCSP Development • Supporting clients preferred recreational/leisure activities • Supporting clients preferred work activities 2nd year- • 12 hour minimum additional training • Behavior Training (if supporting in a licensed site)

			Additional Requirements: • Annual review of Driver license, personal auto insurance, and driving record of all staff that transport clients (annual review) • Criminal Background Check completion (annual review) • Signed DHS and DSPD Code of Conduct (annual review) • Conflict of Interest disclosure (annual review) • Office of Inspector General Exclusion List (annual review) • Contractors Emergency Management and Business Continuity Plan (annual review)

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Division of Services for People with Disabilities	**Annually**

Service Specification - Supported Employment	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Service Definition (Scope)**:**

Supported Employment serves the purpose of supporting participants, based on individual need, to obtain, maintain, or advance in competitive employment in integrated work settings.

Supported Employment can be provided to a participant who is employed in either full or part time employment and occurs in a work setting where the participant works with individuals without disabilities (not including staff or contracted co-workers paid to support the participant). Supported Employment may occur anytime during a twenty four hour day and supports are made available in such a way as to assist the participant to achieve competitive employment (compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities).

Participants in Supported Employment are supported and employed consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the participant as indicated in the participant's support plan.

Supports To Maintain Employment

Individual Supported Employment (ISE) provides ongoing job coaching and supports for Persons to maintain their community integrated employment, or self-employment.

Job Development Supports (“JDS”) provides job experiences and opportunities for Persons that are seeking to advance in current employment with their current employer or support to seek a new Competitive Integrated Employment (CIE) job. The optimal outcome of JDS is upward mobility, and employment development to match the Person’s advancing skill set.

Any of the following activities
may be included:
• Work-related behavioral management
• Job coaching
• On-the-job or work-related crisis intervention
• Assisting with skills related to paid employment including communication, problem solving and safety
• Participant directed attendant care (Intermittent ADL/IADL assistance incidental to the job skill supports provided as a core function of the service.).
• Time management
• Grooming
• Employment-related supportive contacts
• Transportation between work or between activities related to employment. Other forms of transportation must be attempted first. (Transportation furnished during the provision of the service is included in the rate paid).
• On-site vocational assessment after employment
• Employer consultation
• Job development

A participant may be supported individually. Supported Employment may also include activities and supports designed to assist participants who are interested in creating and maintaining their own business enterprises.

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

Limitations: Payment will only be made for adaptations, supervision and training required by a participant as a result of the participant's disability and will not include payment for the supervisory activities rendered as a normal part of the business setting. Documentation will be maintained that supported employment services rendered under the waiver are not available under a program funded by either the Rehabilitation Act of 1973, or the Individuals with Disabilities Education Act. Federal Financial Participation will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses, such as incentive payments made to an employer or beneficiaries to encourage or subsidize an employer's participation in a supported employment program, payments that are passed through to a beneficiary of Supported Employment programs, or for payments for vocational training that is not directly related to a beneficiary's Supported Employment program.

Supported employment provided to an individual does not include facility based, or other similar types of vocational services furnished in specialized facilities that are not a part of the general workplace.

All supported employment service options are required to be reviewed and considered as a component of an individual's person-centered services and supports plan no less than annually, more frequently as necessary or as requested by the individual. These services and supports are designed to support successful employment outcomes consistent with the individual's goals.

Supported employment supports do not include volunteer work. Such volunteer learning and training activities that prepare a person for entry into the paid workforce are addressed through prevocational services.

Participants receiving Supported Employment may receive Attendant Care, Integrated Community Learning, and Prevocational Services as long as these services are neither provided nor billed for at times when the participant is receiving Supported Employment services.

Medicaid funds may not be used to defray the expenses associated with starting up or operating a business.

In total, the supports and services authorized in an individual's PCSP in the LSW may not exceed the Individual Cost Limit established in Appendix B-2.

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

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

Provider Specifications

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

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
	Current Business license	Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. ACRE Certification.	In addition to License/Certification requirements, providers must also be: Under State contract with DHS/DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Enrolled as a Medicaid provider. 30 days- • Emergency Procedures; when to call 911, incident reporting, when to call doctor/hospital, orientation to seizure disorder, notification process for lost client; prevention of choking (if applicable to client), first aid. • Catastrophic Emergency/Crisis Procedures • Positive behavior supports • Legal rights of persons with disabilities • Abuse, Neglect, Exploitation prevention and reporting • DHS/DSPD Code of Conduct • Confidentiality • Orientation to persons with ID.RC or ABI • Medication Training • Prevention of communicable diseases • Knowledge of person supporting • Protective Service Reporting • Client specific medication training

			• Client specific medical/dietary/eating needs • Age appropriate community inclusion/natural supports • Client specific preferences/routines • Client specific functional limitations/disabling conditions 90 days- • CPR Certification 6 months- • Behavior Crisis Intervention • Mandt, SOAR, PART • DHS/DSPD rules, philosophy, mission, beliefs • Contractor Policy, philosophy, mission • Key elements of ADA (Americans with Disabilities Act) • Fraud (Federal/Utah false claim act, UT whistle blower act) • PCSP Development • Supporting clients preferred recreational/leisure activities • Supporting clients preferred work activities 2nd year- • 12 hour minimum additional training • Behavior Training (if supporting in a licensed site) Additional Requirements: • Annual review of Driver license, personal auto insurance, and driving record of all staff that transport clients (annual review) • Criminal Background Check completion (annual review) • Signed DHS and DSPD Code of Conduct (annual review) • Conflict of Interest disclosure (annual review) • Office of Inspector General Exclusion List (annual review) • Contractors Emergency Management and Business Continuity Plan (annual review)

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Division of Services for People with Disabilities	**Annually**

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

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
	Current Business license	Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. ACRE Certification.	In addition to License/Certification requirements, providers must also be: Under State contract with DHS/DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Enrolled as a Medicaid provider. 30 days- • Emergency Procedures; when to call 911, incident reporting, when to call doctor/hospital, orientation to seizure disorder, notification process for lost client; prevention of choking (if applicable to client),

			first aid. • Catastrophic Emergency/Crisis Procedures • Positive behavior supports • Legal rights of persons with disabilities • Abuse, Neglect, Exploitation prevention and reporting • DHS/DSPD Code of Conduct • Confidentiality • Orientation to persons with ID.RC or ABI • Medication Training • Prevention of communicable diseases • Knowledge of person supporting • Protective Service Reporting • Client specific medication training • Client specific medical/dietary/eating needs • Age appropriate community inclusion/natural supports • Client specific preferences/routines • Client specific functional limitations/disabling conditions 90 days- • CPR Certification 6 months- • Behavior Crisis Intervention • DHS/DSPD rules, philosophy, mission, beliefs • Contractor Policy, philosophy, mission • Key elements of ADA (Americans with Disabilities Act) • Fraud (Federal/Utah false claim act, UT whistle blower act) • PCSP Development • Supporting clients preferred recreational/leisure activities • Supporting clients preferred work activities 2nd year- • 12 hour minimum additional training

			• Behavior Training (if supporting in a licensed site) Additional Requirements: • Annual review of Driver license, personal auto insurance, and driving record of all staff that transport clients (annual review) • Criminal Background Check completion (annual review) • Signed DHS and DSPD Code of Conduct (annual review) • Conflict of Interest disclosure (annual review) • Office of Inspector General Exclusion List (annual review) • Contractors Emergency Management and Business Continuity Plan (annual review)

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Division of Services for People with Disabilities	**Annually**

Service Specification – Applied Behavioral Analysis Therapy (Non-Autism/or ASD Support for Non-EPSDT Eligible Individuals)	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope)**:**

Applied Behavioral Analysis Therapy (Non-Autism/or ASD Support for Non-EPSDT Eligible Individuals) include services that are rooted in principles of applied behavior analysis (ABA). ABA is a well-developed discipline based on a mature body of scientific knowledge and established standards for evidence-based practice. ABA focuses on the analysis, design, implementation and evaluation of social and other environmental modifications to produce meaningful changes in behavior. ABA is a behavioral health treatment that is intended to develop, maintain, or restore, to the maximum extent attainable, the functioning of a child with ASD. ABA-based therapies are based on reliable empirical evidence and are not experimental or investigational.

All Applied Behavior Analysis (ABA) services must be delivered under a behavior plan developed by and under the supervision of the behaviorist. The technician is responsible for delivering the behavior services according to the protocol developed by the behaviorist. This service may only be used in conjunction with Behavioral Services when a behaviorist determines that implementation of a behavior plan requires a technician. Technician services may be delivered on a one-on-one basis or in small groups of eight individuals or less.

The Support Coordinator is responsible for oversight of the Registered Behavior Technician service when used through the self-determined services model. Oversight includes confirming that the technician maintains the required certifications and supervision by a licensed behaviorist.

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

Limitations: This service is limited to individuals who are non-EPSDT eligible and for services not otherwise covered under the State Plan, including Autism Spectrum Disorder-related EPSDT Applied Behavior Analysis (ABA) services, but consistent with waiver objectives of avoiding institutionalization. For children under the age of 21, services determined to be medically necessary under the EPSDT benefit are covered pursuant to Section 1905(a) of the Social Security Act.

Documentation will be maintained that behavioral services rendered under the waiver are not available under a program funded by the Individuals with Disabilities Education Act.

Contractors are not permitted to provide direct care to persons (i.e. bathing, feeding, dressing, or supervision) nor are they allowed to transport persons receiving services. Contractors are not permitted to bill a developmental intervention at the same time as ABA.

In total, the supports and services authorized in an individual's PCSP in the LSW may not exceed the Individual Cost Limit established in Appendix B-2.					
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E		x	Provider managed
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐ Legal Guardian

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	x	Agency. List the types of agencies:
			An agency that employs Board Certified Behavior Analysts, Interns or Licensed Psychologists	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
	Current business license	Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	Under State contract with DHS/DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA Providers of this service shall have at least 1 year experience working with people with ID. RC or brain injury, and meet one of the following requirements: ● Completion of board certification and DOPL licensure as a type of behavior analyst; ● Be officially enrolled in a BACB approved program leading to certification and DOPL license within required timeframes; ● Have a DOPL license as a psychologist; or ● Be exempt from DOPL licensure as listed in Utah Code §58-61-

			707(10), §58-61-707 (11), or §58-61-707(12) under Exemptions from licensure. Enrolled as Medicaid provider 30 days- • Emergency Procedures; when to call 911, incident reporting, when to call doctor/hospital, orientation to seizure disorder, notification process for lost client; prevention of choking (if applicable to client), first aid. • Catastrophic Emergency/Crisis Procedures • Positive behavior supports • Legal rights of persons with disabilities • Abuse, Neglect, Exploitation prevention and reporting • DHS/DSPD Code of Conduct • Confidentiality • Orientation to persons with ID.RC or ABI • Medication Training • Prevention of communicable diseases • Protective Service Reporting • Age appropriate community inclusion/natural supports • 90 days- • CPR Certification 6 months- • Behavior Crisis Intervention • Mandt, SOAR, PART • DHS/DSPD rules, philosophy, mission, beliefs • Contractor Policy, philosophy, mission • Key elements of ADA (Americans with Disabilities Act) • Fraud (Federal/Utah false claim act, UT whistle blower act) • PCSP Development • Supporting clients preferred recreational/leisure activities • Supporting clients preferred work activities 2nd year- • 12 hour minimum additional training • Behavior Training (if supporting in a licensed site) Additional Requirements: • Annual review of Driver license, personal auto insurance, and driving record of all staff that transport clients (annual review) • Criminal Background Check completion (annual review) • Signed DHS and DSPD Code of Conduct (annual review) • Conflict of Interest disclosure (annual review) • Office of Inspector General Exclusion List (annual review) • Contractors Emergency Management and Business Continuity Plan (annual review) • Educational transcripts, licenses, and degrees

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Division of Services for People with Disabilities	**Annually**

Service Specification – Attendant Care	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Service Definition (Scope)**:**	
Attendant Care includes teaching habilitative and adaptive skills to assist the individual to reach personal goals; providing personal assistance in activities of daily living and instrumental activities of daily living; and providing respite for caregivers. Attendant Care is available to those who live alone, with family or with roommates. For participants residing with families, Attendant Care includes caregiver respite in order to support a natural support network and to avoid unwanted out of home placement.	

Attendant Care activities are prioritized based upon the participant's assessed needs, but may include maintenance of individual health and safety, personal care services, homemaker, chore, respite, companion, medication observation and recording, advocacy, communication, assistance with activities of daily living, instrumental activities of daily living, keeping track of money and bills, and using the telephone; and indirect services such as socialization, self-help, and adaptive/compensatory skills development necessary to reside successfully in the community.

Examples of tasks that may be performed:

- Transport the individual to the store to purchase groceries;
- Prepare and cook meals;
- Assist the individual in washing up and completing hygiene tasks before a meal and assist them to/at the table;
- Assist the individual in eating which may include the use of an occupational therapy plan;
- Supervise the individual while they enjoy time to themselves before their primary caregiver returns home.

The Attendant Care Worker may assist the person to implement a behavioral, occupational therapy, physical therapy, or speech therapy plan to the extent permitted by state law and as prescribed in the support plan. Implementation activities include assistance with exercise routines, range of motion, reading the therapist's directions, helping the person remember and follow the steps of the plan, or hands-on assistance. It does not include the actual service the professional therapist provides.

The above listed services and service types are combined into a single Attendant Care service, because, in actual practice, a direct support staff provides various services as part of the natural flow of the day. Attendant Care on the LSW intends to support independence and autonomy by encouraging the individual and direct support staff to fluidly support goals and needs. Segregating these activities into discrete services is impractical when considering the intention of the waiver.

Attendant Care includes two tiers of service in order to maximize available service hours and effectively support each individual.

- Tier one targets general supervision and socialization; and minimal intervention and assistance with routine tasks. It is available under the self-directed service model.
- Tier two targets extensive assistance needs and skill building. It is available under the self-directed and provider service model. Support Coordinator will document the need for extensive assistance in the person centered support plan.

Examples of extensive assistive needs include:

- An individual has a documented medical condition that requires constant supervision, or a condition that requires prescription medication or treatment follow-through throughout the service time period.
- An individual has documented behavioral issues that require frequent (at least daily) intervention to prevent property damage or harm to themselves or others.

- An individual requires intermittent full performance of some tasks related to personal care needs including dressing, bathing, and toileting; or assistance with transfers and positioning throughout the day. Overall intervention and assistance by another person is less than 50% of an activity.
- There is a need for a specialized skill (such as an interpreter) or specialized equipment in the service setting to assure health and safety.

This service can be provided remotely through telehealth, when hands-on assistance is not required by the individual.

- Remote Attendant Care includes remote monitoring systems for live video feed, live audio feed, motion sensing, or web-based monitoring
- Telehealth must be:
  - HIPPA compliant, including, a secure network requiring authentication, authorization, encryption of data, and ensuring that access to data is limited to authorized personnel;
  - Engage in live two-way communication with the person.

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

Participants receiving Attendant Care may receive Integrated Community Learning, Prevocational Services,and employment-related services as long as these services are neither provided nor billed for at times when the participant is receiving Attendant Care services.

Overnight Attendant Care may not be provided for more than 13 days continuously (not including date of discharge) and is billed at the tier one rate.

In total, the supports and services authorized in an individual's PCSP in the LSW may not exceed the Individual Cost Limit established in Appendix B-2.

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

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

Provider Specifications				
Provider Category(s) *(check one or both)*:	x	Individual. List types:	☐	Agency. List the types of agencies:
	Self-Directed Services Provider			

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
		Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	Under State contract with DHS/DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA and R539-5. Completed Provider Agreement. Completed/Included in Employee File (Self-Administration) -Employee Agreement -Department of Human Services Provider Code of Conduct -Division of Services for People with Disabilities' Code of Conduct -Emergency Contact Information -Person's Support Book -Service Specific Training -Incident Reporting -Behavior Management (if applicable)

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Division of Services for People with Disabilities	**Annually**

Provider Specifications				
	☐	Individual. List types:	x	Agency. List the types of agencies:

Provider Category(s) *(check one or both)*:		Agency-based - Attendant Care

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
	Current business license	Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	Under State contract with DHS/DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Enrolled as a Medicaid provider. 30 days- • Emergency Procedures; when to call 911, incident reporting, when to call doctor/hospital, orientation to seizure disorder, notification process for lost client; prevention of choking (if applicable to client), first aid. • Catastrophic Emergency/Crisis Procedures • Positive behavior supports • Legal rights of persons with disabilities • Abuse, Neglect, Exploitation prevention and reporting • DHS/DSPD Code of Conduct • Confidentiality • Orientation to persons with ID.RC or ABI • Medication Training • Prevention of communicable diseases • Knowledge of person supporting • Protective Service Reporting • Client specific medication training • Client specific medical/dietary/eating needs • Age appropriate community inclusion/natural supports

			• Client specific preferences/routines • Client specific functional limitations/disabling conditions 90 days- • CPR Certification 6 months- • Behavior Crisis Intervention • Mandt, SOAR, PART • DHS/DSPD rules, philosophy, mission, beliefs • Contractor Policy, philosophy, mission • Key elements of ADA (Americans with Disabilities Act) • Fraud (Federal/Utah false claim act, UT whistle blower act) • PCSP Development • Supporting clients preferred recreational/leisure activities • Supporting clients preferred work activities 2nd year- • 12 hour minimum additional training • Behavior Training (if supporting in a licensed site) Additional Requirements: • Annual review of Driver license, personal auto insurance, and driving record of all staff that transport clients (annual review) • Criminal Background Check completion (annual review) • Signed DHS and DSPD Code of Conduct (annual review) • Conflict of Interest disclosure (annual review) • Office of Inspector General Exclusion List (annual review) • Contractors Emergency Management and Business Continuity Plan (annual review)

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Division of Services for People with Disabilities	**Annually**

Service Specification - Behavioral Services	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Service Definition (Scope)**:**	
Behavioral Services include consultation and recommendations for behavioral interventions and development of behavioral support plans that are related to the individual's developmental disability or brain injury; and are necessary to address an identified behavioral or developmental need of the individual. Behavioral Services also include direct implementation of behavioral interventions. Behavioral Support service can also be accessed for the purpose of reducing the use of restrictions and restraints within a participant’s current plan of care or service environment.	

Behavior intervention and treatment includes a variety of individualized, behavior-related treatment models consistent with best practice and research on effectiveness that are directly related to a person's therapeutic goals. Intervention categories include: Augmentative and Alternative Communication, Developmental Behavioral Intervention (e.g. DIR/Floortime, SCERTS, ESDM, etc.), and Behavior-based Intervention (e.g. Positive Behavior Support, Applied Behavior Analysis). These services are designed to assist individuals to develop or enhance skills with social value; safety; expression of emotions and desires; assertiveness; and communication skills. Key elements are:

- Approach is tailored to address the specific behavioral needs of the person;
- Direct support staff and family training is a key component so that skills can be generalized and communication promoted;
- Services must be directly related to the person's therapeutic goals contained in the support plan, and coordinated with the person's individual education plan (IEP) when applicable; and
- Success is closely monitored with detailed data collection.

Behavioral Plan Assessment Services include observations, interviews of direct staff, functional behavioral analysis and assessment, evaluations and completion of a written assessment document.

Behavioral Services uses two rate tiers, one for the professional licensed or certified to design the behavior plan as well as provide treatment and a lower paid rate paraprofessional implementing the plan and providing treatment.

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

Limitations: The services under Behavioral Services are limited to services not otherwise covered under the State Plan, including Autism Spectrum Disorder-related EPSDT Applied Behavior Analysis (ABA) services, but consistent with waiver objectives of avoiding institutionalization. For children under the age of 21, services determined to be medically necessary under the EPSDT benefit are covered pursuant to Section 1905(a) of the Social Security Act.

Documentation will be maintained that behavioral services rendered under the waiver are not available under a program funded by the Individuals with Disabilities Education Act.

Contractors are not permitted to provide direct care to persons (i.e. bathing, feeding, dressing, or supervision) nor are they allowed to transport persons receiving services. Contractors are not permitted to bill a developmental intervention at the same time as ABA.

In total, the supports and services authorized in an individual's PCSP in the LSW may not exceed the Individual Cost Limit established in Appendix B-2.

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

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

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

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
	Current business license	Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	Under State contract with DHS/DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA Providers of this service shall have at least 1 year experience working with people with ID. RC or brain injury, and meet one of the following requirements: ● Completion of board certification and DOPL licensure as a type of behavior analyst; ● Be officially enrolled in a BACB approved program leading to certification and DOPL license within required timeframes; ● Have a DOPL license as a psychologist; or ● Be exempt from DOPL licensure as listed in Utah Code §58-61-707(10), §58-61-707 (11), or §58-61-707(12) under Exemptions from licensure. Enrolled as Medicaid provider 30 days- • Emergency Procedures; when to call 911, incident reporting, when to call doctor/hospital, orientation to seizure

			disorder, notification process for lost client; prevention of choking (if applicable to client), first aid. • Catastrophic Emergency/Crisis Procedures • Positive behavior supports • Legal rights of persons with disabilities • Abuse, Neglect, Exploitation prevention and reporting • DHS/DSPD Code of Conduct • Confidentiality • Orientation to persons with ID.RC or ABI • Medication Training • Prevention of communicable diseases • Protective Service Reporting • Age appropriate community inclusion/natural supports • 90 days- • CPR Certification 6 months- • Behavior Crisis Intervention • Mandt, SOAR, PART • DHS/DSPD rules, philosophy, mission, beliefs • Contractor Policy, philosophy, mission • Key elements of ADA (Americans with Disabilities Act) • Fraud (Federal/Utah false claim act, UT whistle blower act) • PCSP Development • Supporting clients preferred recreational/leisure activities • Supporting clients preferred work activities 2nd year- • 12 hour minimum additional training • Behavior Training (if supporting in a licensed site) Additional Requirements: • Annual review of Driver license, personal auto insurance, and driving record of all staff that transport clients (annual review) • Criminal Background Check completion (annual review) • Signed DHS and DSPD Code of Conduct (annual review) • Conflict of Interest disclosure (annual review) • Office of Inspector General Exclusion List (annual review) • Contractors Emergency Management and Business Continuity Plan (annual review) • Educational transcripts, licenses, and degrees
Verification of Provider Qualifications			

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Division of Services for People with Disabilities	**Annually**

Provider Specifications				
Provider Category(s) *(check one or both)*:	x	Individual. List types:	x	Agency. List the types of agencies:
	Self-Directed Professional		Agency-based Professional	

Provider Qualifications			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
	Current business license	Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Certification or completed training in the intervention provided.	Under State contract with DHS/DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Providers of this service shall have 1 year experience working with people with ID. RC or brain injury, and also meet one of the following requirements: ● Completion of the requisite education in a psychology or education related field and a DOPL license; or ● Completion of the requisite education in a psychology or education related field and be exempt from DOPL licensure as listed in Utah Code §58-61-707 Enrolled as a Medicaid provider. 30 days- • Emergency Procedures; when to call 911, incident reporting, when to call doctor/hospital, orientation to seizure disorder, notification process for lost client; prevention of choking (if applicable

			to client), first aid. • Catastrophic Emergency/Crisis Procedures • Positive behavior supports • Legal rights of persons with disabilities • Abuse, Neglect, Exploitation prevention and reporting • DHS/DSPD Code of Conduct • Confidentiality • Orientation to persons with ID.RC or ABI • Medication Training • Prevention of communicable diseases • Knowledge of person supporting • Protective Service Reporting • Client specific medication training • Client specific medical/dietary/eating needs • Age appropriate community inclusion/natural supports • Client specific preferences/routines • Client specific functional limitations/disabling conditions 90 days- • CPR Certification 6 months- • Behavior Crisis Intervention • Mandt, SOAR, PART • DHS/DSPD rules, philosophy, mission, beliefs • Contractor Policy, philosophy, mission • Key elements of ADA (Americans with Disabilities Act) • Fraud (Federal/Utah false claim act, UT whistle blower act) • PCSP Development • Supporting clients preferred recreational/leisure activities • Supporting clients preferred work activities 2nd year- • 12 hour minimum additional training • Behavior Training (if supporting in a licensed site) Additional Requirements: • Annual review of Driver license, personal auto insurance, and driving record of all staff that transport clients (annual review) • Criminal Background Check completion (annual review) • Signed DHS and DSPD Code of Conduct (annual review) • Conflict of Interest disclosure (annual review) • Office of Inspector General Exclusion List (annual review) • Contractors Emergency Management

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Division of Services for People with Disabilities	**Annually**

Provider Specifications				
Provider Category(s) *(check one or both)*:	**x**	Individual. List types:	x	Agency. List the types of agencies:
	Self-Directed Behavior Services Paraprofessional Provider		Agency-Based Behavior Services Paraprofessional Provider	

Provider Qualifications			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
	Current business license	Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	Under State contract with DHS/DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Providers of this service shall meet one of the following requirements: ● Completion of the requisite education in a psychology or education related field and a DOPL license; ● Completion of the requisite education in a psychology or education related field and be exempt from DOPL licensure as listed in Utah Code §58-61-707; or ● A paraprofessional working under the supervision of a DOPL licensed Behaviorist or Professional (as defined above) who meets the qualifications required of the intervention they are implementing.

			Enrolled as a Medicaid provider. 30 days- • Emergency Procedures; when to call 911, incident reporting, when to call doctor/hospital, orientation to seizure disorder, notification process for lost client; prevention of choking (if applicable to client), first aid. • Catastrophic Emergency/Crisis Procedures • Positive behavior supports • Legal rights of persons with disabilities • Abuse, Neglect, Exploitation prevention and reporting • DHS/DSPD Code of Conduct • Confidentiality • Orientation to persons with ID.RC or ABI • Medication Training • Prevention of communicable diseases • Knowledge of person supporting • Protective Service Reporting • Client specific medication training • Client specific medical/dietary/eating needs • Age appropriate community inclusion/natural supports • Client specific preferences/routines • Client specific functional limitations/disabling conditions 90 days- • CPR Certification 6 months- • Behavior Crisis Intervention • Mandt, SOAR, PART • DHS/DSPD rules, philosophy, mission, beliefs • Contractor Policy, philosophy, mission • Key elements of ADA (Americans with Disabilities Act) • Fraud (Federal/Utah false claim act, UT whistle blower act) • PCSP Development • Supporting clients preferred recreational/leisure activities • Supporting clients preferred work activities 2nd year- • 12 hour minimum additional training • Behavior Training (if supporting in a licensed site) Additional Requirements: • Annual review of Driver license, personal auto insurance, and driving record of all staff that transport clients (annual review) • Criminal Background Check completion (annual review) • Signed DHS and DSPD Code of Conduct (annual review) • Conflict of Interest disclosure (annual review) • Office of Inspector General Exclusion List (annual review) • Contractors Emergency Management and Business Continuity Plan

			(annual review) • Educational transcripts, licenses, and degrees

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Division of Services for People with Disabilities	**Annually**

Service Specification - Environmental Adaptations - Home	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope)**:**

Environmental Adaptations - Home involve equipment and/or physical adaptations to the participant's residence that are not generally removable and are necessary to assure the health, welfare and safety of the participant or enhance the participant's level of independence and productivity. The equipment/adaptations are identified in the participant's support plan and a qualified professional specifies the model and type of equipment. The adaptations may include purchase, installation, and repairs. Such equipment/ adaptations include:
a. Ramps

b. Lifts/elevators
1. Porch or stair lifts
2. Hydraulic, manual or other electronic lifts

c. Modifications/additions of bathroom facilities
1. Roll-in showers
2. Sink modifications
3. Bathtub modifications/grab bars
4. Toilet modifications/grab bars
5. Water faucet controls
6. Floor urinal and bidet adaptations and plumbing modifications
7. Turnaround space adaptations

d. Widening of doorways/hallways

e. Specialized accessibility/safety adaptations/additions
1. Door-widening
2. Electrical wiring
3. Grab bars and handrails
4. Automatic door openers/doorbells
5. Voice activated, light activated, motion activated and electronic devices
6. Fire safety adaptations
7. Medically necessary air filtering devices
8. Medically necessary heating/cooling adaptations

Other adaptation and repairs may be approved on a case-by-case basis as technology changes (when a newer technology will significantly increase a participant's ability to be more independent than is possible with the current equipment) or as a participant's physical or environmental needs change.

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

Limitations: Each environmental adaptation must be: 1) documented as medically necessary by a physician; 2) prior approved by DSPD in accordance with written policy including defined qualifying criteria; and 3) documented as not otherwise available as a Medicaid State Plan service. Excluded are those adaptations or improvements to the home, which are of general utility, and are not of direct medical or remedial benefit to the participant. General household repairs are not included but repairs to housing modifications will be allowed, as necessary, if identified in the participant's support plan. These repairs must be limited to the repair of previously approved modifications or adaptations that are directly and exclusively related to allowing the participant to remain in housing within their community and avoid placement in a Nursing Facility (NF) or Intermediate Care Facility (ICF). All services shall be provided in accordance with applicable State or local building codes.

Environmental Adaptations are only available in the private residence of the participant or the participant's family. Environmental Adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.

The services under Environmental Adaptations are limited to additional services not otherwise covered under the State Plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

In total, the supports and services authorized in an individual's PCSP in the LSW may not exceed the Individual Cost Limit established in Appendix B-2.

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

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

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	x	Agency. List the types of agencies:
			Environmental Adaptations Supplier	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
	Current business license. (and Contractor's license when applicable)		Under State contract with DHS/DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Division of Services for People with Disabilities	**Annually**

Service Specification - Environmental Adaptations - Vehicle
HCBS Taxonomy

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

Service Definition (Scope)**:**

Environmental Adaptations for the vehicle involve equipment and/or physical adaptations to the individual's vehicle that are necessary to assure the health, welfare and safety of the individual or enhance the individual's level of independence. The equipment/adaptations are identified in the individual's support plan and a qualified professional specifies the model and type of equipment. The adaptations may include purchase, installation, and repairs. Such equipment/adaptations include:

a. Lifts
b. Door modifications
c. Steering/braking/accelerating/shifting modifications
d. Seating modifications
e. Safety/security modifications

Other adaptation and repairs may be approved on a case-by-case basis as technology changes (when a newer technology will significantly increase an individual's ability to be more independent than is possible with the current equipment) or as an individual's physical or environmental needs change.

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

Limitations: Each environmental adaptation must be: 1) documented as medically necessary by a physician; 2) prior approved by DSPD in accordance with written policy including defined qualifying criteria; and 3) documented as not otherwise available as a Medicaid State Plan service. Excluded are those adaptations or improvements to the vehicle, which are of general utility, and are not of direct medical or remedial benefit to the individual. General vehicle repairs are not included but repairs to vehicle modifications will be allowed, as necessary, if identified in the individual's support plan. These repairs must be limited to the repair of previously approved modifications or adaptations that are directly and exclusively related to allowing the individual to remain in housing within their community and avoid placement in a Nursing Facility (NF) or Intermediate Care Facility (ICF). All services shall be provided in accordance with applicable State or local vehicle codes.

The vehicle that is adapted may be owned by the individual, a family member with whom the individual lives or has consistent and on-going contact, or a non-relative who provides primary long-term support to the individual and is not a paid provider of such services.

Payment may not be made to adapt the vehicles that are owned or leased by paid providers of waiver services. The costs of necessary adaptations to provider vehicles may be compensated in the payment rate for transportation or other services that include the cost of transportation.

The services under Environmental Adaptations are limited to additional services not otherwise covered under the State Plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

In total, the supports and services authorized in an individual's PCSP in the LSW may not exceed the Individual Cost Limit established in Appendix B-2.

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

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

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	x	Agency. List the types of agencies:
				Environmental Adaptations Suppliers

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
	Current business license. (and Contractor's license when applicable)		Enrolled with DHS/DSPD as an authorized provider of services as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Division of Services for People with Disabilities	**Annually**

Service Specification - Individual and Family Peer Support	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Service Definition (Scope)**:**	

Individual and Family Peer Support provides mentors who have lived experience as a person with disabilities, family member of a person with disabilities, or both to support and guide the participant and their family members. Peer supports use their lived experience to explain community services, programs, and strategies to achieve the waiver participant's goals. It fosters connections and relationships that build the resilience of the participant and their family, which includes sibling support. Peer supports requires face-to-face interactions including audio/video call applications supported by computer, android, and iOS devices that are designed to facilitate ongoing engagement of waiver participants that promotes progress toward the participant’s personal goals. A peer support agency facilitates a peer support and participant or family member "match"; and offers ongoing support to assure the matched relationship meets expectations.

Peer support services encourage participants and their family members to share their successful strategies and experiences in navigating a broad range of community resources beyond those offered through the waiver with other waiver participants and their families. All peer supports will promote the individuals strengths and

abilities to continue improving socialization, self-advocacy, development of natural supports, and maintenance of community living skills. Support also includes communication and coordination with medical providers including behavioral health services providers and/or others in support of the participant.

Peer support also includes instruction on how to access waiver services, how to participate in the self-direction of care, how to hire, fire and evaluate service providers, participant choices and rights, participant's personal responsibilities and liabilities when receiving services under the self-directed services method (e.g., billing, reviewing and approving timesheets), instruction to the family, and skills development training to the participant relating to interventions to cope with problems or unique situations occurring within the family, techniques of behavior support, social skills development, and accessing community cultural and recreational activities.

Service can be provided in the participant's home and community.

Individual and family peer support is provided by an experienced peer support specialist. A peer support specialist can be a parent, caregiver, or other family member who is a primary unpaid support to a person with a disability; and an individual with developmental disabilities.

Support needs for peer supports are identified in the participant's Person-Centered Plan.

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

Peer support does not provide targeted case management services to a waiver participant; peer support does not include determination of level of care, functional or financial eligibility for services or person-centered service planning.

Peer support may not duplicate, replace, or supplant Support Coordination. This service, limited in nature, is aimed at providing support and advice based on lived experience of a family member or self-advocate. Peer support specialists cannot provide peer supports to their own family members.

Prior to accessing DSPD funding for this service, all other available and appropriate funding sources, including those offered by Medicaid State Plan, Vocational Rehabilitation, State Department of Education, and Department of Human Services, must be explored and exhausted to the extent applicable. These efforts must be documented in the participant's file.

In total, the supports and services authorized in an individual's PCSP in the LSW may not exceed the Individual Cost Limit established in Appendix B-2.

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

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

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	x	Agency. List the types of agencies:
			Peer Support Agency	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
	Current business license	Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	Under State contract with DHS/DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Enrolled as a Medicaid provider. 30 days- • Person-centered planning • Legal rights of persons with disabilities • Abuse, Neglect, Exploitation prevention and reporting • DHS/DSPD Code of Conduct • Confidentiality • Knowledge of person supporting 60 days- Peer support core competencies; Understanding the person's/families strengths, needs, personal/family culture; Assisting in identification of natural, formal and informal supports; Prioritizing needs/goals; Crisis Prevention; Implement action steps and celebrating successes; Transition Planning; Resource Coordination; Family Education and Support; Family Advocacy; Ethics of Peer Support, including professional relationships, dual relationships, boundaries and limits;

			6 months- • DHS/DSPD rules, philosophy, mission, beliefs • Contractor Policy, philosophy, mission • Key elements of ADA (Americans with Disabilities Act) • Fraud (Federal/Utah false claim act, UT whistle blower act) • Person-centered thinking Multi-agency coordination; Stress Management Techniques. 2nd year- • 12 hour minimum additional training Additional Requirements: • Annual review of Driver license, personal auto insurance, and driving record of all staff that transport clients (annual review) • Criminal Background Check completion (annual review) • Signed DHS and DSPD Code of Conduct (annual review) • Conflict of Interest disclosure (annual review) • Office of Inspector General Exclusion List (annual review)

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Division of Services for People with Disabilities	**Annually**

Provider Specifications

Provider Category(s) *(check one or both)*:	x	Individual. List types:	☐	Agency. List the types of agencies:
	Peer Support Specialist			

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
		Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	• Be at least 18 years old; • Minimum 2 years of personal experience that can be used to engage the participant in order to continually reinforce and maintain skills; and • Other qualifications as determined by the participant in their individual plan.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Division of Services for People with Disabilities	**Annually**

Service Specification - Individual Goods & Services	
HCBS Taxonomy	
Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope)**:**

Individual Goods & Services (IGS). IGS offers services, equipment or supplies that will provide direct remedial benefit and support specific outcomes that are identified in the waiver participant's service plan.

Individual Goods and Services must:

- promote community involvement and engagement,
- provide resources to expand opportunities for self-advocacy,
- decrease the need for other Medicaid services,
- reduce the reliance on paid support, or
- be directly related to the health and safety of the waiver participant in their home or community.

Individual Goods and Services are used:

- when the waiver participant does not have the funds to purchase the item or service from any other source, and
- are not provided through other waiver services, the Medicaid State Plan, or any other federal/State/locally funded entity.

Individual Goods and Services must be authorized by the operating agency prior to service delivery. During evaluation and authorization of services, requests are evaluated to confirm no other payers are available and that services have not been duplicated within similar waiver or State Plan services.

Each purchase must be authorized by the Support Coordinator prior to purchase in order to be eligible for reimbursement. Authorization for these services requires Support Coordinator documentation that specifies how the Individual Goods and Services meet the above-specified criteria for these services. If purchased through a State contract, the participant/representative must submit a request to the Support Coordinator for the goods or service to be purchased that will include the supplier/vendor name and identifying information and the cost of the service/goods. If purchased by the participant/representative, a paid invoice or receipt must be submitted for

reimbursement. The paid invoice or receipt that provides clear evidence of the purchase must be on file in the participant's records to support all goods and services purchased.

The following restricted items are excluded from the Individual Goods and Services category:

- Vacations Cost for travel, lodging, food, and entertainment
- Consumables
- Alternative Medicines
- Experimental or prohibited treatments
- Anything solely for entertainment or recreation
- Fees associated with telecommunications
- Purchases over $2,000
- Item or service is illegal or otherwise prohibited by State or Federal law
- Room and Board, recurring expenses, utilities, food, and other housing costs
- Cigarettes and alcohol or fees to access establishments that serve alcohol
- Clothing Cost for personal clothing that is not related to the person's disability
- Personal hygiene items
- Discretionary cash
- Gratuities
- Fines
- Debts
- Gifts, gift certificates, or gift cards for any purpose
- Activity fees
- Legal fees or Advocate fees
- Donations and Contributions
- Cost for items or services that are of general utility to the members of a household.
- Any cost that does not provide a direct support or remedial benefit to the participant
- Costs for items or services that are available to the participant through private insurance, State Plan Medicaid, contracted provider, or other State agency

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

Individual Goods and Services are limited to $2,000 per year from the total self-directed budget. Equipment purchases are expected to be a one-time only purchase. Replacements, upgrades or enhancements made to existing equipment will be paid if documented as a necessity and approved by DSPD.

This service must be pre-approved by DSPD and follow DSPD Cost Standards. DSPD Cost Standards are a set of guidelines which are used to ensure DSPD applies consistent criteria with respect to the appropriateness of the services or items to be approved in this service definition and their cost. Use of funds from a prior budget period is not allowed.

Expenditures for individual goods and services will be in accordance with the Division of Services for People with Disabilities policy and all purchases will comply with State procurement requirements.

For children under the age of 21, services determined to be medically necessary under the EPSDT benefit are covered pursuant to Section 1905(a) of the Social Security Act.

In total, the supports and services authorized in an individual's PCSP in the LSW may not exceed the Individual Cost Limit established in Appendix B-2.

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

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

Provider Specifications

Provider Category(s) *(check one or both)*:	x	Individual. List types:	☐	Agency. List the types of agencies:
	Entity			

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
			Based on the service, equipment or supplies vendors may include: 1. Commercial business 2. Community organization 3. Licensed professional

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Division of Services for People with Disabilities	**Prior to purchase**

Service Specification – Remote Support Equipment – Periodic Fee	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Service Definition (Scope)**:**	
Remote Support Equipment - Monthly Fee is a periodic service (e.g., monthly) fees for ongoing support services and/or rental associated with devices, sensors, or cameras, specified in the individual support plan, which enable participants to increase their autonomy, or to communicate with their support staff. The monthly fee can include costs associated with: ● Leasing remote monitoring system equipment ● Availability of customer service staff trained in using remote monitoring equipment who can promptly respond to Person's questions within 24 hours ● Maintenance on remote support equipment to ensure that the equipment is operational at all times by periodically testing, repairing, or replacing equipment. ● Use of a software application that can be used by other support staff or family members via a mobile device.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Limitations: Expenditures for remote support equipment and the supplies necessary to operate that equipment will be in accordance with the Division of Services for People with Disabilities policy and all purchases will	

comply with State procurement requirements. Each item of remote support equipment and supplies necessary for the operation of that equipment must be approved prior to purchase by a DHS/DSPD Administrative Program Manager based on an assessed need and a determination that the item is not available as a Medicaid State Plan service.

During evaluation and authorization of services, requests are evaluated to confirm no other payers are available and that services have not been duplicated within similar waiver or State Plan services.

The services under Remote Support Equipment—Monthly Fee are limited to additional services not otherwise covered under the State Plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. Services and devices are for the primary purpose of telehealth; any use for entertainment purposes must be incidental.

- Telehealth must be:
  - HIPPA compliant, including, a secure network requiring authentication, authorization, encryption of data, and ensuring that access to data is limited to authorized personnel;
  - Engage in live two-way communication with the person.

In total, the supports and services authorized in an individual's PCSP in the LSW may not exceed the Individual Cost Limit established in Appendix B-2.

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

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

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	x	Agency. List the types of agencies:
				Remote Support Equipment Suppliers

Provider Qualifications			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
	Current business license		Enrolled with DHS/DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-

			103, UCA. Enrolled as a Medicaid provider

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Division of Services for People with Disabilities	**Annually**

Service Specification - Remote Support Equipment	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Service Definition (Scope)**:**	
Remote Support Equipment - Initial installation includes the costs associated with one-time fees and the installation of devices, sensors, or cameras, specified in the individual support plan, which enable participants to increase their autonomy, or to communicate with their support staff. All items shall meet applicable standards of manufacture, design and installation.	

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Limitations: Expenditures for remote support equipment and the supplies necessary to operate that equipment will be in accordance with the Division of Services for People with Disabilities policy and all purchases will comply with State procurement requirements. Each item of remote support equipment, supplies necessary, and any one-time fees for the operation of that equipment must be approved prior to purchase by a DHS/DSPD Administrative Program Manager based on an assessed need and a determination that the item is not available as a Medicaid State Plan service. During evaluation and authorization of services, requests are evaluated to confirm no other payers are available and that services have not been duplicated within similar waiver or State Plan services. The services under Remote Support Equipment are limited to additional services not otherwise covered under the State Plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. Services and devices are for the primary purpose of telehealth; any use for entertainment purposes must be incidental. ● Telehealth must be: ○ HIPPA compliant, including, a secure network requiring authentication, authorization, encryption of data, and ensuring that access to data is limited to authorized personnel; ○ Engage in live two-way communication with the person. In total, the supports and services authorized in an individual's PCSP in the LSW may not exceed the Individual Cost Limit established in Appendix B-2.

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

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

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	x	Agency. List the types of agencies:
				Remote Support Equipment Suppliers

Provider Qualifications			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

	Current business license		Enrolled with DHS/DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Enrolled as a Medicaid provider.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Division of Services for People with Disabilities	**Annually**

Service Specification Specialized Medical Equipment/Supplies/Assistive Technology—Periodic Fee	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Service Definition (Scope)**:**	
Specialized Medical Equipment/Supplies/Assistive Technology—Periodic Fee is a periodic service (e.g., monthly) fees for ongoing support services and/or rental associated with devices, controls, or appliances,	

specified in the individual support plan, which enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.

Automated medication dispensary devices are also included under this service description. Automated medication dispensary devices consist of timed alarmed monitoring systems that have the ability to store and dispense proper dosages of medications at scheduled times as prescribed by the person's medical practitioner(s). Use of medication dispensary devices shall only be an option when more simple methods of medication reminders are determined to be ineffective by the operating agency. The need for such devices must also be specified in the participant's PCSP.

During evaluation and authorization of services, requests for Specialized Medical Equipment are evaluated to confirm no other payers are available and that services have not been duplicated within similar waiver or State Plan services.

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

Limitations: Expenditures for specialized medical equipment and the supplies necessary to operate that equipment will be in accordance with the Division of Services for People with Disabilities policy and all purchases will comply with State procurement requirements. Each item of specialized medical equipment and supplies necessary for the operation of that equipment must be approved prior to purchase by DHS/DSPD based on a determination of medical necessity by a physician or an advanced practice registered nurse with prescriptive privileges and a determination that the item is not available as a Medicaid State Plan service.

The services under Specialized Medical Equipment/Supplies/Assistive Technology—Periodic Fee are limited to additional services not otherwise covered under the State Plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

In total, the supports and services authorized in an individual's PCSP in the LSW may not exceed the Individual Cost Limit established in Appendix B-2.

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

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

Provider Specifications				
	☐	Individual. List types:	x	Agency. List the types of agencies:

Provider Category(s) *(check one or both)*:		Medical Equipment and Supply Suppliers

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
	Current business license		Enrolled with DHS/DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Division of Services for People with Disabilities	**Annually**

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	x	Agency. List the types of agencies:
			Automated Medication Dispensary Equipment and Supply Suppliers	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

	Current business license		FCC registration of equipment placed in participant's home. Enrolled with DHS/DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Enrolled as a Medicaid provider.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Division of Services for People with Disabilities	**Annually**

Service Specification - Specialized Medical Equipment/Supplies/Assistive Technology – Purchase	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Service Definition (Scope)**:**	

Specialized Medical Equipment/Supplies/Assistive Technology – Purchase includes the purchase of devices, controls, or appliances, specified in the individual support plan, which enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies necessary for the operations of that equipment furnished under the State Plan and shall exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.

Automated medication dispensary devices are also included under this service description. Automated medication dispensary devices consist of timed alarmed monitoring systems that have the ability to store and dispense proper dosages of medications at scheduled times as prescribed by the person's medical practitioner(s). Use of medication dispensary devices shall only be an option when more simple methods of medication reminders are determined to be ineffective by the operating agency. The need for such devices must also be specified in the participant's PCSP.

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

During evaluation and authorization of services, requests for Specialized Medical Equipment are evaluated to confirm no other payers are available and that services have not been duplicated within similar waiver or State Plan services.

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

Limitations: Expenditures for specialized medical equipment and the supplies necessary to operate that equipment will be in accordance with the Division of Services for People with Disabilities policy and all purchases will comply with State procurement requirements. Each item of specialized medical equipment and supplies necessary for the operation of that equipment must be approved prior to purchase by DHS/DSPD based on a determination of medical necessity by a physician or an advanced practice registered nurse with prescriptive privileges and a determination that the item is not available as a Medicaid State Plan service.

For children under the age of 21, services determined to be medically necessary under the EPSDT benefit are covered pursuant to Section 1905(a) of the Social Security Act.

In total, the supports and services authorized in an individual's PCSP in the LSW may not exceed the Individual Cost Limit established in Appendix B-2.

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

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

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	x	Agency. List the types of agencies:
				Automated Medication Dispensary Equipment and Supply Suppliers

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
	Current business license		FCC registration of equipment placed in participant's home. Enrolled with DHS/DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Enrolled as a Medicaid provider.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Division of Services for People with Disabilities	**Annually**

Provider Specifications				
	☐	Individual. List types:	x	Agency. List the types of agencies:

Provider Category(s) *(check one or both)*:		Medical Equipment and Supply Suppliers

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
	Current business license		Enrolled with DHS/DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Enrolled as a Medicaid provider.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Division of Services for People with Disabilities	**Annually**

Service Specification – Transportation Services (non-medical)	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Service Definition (Scope)**:**

Transportation Services (non-medical) provide waiver participants with the opportunity to access other waiver supports as necessary to encourage, to the greatest extent possible, an independent, productive and inclusive community life.

Whenever possible, participants receiving waiver services are trained, assisted, and provided opportunities to use available transportation services offered through family, neighbors, friends or community agencies which can provide this service without charge. If these transportation options are not available or do not meet the needs of the waiver enrollee, waiver non-medical transportation becomes an option.

Transportation Supports (non-medical) are only provided as independent waiver services when transportation is not otherwise available as an element of another waiver service. The need for transportation must be documented as necessary to fulfill other identified supports in the individual support plan and the associated outcomes.

During audit, the OA monitors for the billing of Transportation Services (non-medical) and validates that the trips met criteria to be billed as supplemental services.

Elements of Transportation Services (non-medical):
The Transportation Services (non-medical) category consists of elements for enrollee/family arranged transportation, for transportation by an agency-based provider, and for a multi-pass for a public transit system.

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

Limitations: Medicaid payment for transportation under the approved waiver plan is not available for medical transportation. Medical transportation is defined as transportation covered by the State Plan that transports participants to medical services that are covered by the State Plan. In addition, Medicaid payment is not available for any other transportation available through the State Plan, transportation that is available at no charge, or as part of administrative expenditures. Additional transportation supports will not be available to community living, day habilitation, or supported employment providers contracted to provide transportation to and from the person’s residence to the site(s) of a day program when payment for transportation is included in the established rate paid to the provider.

Transportation may not be offered to those who receive attendant care services that include transportation, as well as to those who receive integrated community learning or supported employment services (specifically customized employment or supported employment–individual or supported employment co-worker) that include transportation.

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

Additionally, this service is not available to children in the custody of the State of Utah: Department of Human Services, Division of Child and Family Services for the purposes of visitation to a family home as the State perceives this to supplant service to be provided by DCFS.

Training for individuals in how to navigate public transportation does not fall under the scope of Transportation Services.

In total, the supports and services authorized in an individual's PCSP in the LSW may not exceed the Individual Cost Limit established in Appendix B-2.

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

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

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	x	Agency. List the types of agencies:
			Agency-based—Non-Medical Transportation	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
	Licensed public transportation carrier OR Individual with driver's license and registered vehicle, per 53-3-202, UCA and 41-12a-301 through 412, UCA Current business license	Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	Under State contract with DHS/DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. • Driver must possess a current Utah Driver License and proof of auto liability insurance in amounts required by State law. • Enrolled as a Medicaid provider. 30 days- • Emergency Procedures; when to call 911, incident reporting, when to call doctor/hospital, orientation

			to seizure disorder, notification process for lost client; prevention of choking (if applicable to client), first aid. • Catastrophic Emergency/Crisis Procedures • Positive behavior supports • Legal rights of persons with disabilities • Abuse, Neglect, Exploitation prevention and reporting • DHS/DSPD Code of Conduct • Confidentiality • Orientation to persons with ID.RC or ABI • Medication Training • Prevention of communicable diseases • Knowledge of person supporting • Protective Service Reporting 90 days- • CPR Certification 6 months- • Behavior Crisis Intervention • Mandt, SOAR, PART • DHS/DSPD rules, philosophy, mission, beliefs • Contractor Policy, philosophy, mission • Key elements of ADA (Americans with Disabilities Act) • Fraud (Federal/Utah false claim act, UT whistle blower act) 2nd year- • 12 hour minimum additional training • Behavior Training Additional Requirements: • Annual review of Driver license, personal auto insurance, and driving record of all staff that transport clients (annual review) • Criminal Background Check completion (annual review) • Signed DHS and DSPD Code of Conduct (annual review) • Conflict of Interest disclosure (annual review)

			• Office of Inspector General Exclusion List (annual review) • Contractors Emergency Management and Business Continuity Plan (annual review)

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Division of Services for People with Disabilities	**Annually**

Provider Specifications				
Provider Category(s) *(check one or both)*:	x	Individual. List types:	☐	Agency. List the types of agencies:
	Self-Directed Service Provider			

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
	Individual with driver's license and registered vehicle, per 53-3-202, UCA and 41-12a-301 through 412, UCA	Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	• Under State contract with DHS/DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA and R539-5. • Driver must possess a current Utah Driver License and proof of auto liability insurance in amounts required by State law. • Completed Provider Agreement.

			Completed/Included in Employee File (Self-Administration) -Employee Agreement -Department of Human Services Provider Code of Conduct -Division of Services for People with Disabilities' Code of Conduct -Emergency Contact Information -Person's Support Book -Service Specific Training -Incident Reporting -Behavior Management (if applicable)

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Division of Services for People with Disabilities	**Annually**

Service Specification - Financial Management Services	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope)**:**

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

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

Financial Management Services are intended to provide payroll services to Home and Community-Based Services waiver participants who elect participant direction. This service is provided to those utilizing Self-Directed Services. This service does not provide persons with assistance in managing their personal funds or budgets and does not provide representative payee services.

In total, the supports and services authorized in an individual's PCSP in the LSW may not exceed the Individual Cost Limit established in Appendix B-2.

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

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

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	x	Agency. List the types of agencies:
				Licensed Public Accounting Agency

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

	Certified Public Accountant Sec 58-26A, UCA And R 156-26A, UAC	Certified by the BACBS as an authorized provider of services and supports.	Under State contract with DHS as an authorized provider of services and supports. ● Comply with all applicable State and Local licensing, accrediting, and certification requirements. ● Understand the laws, rules and conditions that accompany the use of State and local resources and Medicaid resources. ● Utilize accounting systems that operate effectively on a large scale as well as track individual budgets. ● Utilize a claims processing system acceptable to the Utah State Medicaid Agency. ● Establish time lines for payments that meet individual needs within DOL standards. ● Generate service management, and statistical information and reports as required by the Medicaid program. ● Develop systems that are flexible in meeting the changing circumstances of the Medicaid program. ● Provide needed training and technical assistance to clients, their representatives, and others. ● Document required Medicaid provider qualifications and enrollment requirements and maintain results in provider/employee file. ● Act on behalf of the person receiving supports and services for the purpose of payroll reporting. ● Develop and implement an effective payroll system that addresses all related tax obligations. ● Make related payments as approved in the person's budget, authorized by the case management agency. ● Generate payroll checks in a timely and accurate manner and in compliance with all federal and State regulations pertaining to "domestic service" workers. ● Coordinate background checks as required and maintain results in employee file. ● Process all employment records. ● Obtain authorization to represent the participant/person receiving supports. ● Prepare and distribute an application package of information that is clear and easy for the participants hiring their own staff to understand and follow. ● Establish and maintain a record for each employee and process employee employment

			application package and documentation. ● Utilize and accounting information system to invoice and receive Medicaid reimbursement funds. ● Utilize and accounting and information system to track and report the distribution of Medicaid reimbursement funds. ● Generate a detailed Medicaid reimbursement funds distribution report to the individual Medicaid recipient or representative semi-annually. ● Withhold, file and deposit FICA, FUTA and SUTA taxes in accordance with federal IRS and DOL, and State rules. ● Generate and distribute IRS W-2's. Wage and Tax Statements and related documentation annually to all support workers who meet the statutory threshold earnings amounts during the tax year by January 31st. ● File and deposit federal and State income taxes in accordance with federal IRS and State rules and regulations. ● Assure that employees are paid established unit rates in accordance with the federal and State Department of Labor Fair Labor Standards Act (FLSA) ● Process all judgments, garnishments, tax levies or any related holds on an employee's funds as may be required by local, State or federal laws. ● Distribute, collect and process all employee time sheets as summarized on payroll summary sheets completed by the person or his/her representative. ● Prepare employee payroll checks, at least monthly, sending them directly to the employees. ● Keep abreast of all laws and regulations relevant to the responsibilities it has undertaken with regard to the required federal and State filings and the activities related to being a Fiscal/Employer Agent. ● Establish a customer service mechanism in order to respond to calls from participants or their representative employers and workers regarding issues such as withholding and net payments, lost or late checks, reports and other documentation.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Division of Services for People with Disabilities	**Annually**

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

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

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

Division of Services for People with Disabilities

Qualifications listed in Appendix B-6-c.

Support Coordinators are monitored and evaluated on an ongoing basis by the Department of Human Services quality management team.

Appendix C-2: General Service Specifications

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

X	**Yes**. Criminal history and/or background investigations are required. Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., State, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):
	UCA 62A-2-120 and R501-14 of the Utah Human Services Administration requires all persons having direct access to children or vulnerable adults to undergo a criminal history/ background investigation. If the person has lived in Utah continuously for five years or more a regional check is conducted. For those not having lived in Utah for five continuous years a national check through the FBI is conducted. The Office of Licensing, an agency within the Utah Department of Human Services has the responsibility of conducting background checks on all direct care workers who provide waiver services. The scope of the investigation includes a check of the State's child and adult abuse registries, and a Criminal History check through the Criminal Investigations and Technical Services Division of the Department of Public Safety. If a person has lived within two to five years outside the State of Utah or in foreign countries the FBI National Criminal History Records and National Criminal History will be accessed to conduct a check in those States and countries where the person resided. For providers under the Self-Directed Service Model, the State will withhold payments for services for anyone who has not completed a background check. DSPD, through its contracted fiscal intermediaries, has access to all approved employees. Individuals hired through self-direction services may not provide service, without supervision, until their background checks are returned and they are authorized to perform service. 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. The State uses contract reviews of providers (including Financial Management Services agencies for individuals using self-direction) to validate that mandatory background checks are completed. Validation of background checks may also occur during the review of critical incidents.
○	**No**. Criminal history and/or background investigations are not required.

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

X	**Yes**. The State maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):
	Utah Code Annotated § 62A-2-121, 122 and R501-14 of the Utah Administrative Code require all persons having direct access to children or vulnerable adults must undergo an abuse screening. The Utah Division of Aging and Adult Services and The Utah Division of Child and Family Services maintain these abuse registries. A designated staff person within DHS, Office of Licensing, completes all screenings. DSPD, through its contracted fiscal intermediaries, has access to all approved employees and will not approve continued employment or provider payments if the required screenings have not been completed in a timely fashion. The State uses contract reviews of providers (including Financial Management Services agencies for individuals using self-direction services) to validate that mandatory abuse registry checks are completed. Validation of abuse registry checks may also occur during the review of critical incidents.
○	**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:*

X	**No**. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
○	**Yes**. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services. Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

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

○	**The State does not make payment to relatives/legal guardians for furnishing waiver services.**
○	**The State makes payment to relatives/legal guardians under *specific circumstances* and only when the relative/guardian is qualified to furnish services**. Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-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 attendant care and employment 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 SDS programs that focus on service usage and interviews with clients and employees about service utilization. DSPD monitors service utilization each month and if there is any indication of fraud or abuse of funds, DSPD immediately notifies the contract monitoring units so a more in-depth audit will be performed to verify if any fraud or abuse of funds occurred.
○	Other policy. *Specify*:

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

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

The Utah Department of Human Services in conjunction with the Bureau of Contract Management will issue a solicitation for the purpose of entering into a contract with willing and qualified individuals and public or private organizations.

The solicitation is distributed to all qualified providers and remains open, allowing for continuous recruitment. The request includes service requirements and expectations. A review committee evaluates the proposals against the criteria contained in the solicitation and selects those who meet the qualifications.

A specific time frame is not established to process a provider's enrollment, but a provider may not begin performing service until all required elements of contracting are completed.

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/certified providers that meet criteria both at initial enrollment and ongoing. The numerator is the number of providers in the review which meet licensure/certification criteria prior to furnishing waiver services and on-going; the denominator is the total number of providers reviewed.*

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

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:	☐ *Annually*	*95% Confidence Level, 5% Margin of Error*
	DHS Office of Licensing	☐ *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:*

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-Directed Services (SDS) providers who have a Self-Directed 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):*			
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*	*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:*

Performance Measure:	*Number and percentage of non-licensed/non-certified providers who meet DHS 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):*	
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*	*x Representative Sample; Confidence Interval =*
	x Other Specify:	*x Annually*	*95% Confidence Level, 5% Margin of Error*
	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:*	*x Annually*
DHS	*☐ 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 that have a process to assure staff receive all required training. The numerator is the total number of provider agencies in compliance with training requirements; the denominator is the total number of providers requiring training.*
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
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 =*
	X Other Specify:DHS	*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:	*x Annually*
DHS	*☐ Continuously and Ongoing*

	☐ *Other Specify:*

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

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

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 Office of Quality and Design (OQD) reviews provider sites to assure that they are safe and in good repair. OQD 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 SDS 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 LSW 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.

ii Remediation Data Aggregation

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

c. Timelines

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

X	**No**
○	**Yes** Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C-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.**
○	**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 LSW is fully compliant with HCBS setting requirements.

Support Coordinators will be responsible for oversight and ongoing monitoring of the settings in which waiver services are being provided.

In the course of quality assurance activities, additional settings compliance monitoring will be conducted by the operating agency and State Medicaid Agency.

Waiver participants will receive services in settings that meet the following indicators of compliance with the Settings Rule: The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS. The setting is selected by the individual from among setting options, including non-disability specific settings. The settings options are identified and documented in the person-centered plan and are based on the individual's needs and preferences. The setting ensures an individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint. The setting optimizes, but does not regiment individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact. The setting facilitates individual choice regarding services and supports, and who provides them. The setting enforces the Home and Community-Based Settings Regulation requirements.

These specific settings will include personal or family residences, and any private or publicly owned community site including, but not limited to, libraries, parks, recreation centers, and theaters.

All providers contracted with the Medicaid Operating Agency to provide Medicaid service to participants on this waiver are required to participate in a training on the Settings Rule criteria and their agency's policies and practices will be reviewed to ensure they meet the Settings Rule criteria.

Any HCBS setting pulled for monitoring by the quality assurance entity or the Medicaid Operating Agency will be monitored for HCBS Setting Rule compliance using the indicators mentioned above. Follow up and resolution measures for any noncompliance areas will be completed on a site by site evaluation by the State. All HCBS settings will be assessed in the ongoing monitoring process. Case management, licensing & certification, and quality management review processes will include HCBS Setting Rule compliance monitoring. Strategies to ensure ongoing compliance include:

Conducting periodic Participant Experience Surveys;
Building questions from the HCBS Settings Rule into annual support planning processes;
Settings policy guidance as defined by provider manuals and State Implementation Plans;
Ongoing provider certification that they have received information about and understand the HCBS Setting Requirements.

The State will continue to engage Stakeholders to evaluate progress, identify areas of concern, and propose solutions.

Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	Person Centered Support Plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(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)**
☐	**Case Manager** (qualifications specified in Appendix C-1/C-3)
x	**Case Manager** (qualifications not specified in Appendix C-1/C-3). *Specify qualifications*:
	qualifications specified in Appendix B-6-c
☐	**Social Worker** *Specify qualifications:*

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

b. Service Plan Development Safeguards.

Select one:

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

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

In accordance with CFR 441. 301 (c) (1), the waiver includes the following processes to support the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in support plan development:

(1) Person-centered planning process. The Support Coordinator is responsible to ensure the individual leads the person-centered planning process where possible. As a part of pre-planning the Support Coordinator works with the individual to determine the role they would like to have in their upcoming meeting, any accommodations or support they may need to accomplish this task, as well as any preparatory work that may be required to help them be successful. The individual's representative has a participatory role, as needed and as defined by the individual, unless State law confers decision-making authority to the legal representative. All references to individuals include the role of the individual's representative. In addition to being led by the individual receiving services and supports, the person-centered planning process:

(i) Includes people chosen by the individual. The Support Coordinator utilizes the pre-planning process to ask the individual who they would like to attend their person-centered planning meeting.

(ii) Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions. In addition to accommodations, supports, and preparation provided by the Support Coordinator to the individual to help them lead their person-centered planning process, accommodations are made to ensure the individual can make informed choices and decisions. For example, the individual can take their plan home to think about it if they wish, pictures or graphics can be

used to represent information in the plan although a written plan is also required, the Support Coordinator can coordinate experiences for the individual to increase their understanding of other services, community settings, or providers that are available to them, etc.

(iii) Is timely and occurs at times and locations of convenience to the individual. As a part of the pre-planning process the Support Coordinator works with the individual to determine times and locations that will work for them and their chosen team. It is recommended that the Support Coordinator begin the pre-planning process several weeks prior to the end of the previous 12 month cycle to ensure all aspects of the process are completed timely and times and locations are convenient for the individual.

(iv) Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with CFR 435.905(b). Support Coordinators are responsible to ensure the meeting is conducted in plain language and in a manner accessible to the individual. The Support Coordinator assists individuals who are limited English proficient to utilize Medicaid contracted interpretive services at no cost to the individual including, oral interpretation and written translations. Access to and use of auxiliary aids and services is supported by the Support Coordinator and/or team at no cost to the individual in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act. The Support Coordinator informs individuals of the availability of the accessible information and language services described in this paragraph and how to access such information and services.

(v) Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants. The Support Coordinator must authorize services according to documented and assessed needs, and the individual's choice and preferences. If assessments and/or other documentation do not support needs described by some members of the team, or documentation is conflicting, a new assessment can be requested of State staff. The Support Coordinator must inform the family they can request a fair hearing in the event services are reduced, terminated, or denied as a part of the planning process. State staff provide timely notice of hearing rights in writing to the individual. Additionally, individuals can contact constituent services at the SMA or the OA at any point there is conflict or they are in disagreement with the process.

(vi) Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered support plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered support plans in a geographic area also provides HCBS. In these cases, the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process.

(vii) Offers informed choices to the individual regarding the services and supports they receive and from whom. Support Coordinators are responsible to support individuals to make informed choices and decisions. For example, the Support Coordinator can suggest that the individual take their plan home to think about it if they wish, use pictures or graphics to represent information in the plan although a written plan is also required, coordinate experiences for the individual to increase their understanding of other services, community settings, or providers that are available to them, etc.

(viii) Includes a method for the individual to request updates to the plan as needed. The Support Coordinator informs the individual they may be contacted at any time to update the plan as needed.

(ix) The Support Coordinator records the alternative home and community-based settings that were considered by the individual on the person-centered support plan

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 Support Coordinator, as part of the Person Centered Support Plan (PCSP) team previously identified as the participant, legal representative, primary paid service providers and any others at the invitation of the participant, works in concert with the entire PCSP team to develop the PCSP. The PCSP team meets together at scheduled times and locations convenient to both the waiver participant and other individuals whom the participant has invited to participate. As part of the process to develop the PCSP, the PCSP team identifies the waiver participant's strengths, risk factors, goals, preferences, needs, capacities and desired outcomes. The PCSP is developed and implemented in a manner that supports and recognizes the person as central to the process. The Support Coordinator also works with the PCSP team to enable and assist the participant to identify and access a unique mix of services to meet the participant's assessed needs and desired life outcomes.

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 PCSP and the budget are reviewed by the PCSP team and must be agreed upon by the participant or the participant's legal representative, the Support Coordinator, and the selected service providers.

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

The Support Coordinator has ultimate responsibility to document the PCSP; however, it is the entire PCSP team's responsibility to participate and develop the PCSP. The PCSP is reviewed and updated at least once a year with changes made throughout the year as needed based on the participant's needs. Anytime during the plan year the Support Coordinator can choose to complete a whole new plan or make modifications (addendums) to the existing plan. The

waiver participant or the participant's legal representative may also request updates or changes to the existing plan outside of annual, formal reviews of the PCSP. Such requests would be addressed directly with the participant's Support Coordinator. Once approved, service authorizations are provided to each of the selected agencies with the amount, frequency, duration, type and scope of the services they have been requested to provide. The Support Coordinator works with the individual and the selected provider to determine service schedules (should the individual require assistance).

(b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status:

The framework utilized to support service plan development is the University of Missouri-KanSDS City Institute for Human Development's Charting the Lifecourse. As needed, other formal and informal assessments include: the Utah Comprehensive Assessment of Needs and Strengths (UCANS), educational assessments, psychological assessments, psychiatric assessments, medical assessments, Comprehensive Brain Injury Assessment (CBIA), Needs Assessment Questionnaire (NAQ), and other therapy evaluations. When these assessments are available, they should be reviewed during the planning process and updated as needed.

(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 legal representative is given a list of all the services provided on the LSW including the definition of each service. The Support Coordinator is responsible to ensure that the individual or their representative understands their options for service providers; and their opportunities to seek employment/work in competitive integrated settings and engage in community life to the same degree of access as individuals not receiving Medicaid HCBS. Ensuring informed choice may include visiting possible service providers and/or settings. The list of LSW 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 Support Coordinator conducts a comprehensive assessment which includes a review of previous assessments/clinical documentation and completion of comprehensive assessment forms. This includes sections for documenting information related to:

- Comprehensive health history;
- Other formal, informal, and natural supports involved in the participant's care;
- Functional limitations;
- Financial, SSI and private insurance information;
- Strengths and capacities;
- Participant needs, risks, preferences, and goals; and
- Any identified health and safety risks including plans for mitigation.

Other formal and informal assessments can be completed as the planning process calls for additional information to plan services that facilitate the person's desired success in the community and assure their health and welfare. If the person has an acquired brain injury, ABISCs must review the person's current CBIA during the planning process. A planning meeting can be requested by the person at any time, but must be completed at least annually.

A finished plan will affirmatively indicate that the person was informed of their rights, responsibilities, opportunities for choice; was actively involved in the process; and consented to the plan. Following plan development, DSPD will provide the person with a post-plan survey to assess the effectiveness of the planning process.

(e) how waiver and other services are coordinated:

Support Coordinators are responsible to oversee the coordination of waiver services.
The PCSP lists all the person's supports and services including, but not limited to: 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. Participants may be referred to and assisted with coordinating non-waiver services included in the PCSP; but the Support Coordinator is not responsible for ensuring their delivery. When non-waiver services are needed to meet the needs of the participant, the Support Coordinator assists, coordinates and monitors the implementation of the needed non-waiver services.

(f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan:

The Support Coordinator will discuss their responsibilities related to implementation and monitoring of the PCSP with the participant. The participant will be instructed to contact their Support Coordinator with any questions or concerns about services, coordination with other benefits or health and safety concerns. The participant and the service provider will be instructed to report hospitalizations or other incidents involving the participant. Service providers will develop, implement, and document support strategies to reach desired outcomes identified in the PCSP. The participant will be informed of the Support Coordinator's authority to approve and coordinate waiver services. The Support Coordinator will support the participant to obtain non-waiver services but has no authority other than to link, refer and coordinate with other entities for such services.

The PCSP contains information about waiver and non-waiver supports and services, including:

- details on amount, duration, and frequency;
- who is providing the support;
- date the support will begin and end; and
- provider requirements such as objectives, methods, procedures, data reporting, etc.
- payment source

The PCSP also includes information related to communication and coordination of services or supports. For supports funded by the LSW, the following information must be documented: the name of the contracted provider, the service code, and the provider summaries describing support strategies.

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

The PCSP is reviewed and revised as frequently as necessary (significant change in circumstances, progress notes, or at the person's request) to address the 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 comprehensive planning approach identifies potential risks and mitigation strategies throughout the process. Identified potential risks are reviewed by the Person Centered Support Plan (PCSP) team and addressed in the PCSP as needed. Back up plans are developed and incorporated into support strategies. Back-up plans include a description of the circumstances and procedures; applicable contact information and timeframes for response. Services that address risk are identified and included in the PCSP.

Prior to the planning meeting, other assessments and the results of the past year's supports are reviewed. During the planning meeting the PCSP team reviews items identified as areas of concern. Decisions are made based on the participant's identified needs and supports and services. Risks are described in support strategies and are tracked in progress notes from the service provider. Support strategies and services that address risks are followed up and addressed by Support Coordinators during visits with participants, families, and providers. Issues are discussed with the Support Coordinator's supervisor and other pertinent individuals. DSPD Program Specialists and other DSPD staff are available to provide consultation to Support Coordinators for the mitigation of risks.

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

Upon enrollment, the participant and/or legal representative are informed of all available qualified providers of waiver services in a manner consistent with their individual needs. This also occurs annually thereafter and when changes occur to the PCSP, specifically during the PCSP planning meeting.

Each participant or legal representative is given a copy of the booklet, "An Introductory Guide-Division of Services for People with Disabilities" that contains lists of contracted providers. The USTEPS case management system used to develop the PCSP includes pull down lists of all current providers for each specific waiver service. Additionally, the DSPD website contains a list with contact information for all contracted providers which can be filtered by county and service category.

As a part of the support planning process or at any point the individual requests a change in provider, the Support Coordinator sends an Invitation to Submit an Offer (ISO) to all enrolled

DSPD providers. The individual is then provided with a list of providers who responded to the ISO stating that they are willing and able to serve the individual. The Support Coordinator then assists the individual to exercise informed choice through interviews, site visits, and/or experiences in order to make their selection. The participant's choice of providers of services is documented on the PCSP.

The process for assisting individuals to obtain information about and select from qualified providers reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with CFR 435.905(b). Support Coordinators are responsible to ensure information is presented in plain language and in a manner accessible to the individual. The Support Coordinator assists individuals who are limited English proficient to utilize Medicaid or OA contracted interpretive services at no cost to the individual including, oral interpretation and written translations. Access to and use of auxiliary aids and services is supported by the Support Coordinator and/or team at no cost to the individual in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act. The Support Coordinator informs individuals of the availability of the accessible information and language services described in this paragraph and how to access such information and services

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

The SMA retains final authority for oversight and approval of the service planning process. The oversight function involves an annual superior review of all approved performance measures, of a representative sample of waiver enrollee's service plans that will be sufficient to provide a confidence level equal to 95% and a confidence interval equal to five. A response distribution equal to 50% will be used to gather base line data for the first waiver year. Base line data will be collected over a two year period with 50% of the total sample size collected each year. The response distribution used for further reviews will reflect the findings gathered during the base line review.

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

Appendix D-2: Service Plan Implementation and Monitoring

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

The entire Person Centered Support Plan (PCSP) team will work with the participant to identify the person's desired success in the community and assure their health and welfare. Support Coordinators have the ultimate responsibility to employ a person centered approach during the comprehensive person-centered planning process.

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

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

The PCSP is updated or revised as necessary by the Support Coordinator. For temporary increases in service need, Support Coordinators can request an annual funding increase up to $10,000. For

ongoing service need changes that exceed the individual budget cap, the OA may re-authorize the additional funds annually.

The Support Coordinator monitors the implementation of the PCSP by doing the following:
1. Regularly scheduled face to face visits with the person (while quarterly face to face visits are the standard, the Support Coordinator has the discretion to conduct face to face visits with the client more frequently than quarterly. In all cases frequency will be dependent on the assessed needs of the client and will not exceed 90 days without a face to face visit).
2. Monthly review of progress reports
3. Working/ meeting with providers of supports and families to ensure that participants are receiving quality supports in the environment of their choice.

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

Monitoring of PCSPs is conducted at least every two years by DHS/DSPD and 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 LSW and have been offered choice among available providers. Records are also reviewed for compliance with health and welfare standards. This includes the documentation that prevention strategies are developed and implemented (when applicable) when abuse, neglect or exploitation is identified, verification (during face to face visits) that the safeguards and interventions are in place, notification of incidents to Support Coordinators has occurred , and documentation that participants have assistance, when needed, to take their medications and verification that back up plans are effective, Records are also reviewed to determine that the PCSP addresses all of the participant's assessed needs, including health needs, safety risks and personal goals either by the provision of waiver services or other funding sources (State Plan services, generic services and natural supports. Significant findings from these reviews will be addressed with DHS/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.

Multiple monitoring methods are utilized to assess the effectiveness of back-up plans. The Support Coordinator is required to have monthly contact with the individual to assure participant health and welfare. If a situation occurred where the individual needed to implement their back-up plan, the Support Coordinator discusses with the individual whether or not the plan was effective and makes any necessary changes.

Additionally, the Support Coordinator must take action on critical incident reports made for the individuals on their caseload. If an incident occurs which indicates a back-up plan needs to be changed, the Support Coordinator must work with the individual to make these changes in order to prevent future problems from occurring. State staff review level one critical incidents and ensure back-up plans are updated as appropriate as a part of the investigation process. The State analyzes data for critical incidents to determine if Support Coordinator follow-up occurred where necessary, and of those incidents requiring follow-up, whether recommended actions to protect individuals' health and welfare were implemented.

Finally, the Quality Management Team with the Office of Quality and Design reviews individual back-up plans as a part of their consumer file audits. Where problems are identified during

monitoring, a corrective action plan is required of the Support Coordinator. The SMA receives a detailed list of findings following the completion of annual compliance reviews. Ad hoc reviews can be completed and additional data provided as determined necessary by the OA or SMA.

The Choice of Services form, which includes information on freedom of choice of provider, is required annually as a part of the person-centered planning process for all individuals on the waiver. OQD reviews a statistically significant sample of these forms each year as a part of routine performance measure reviews to ensure the person has been informed of this choice, as evidenced by their signature.

Health and safety issues must be addressed in an identified section within the person-centered plan as designed by the USTEPS system. Additionally, all goal and non-goal supports must be included in the person-centered plan, whether they are funded by the waiver or not. Annual consumer file reviews evaluate the 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 Support Coordinator is responsible to monitor implementation of the person-centered service plan on at least a monthly basis for all waiver and non-waiver services, including health services. This may involve direct contact with the participant, working with the servicing provider to determine progress/outcomes on assessed goals, conducting a health status screening, and/or supporting a person to access needed community resources or entitlements. Annual consumer file reviews evaluate the number and percentage of Support Coordinator monthly summary reports indicating that services are being delivered in accordance with the PCSP.

b. Monitoring Safeguards. *Select one:*

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

Quality Improvement: Service Plan

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

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

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 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 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):*			
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 =*
	☐ Other Specify:	*x Annually*	*95% Confidence Level, 5% Margin of Error*
		☐ 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 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):*

If 'Other' is selected, specify:

PCSP, SIS, 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 =*
	☐ Other Specify:	*x Annually*	*95% Confidence Level, 5% Margin of Error*
		☐ 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	***Frequency of data aggregation and analysis:***

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

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

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:	*# and % of PCSPs created which appropriately address the assessed needs/goals of the participant & are agreed upon by the participant/legal rep before waiver services were provided. The N = # of PCSPs which appropriately address the assess needs/goals of the participant & are agreed upon by the participant/legal rep before waiver services were provided. The D = total # 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*
	x Operating Agency	*☐ Monthly*	*x Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*x Representative Sample; Confidence Interval =*
	☐ Other Specify:	*x Annually*	*95% Confidence Level, 5% Margin of Error*
		☐ 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)

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 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 which are updated/revised when warranted by changes in the participant's needs. The numerator is the number of PCSPs which were updated/revised when warranted by changes in the participant's needs.; 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):*			
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 =*
	☐ Other Specify:	*x Annually*	*95% Confidence Level, 5% Margin of Error*
		☐ 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 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):*

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 =*
	☐ Other Specify:	*x Annually*	*95% Confidence Level, 5% Margin of Error*
		☐ 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)

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, duration, type and scope for each service authorized. The numerator is the total number of PCSPs in the review which clearly identify the amount, frequency, duration, type and scope 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):*	
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 =*
	☐ Other Specify:	*x Annually*	*95% Confidence Level, 5% Margin of Error*
		☐ 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 & Percentage of Support Coordinator monthly summary reports indicating that services are being delivered in accordance with the PCSP (Type, scope, amount, duration & frequency). 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):*			
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 Interval =*
	☐ *Other Specify:*	*x Annually*	*95% Confidence Level, 5% Margin of Error*
		☐ *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)

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.

Performance Measure:	*Number and percentage of participants who are made aware of all services available on the LSW. The numerator is the total number of participants reviewed who were made aware of all services available on*

	the LSW as indicated by their or their legal representative's signature on the Choice of Services section of the PCSP; the denominator is the total number of participants reviewed.

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

If 'Other' is selected, specify:

Participant records, PCSP, 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 =*
	☐ Other Specify:	*x Annually*	*95% Confidence Level, 5% Margin of Error*
		☐ 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 % of participants who are offered choice among providers when more than one is available. The numerator is the total number of participants reviewed who sign or have their legal representative sign the Choice of Services section of the PCSP when more than one provider is available; the denominator is the total number of participants in the sample that have more than one provider available.*

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

If 'Other' is selected, specify:

Participant records, PCSP, 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 =*
	☐ Other Specify:	*x Annually*	*95% Confidence Level, 5% Margin of Error*

		☐ *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)

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 with the University of Missouri-KanSDS City Institute for Human Development's Charting the Lifecourse tools and in consultation with the participant and/or the participant's representative, to 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 support plan. Once an individual is enrolled in the waiver they are to receive

the amount of covered services necessary to meet their health and welfare needs and to prevent unnecessary institutionalization. The comprehensive assessment is conducted when a participant enters the waiver and at a minimum every twelve months. If there have been significant changes, the assessment is re-administered. All services are identified on the support plan regardless of funding source. Participants are offered a choice of either ICF/ID care or LSW services and choice is documented in USTEPS. Participants are made aware of all services available on the LSW and are offered choice among providers whenever choice exists. Choice of providers is documented in the participant's record.
The SMA/DHS may include as part of the sample, participants from prior reviews or participants who 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 or 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

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.

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.
○	**No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges States to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

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

Appendix E-1: Overview

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

Self-Directed Services are made available to all waiver enrollees who elect to participate in this method. Service selection (provider or self-directed) is provided at least annually, and more frequently as needed. Support Coordinators provide ongoing oversight of the enrollees' ability to successfully utilize self-directed services. Individual and Family Peer Support Services are available to participants needing additional assistance and training in aspects of self-direct. Enrollees who subsequently demonstrate to their Support Coordinator their incapacity to successfully self-direct their services are transferred to Agency Based Provider Services.

Under Self-Directed Services, participants and/or their chosen representatives hire individual employees to perform a waiver service/s. The participant 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 participant's employee/s. Participants and/or their chosen representatives may avail themselves of the assistance offered them within the Individual and Family Peer Support Service should they request and/or be assessed as requiring additional support and assistance in carrying out these responsibilities. In the case of a participant 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 participant or appointed person may also train the employee to perform assigned activities. Appointed decision-makers cannot also be providers of self-directed 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). Participants authorized to receive services under the Self Directed 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 participant's needs. For persons utilizing the Self-Directed Services method, Financial Management Services are offered in support of the self-directed option. Financial Management Services, (commonly known as a "Fiscal Agent") facilitate the employment of individuals by the waiver participant 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 participant 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 PCSP and budget have been developed and the participant chooses to participate in Self-Directed Services, the participant will be provided with a listing of the available Financial Management Services providers from which to choose. The participant will be referred to the Financial Management Services provider once a selection is made.

A copy of the participant'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 participant, but to and in the name of the employee hired by the person or the person's representative. The person will be authorized for a rate to cover the costs of the employee wages and benefits reimbursement.

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

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

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

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

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

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

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

	the individual's overall well-being), corrective action will be attempted prior to requiring an individual to switch to an agency model. Opportunities for self-direction are not available to those in the custody of the Division of Child and Family 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 State Support Coordinator provides the participant with an individualized orientation to waiver home and community based services, which involves providing written materials as well as describing services available under the self-directed model. The orientation typically occurs at the initial visit when the individual is transitioning into services, after needs have been assessed but prior to developing the support plan and approving the individual's budget. At that time it is further explained that by using the self-directed 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 using the Self-Directed Support book as a guide. State Support Coordinators are trained on all information within the book which includes an introduction to SDS services, definitions, service descriptions, the SDS agreement, roles and responsibilities, background screenings, incident reporting, time sheets, rate information, compliance reviews, record keeping, and other resources. The SDS booklet is available on the DSPD website in both English and Spanish.

Individuals transitioning onto the waiver who have a potential interest in SDS services have sufficient time to weigh the pros and cons, gather more information, and ask questions before electing participant direction as they are given the information early in the process. While the State aims to transition individuals into services in a timely manner, State Support Coordinators provide individuals and families with the information and time they need to make an informed choice regarding participant direction. The process for providing information about participant direction opportunities reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with CFR 435.905(b). Support Coordinators are responsible to ensure information is presented in plain language and in a manner accessible to the individual. The Support Coordinator assists individuals who are limited English proficient to utilize Medicaid or OA contracted interpretive services at no cost to the individual including, oral interpretation and written translations. Access to and use of auxiliary aids and services is supported by the Support Coordinator and/or team at no cost to the individual in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act. The Support Coordinator informs individuals of the availability of the accessible information and language services described in this paragraph and how to access such information and 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 direct the set of waiver services authorized to be provided under the self-directed services model, that they receive. The informed preferences of the individual waiver participant 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 participant, 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 a participant 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 participant or appointed person may also train the employee to perform assigned activities. Appointed decision-makers cannot also be providers of self-directed services. Necessary safeguards that are in place include the requirement that once chosen, the non-legal representative becomes a member of the person's Person Centered Support Plan (PCSP) team. In addition to the non-legal representative, the PCSP 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 participant's PCSP team. If a non-legal representative and the PCSP team disagree with a decision made and or a non-legal representative appears to jeopardize a participant's health and welfare, then 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. Minimum monitoring schedule and time frames for Persons participating in self direction: 1. Monthly, review documentation of services provided; 2. Monthly, review/approve billing forms for services provided; 3. Monthly, monitor both the spending, and remaining budget for the plan year;	

		4. Annually review services and develop a Person-Centered Support Plan with the Person's team; 5. Monthly, review monthly summaries of services to ensure the Person is receiving support as specified in the PCSP and meet the Person's needs; 6. Annually, ensure self- directed families/staff, are trained on and maintain current records of the Person's health and medical status, medication utilization, Behavior Supports Plan, staff instructions sheets, and other support related service support strategies; 7. Annually, ensure self-directed families/staff are training on their Emergency Management and Business Continuity Plan; 8. Annually, ensure all staff have a passed a background screening;

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)*:

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Attendant Care	x	□
Individual and Family Peer Support	x	□
Transportation Services (non-medical)	x	□
Behavioral Services	x	□
Supported Employment	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 services.	
ii.	**Payment for FMS**. Specify how FMS entities are compensated for the administrative activities that they perform:	
	FMS is reimbursed on a per month basis.	
iii.	**Scope of FMS**. Specify the scope of the supports that FMS entities provide *(check each that applies):*	
	Supports furnished when the participant is the employer of direct support workers:	
	X	**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.

7. File consolidated payroll reports for multiple employers. The Financial Management Services provider must obtain federal designation as Financial Management Services provider under IRS Rule 3504, (Acts to be Performed by Agents). A Financial Management Services provider applicant must make an election with the appropriate IRS Service Center via Form 2678, (Employer Appointment of Agent). The Financial Management Services provider must carefully consider if they want to avail the Employers of the various tax relief provisions related to domestics and family employers. The Financial Management Services provider may forego such benefits to maintain standardization. Treatment on a case-by-case basis is tedious, and would require retroactive applications and amended employment returns. The Financial Management Services provider will, if required, comply with IRS Regulations 3306(a)(3)(c)(2), 3506 and 31.3306(c)(5)-1 and 31.3506 (all parts), together with IRS Publication 926, Household Employer's Tax Guide. In order to be fully operational, the Form 2678 election should be postured to fall under two vintages yet fully relevant Revenue Procedures; Rev. Proc. 70-6 allows the Financial Management Services provider file one employment tax return, regardless of the number of employers they are acting for, provided the Financial Management Services provider has a properly

		executed Form 2678 from each Employer. Rev. Proc 80-4 amplifies 70-6, and does away with the multiple Form 2678 requirements, by imposing more stringent record keeping requirements on the Financial Management Services provider. 8. Obtain IRS approval for Agent status. The Financial Management Services provider shall consolidate the federal filing requirements, obtain approval for Utah State Tax Commission consolidated filings, and obtain approval for consolidated filing for unemployment insurance through the Department of Workforce Services. For those Employers retaining domestic help less than 40 hours per week, Workers Compensation coverage is optional. If the 40-hour threshold is achieved or exceeded, the Worker's Compensation Act requires coverage. Statutory requirements and the nature of insurance entail policies on an individual basis. Consolidated filings of Workers Compensation are not an option. 9. Financial Management Services provider cannot provide waiver participants with community-based services in addition to Financial Management Services.
	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:*

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) participant/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 accountability of SDS service delivery is also supported through standardized mandatory training & manuals for SDS families and Support Coordinators, the Family to Family Network, and a formal documentation monitoring tool used by Support Coordinators to audit SDS employers.

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

X	**Case Management Activity**. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. *Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*	
	In order to provide information and assistance to participants about self-directing their services, the Support Coordinator is responsible to provide the participant/representative with a Self-Directed Support (SDS) Book. The Support Coordinator reviews the information in the Support Book with the participant/participant family and is available to answer any questions and provide assistance as needed. The Support Coordinator is responsible to assess whether the information provided is sufficient to meet the needs of the individual. If the assessment of the situation shows that the participant/representative requires additional training – such as hiring, scheduling, or training or employees, the Support Coordinator will order Individual and Family Peer Support Services which is geared toward providing more detailed training on how to self-direct services. The Support Coordinator monitors payments, reviews actual expenditure in comparison with the PCSP and budget, contacts the waiver participant or their representative if any concerns arise, and assists in resolution of billing problems.	
X	**Waiver Service Coverage**. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-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)	□
□	**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.**
○	**Yes**. Independent advocacy is available to participants who direct their services. *Describe the nature of this independent advocacy and how participants may access this advocacy*:

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 Support Plan team. Health and welfare and continuity of services are assured during the transition process, because the participant continues to receive services under the self-direction 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-direction occur. Prior to that occurrence however, the State offers participants who are struggling with self-directinging their services repeated assistance rendered by Support Coordinators and/or through Individual and Family Peer Support 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-direction for a participant.

DSPD will terminate self-directed services involuntarily only upon the discovery of the individual's incapacity to self-direct as determined by the individual's Person Centered Support Plan (PCSP) 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 PCSP team.

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

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

Prior to enrolling in self-direction, the participant/representative is informed of their responsibilities and the rules that must be followed in order to participate. The individual is provided with Self-Directed Support Book which outlines the rules for participating in self-direction. In addition, the participant/representative is required to sign a self-direction agreement which outlines the conditions which the participant must comply with in order to use the self-direction 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	30	0
Year 2	30	0
Year 3	30	0
Year 4 (only appears if applicable based on Item 1-C**)**	30	0
Year 5 (only appears if applicable based on Item 1-C**)**	30	0

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.

□	**Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3. Specify the State's method to conduct background checks if it varies from Appendix C-2-a:**
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**
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 participant-directed budget without prior approval.** Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

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.

RIGHTS TO A FAIR HEARING DOCUMENTATION

A participant and the participant'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

participant 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. If the participant is enrolled in services, the State follows regulation in accordance with 42 CFR §431.230. In instances in which a participant is found to be ineligible for entrance to the waiver, they may request an administrative fair hearing from the Depart of Human Services, which is dispositive. Services are not afforded during this period of pendency.

The Notice of Agency Action delineates the participant's right to appeal the decision through an informal hearing process at the Department of Human Services or an administrative hearing process at the Department of Health, or both. The participant is encouraged to utilize an informal dispute resolution process to expedite equitable solutions. Notices and the opportunity to request a fair hearing documentation are kept in the participant's case record/file.

The process for assisting individuals to obtain information about a fair hearing reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with CFR 435.905(b). Support Coordinators are responsible to ensure information is presented in plain language and in a manner accessible to the individual. The Support Coordinator assists individuals who are limited English proficient to utilize Medicaid or OA contracted interpretive services at no cost to the individual including, oral interpretation and written translations. Access to and use of auxiliary aids and services is supported by the Support Coordinator and/or team at no cost to the individual in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act. The Support Coordinator informs individuals of the availability of the accessible information and language services described in this paragraph and how to access such information and services. Support Coordinators are asked to assist individuals to request a fair hearing if an adverse decision has been made regarding waiver eligibility, amount, frequency, and duration of waiver services and/or choice of providers from which to receive waiver services.

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 Human Services has an informal hearings process and the Division of People with Disabilities has an informal dispute resolution process. The informal dispute resolution process is designed to respond to a participant's concerns without unnecessary formality. The dispute resolution process is not intended to limit a participant's access to formal hearing procedures; the participant may file a Request for Hearing any time in the first 30 days after receiving Notice of Agency Action.
When DSPD receives a Hearing Request Form (490S) a two- step resolution process begins with:

1. The Division staff explaining the regulations on which the action is based and attempt to resolve the disagreement.

2. If resolution is not reached, Division staff arranges a Review meeting between the individual and/or their legal representative and the Director or the Director's designee.

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

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

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

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

submitted with the complaint. The Division will take appropriate action to resolve the dispute and respond to all parties concerned. If the parties are unable to resolve the dispute either party may appeal to the Division Director or the Director's designee.

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

Appendix F-3: State Grievance/Complaint System

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

○	**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 Long Term Services and Supports

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 participants may file a written or verbal complaint/grievance with the DHS/DSPD Constituent Service Representative. There is no limit to the amount of elapsed time that has occurred when a complaint may be filed. This Representative is specifically assigned to the operating agency, although operates independent of them. When the Representative receives a complaint there is an investigation involving all pertinent parties. The Representative then works with the parties to come to a resolution.

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

The types of complaints that can be addressed through the grievance/complaint system include but are not limited to: Complaints about a provider of waiver services including Support Coordinators, complaints about the way in which providers deliver services, complaints about individual personnel within a provider agency, complaints about DSPD and its personnel associated with the operating agency or decisions made or actions taken by those personnel, etc.

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

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

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

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

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

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

The SMA requires that DHS/DSPD report critical events/incidents within one business day of the event that occurs either to or by a participant. Reportable incidents or events include: unexpected or accidental deaths, suicide attempts, medication errors that lead to death or medical treatment, abuse or neglect that results in death, hospitalization or other medical treatment (inpatient or outpatient care), accidents that result in hospitalization, missing persons, human rights violations such as unauthorized use of restraints, criminal activities that are performed by or perpetrated on waiver participants (including sexual abuse), 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 participant/ their representative or a provider agency to report to the case manager if at any time the participant's health and/or safety is jeopardized. Such instances may include, but are not limited to:
1. Actual or suspected incidents of abuse, neglect, exploitation or maltreatment per the DHS/DSPD Code of Conduct and Utah Code Annotated Sections 62-A-3-301 through 321 (mandatory reporting to Adult Protective Services)
2. Drug or alcohol misuse
3. Medication overdose or error requiring medical intervention
4. Missing person
5. Evidence of a seizure in person with no seizure diagnosis
6. Significant property destruction ($500.00 or more)
7. Physical injury requiring medical intervention
8. Law enforcement involvement
9. Emergency hospitalizations

The death of a waiver recipient is subject to a full review of the circumstances surrounding the death and includes a review of documentation by the DSPD Fatality review Coordinator for the most recent year of services. The DHS Fatality Review Committee meets at least quarterly and reports annually to DHS and SMA leadership.

Incidents that require reporting may be done verbally and must be made within one business day. Within 5 days the person reporting the incident completes and submits the DSPD Form 1-8 to the Support Coordinator. If the person reporting is unable to complete the DSPD Form 1-8, accommodations are made and the Support Coordinator completes Form 1-8.

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

Incident reports are compiled, logged into the DSPD electronic database, analyzed and trends are identified. The information is utilized by the DSPD to identify potential areas for quality improvement. The DSPD generates a summary report of the incident reports annually and submits to the SMA. The SMA reviews the report to assure systemic issues have been addressed. In the event the SMA determines that a system issue has not been adequately addressed DSPD will submit a plan of correction to the SMA. All plans of correction are subject to acceptance by the SMA. The SMA will conduct follow-up activities to determine that systems corrections have been achieved and are sustaining.

DSPD Provider Contract - Supervisory Requirements:

A. Incident Reports: Within one business day of any incident requiring a report, the Contractor shall notify both the DHS/DSPD Support Coordinator and the person's Guardian by phone, email, or fax.

Within five (5) business days of the occurrence of an incident, the Contractor shall complete a DHS/DSPD Form 1-8 Incident Report and file it with the 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 an incident report with DSPD:
1. Actual or suspected incidents of abuse, neglect, exploitation, or maltreatment per the DHS/DSPD Code of Conduct and Utah Code §§ 62-A-3-301 through 321, which can be found at http://www.le.State.ut.us/~code/TITLE62A/62A03.htm for adults; and, Utah Code §§ 62-4a-401 through 412 for children, which can be found at http://www.le.State.ut.us/~code/TITLE62A/62A04.htm.
2. Drug or alcohol abuse, medication overdoses or errors reasonably requiring medical intervention,
3. Missing person,
4. Evidence of seizure in a person with no existing seizure diagnosis,
5. Significant property destruction (damage totaling $500.00 or more). Property damage shall be covered by the Contractor's insurance unless it is agreed upon by the person's team that the person shall pay for damages,
6. Physical injury reasonably requiring a medical intervention,
7. Law enforcement involvement,
8. Any use of manual restraint, mechanical restraints, exclusionary time-out or time-out rooms as defined in Utah Administrative Code, Rule R539-4, and level II emergency interventions not outlined in the person's behavioral plan (e.g., response cost, overcorrection). http://rules.utah.gov/publicat/code/r539/r539.htm
9. Any other instances the Contractor determines should be reported.

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

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

A written description of the rights and responsibilities of each Person shall be provided and explained by the Support Coordinator and Provider at the admission meeting. The Human Rights policy shall be reviewed with each Person annually during the Person’s planning or review of services meeting by the Support Coordinator and Provider representative. The Provider shall ensure that grievance procedures are communicated to Persons at the annual planning meeting.

All provider types, 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. R539-3-4(1) and (2). Exempt contracted provider types include: service providers under the self-direction model; and providers who only offer respite, chore, homemaker, personal budget assistance, limited professional consultation, durable goods, or payroll services. Exempt provider types are listed in R539-3-4; the provider contract DHS90743 Scope of Work; and DSPD Directive 1.1 Human Rights.

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.

All Self-Directed Corporations that deliver direct services or supports to a person are responsible to ensure that a Self-Directed Human Rights Plan is developed and approved by the Self-Directed Corporation board and the Support Coordinator. The Division will provide the Self-Directed Corporation with an approved format and training materials necessary to complete the Self-Directed Human Rights Plan. The board of the Self-Directed Corporation and the Support Coordinator will act as the Human Rights Committee as defined in DSPD Directive 1.1. A. Board members (Human Rights Committee), when reviewing a Self-Directed Human Rights Plan, are responsible to: i. determine if any proposed procedure is necessary to protect the health, safety and/or life of the Person; ii. weigh the potential risk and benefits of the decision thoroughly; iii. ensure a method is in place to document, monitor and, if appropriate, cease to the procedure and ensure the method is communicated to staff; iv. render a decision; and v. get signed approval of Self-Directed Human Rights Plan by region director or designee.

According to Utah Code 76-5-111.1.

As provided in Utah Human Services Code, Aging and Adult Services, 62A3-305:

(1) A person who has reason to believe that a vulnerable adult has been the subject of abuse, neglect, or exploitation shall immediately notify Adult Protective Services intake or the nearest law enforcement agency. When the initial report is made to law enforcement, law enforcement shall immediately notify Adult Protective Services intake. Adult Protective Services and law enforcement shall coordinate, as appropriate, their efforts to provide protection to the vulnerable adult.

(4)(a) A person who willfully fails to report suspected abuse, neglect, or exploitation of a vulnerable adult is guilty of a class B misdemeanor.
(b) A covered provider or covered contractor, as defined in Section 26-21-201, that knowingly fails to report suspected abuse or neglect, as required by this section, is subject to a private right of action and liability for the abuse or neglect of another person that is committed by the individual who was not reported to Adult Protective Services in accordance with this section.

The State uses the following standard in its evaluation of allegations: "The probability that the incident occurred as a result of the alleged/suspected abuse, neglect and/or exploitation is clear and convincing."

The State does not review incident reports/findings differently when a single provider renders both residential and day services.

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

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 support 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 Office of Licensing will conduct independent State investigations of all critical incidents in regard to licensed providers in accordance with Utah Administrative Code, Rule 501-1-2. Additionally, OL will inform and collaborate with DOH, Support Coordinators and OQD whenever an investigation is opened (and concluded) in a DSPD Contracted/Waiver setting.

Support Coordinators and OQD staff are delegated to conduct all unlicensed entities' incident investigations under all of the same guidelines and priority classifications as Licensing Investigations and will work in conjunction with OQD and DOH for all non-licensed programs.

I. Critical Incidents

Other than incidents specifically outlined in the DHS Incident Reporting Guide 2018, all CIs are detailed and outlined in Office of Licensing Rule. What constitutes a CI is defined specifically in Utah Administrative Code, Rule 501-1-2(9).

C. Reporting requirements for CIs:
Any incident that arises to, or meets the specific definition of a CI, as defined in section I.A. or I.B. shall be reported in accordance with Utah Administrative Code, Rule 501-1-9, unless Stated otherwise in this guide. R Rule 501-1-9 States:
(i) report shall be made to DHS and legal guardians of involved clients within one business day;
(A) if the critical incident involves a client or service under a DHS contract, the critical incident report must be completed within one business day and may require a five day follow up report to the involved DHS Division;
(B) if the critical incident involves a client or service to a youth currently in the custody of DHS or its Divisions an immediate live-person verbal notification to the involved Division is additionally required.
(ii) Initial critical incident reports to DHS shall include the following in writing:
(A) name of provider and all involved staff, witnesses and clients;
(B) date, time, and location of the incident, and date and time of incident discovery, if different from time of incident;
(C) descriptive summary of incident;
(D) actions taken; and
(E) actions planned to be taken by the program at the time of the report.
(F) identification of DHS contracts status, if any.
(iii) It is the responsibility of the licensee to collect and maintain and submit as requested original witness and participant witness Statements and supporting documentation regarding all critical incidents that require individual perspectives to be understood.

D. Process for reporting:
2. In addition, notification of the incident shall also be given to the appropriate case manager, case worker or Support Coordinator. This may be accomplished via entry into USTEPS when applicable. Although they may conduct follow-up relative to the needs of the client, case managers, case workers or Support Coordinators shall not independently engage in any investigatory actions or functions relative to an incident reported to them. Investigations of CIs will be conducted by or under the direction of the Office of Licensing.
3. For incidents involving individuals in the DSPD system, CIs shall be reported through USTEPS and shall include any additional information required by that system. OL staff assigned to process and evaluate these incidents will then refer them to the Office of Licensing, if the incident involves a licensee and rises to the level of a CI as defined above.

II. Non-Critical Incidents (only applicable to providers with DHS contracts) Non-Critical Incidents ("NCI") are those events or occurrences that do need to be reported, but do not need to be reported to the Office of Licensing. Reporting requirements or procedures for NCIs are outlined below. In addition, the requirements relating to NCIs only applies to those entities serving a DHS population under a State contract. These do not apply to non-contracted private providers.
A. The following are NCIs that shall be reported:
1. Unexpected hospitalizations that result in admission. This includes any admission to psychiatric facilities.
2. Any destruction of property attributed to an individual receiving services, the value of which exceeds $500.00, unless such behavior is one identified as a target behavior in a Behavior

Support Plan and is reported in a monthly behavior summary sent to appropriate case management/support coordination.
3. Suicidal ideation or threats of suicide when the individual does not have services and supports in place to address such behaviors, a description of which are also not being reported on a monthly summary to appropriate case management.
4. Use of emergency behavior interventions as such are defined in Utah Administrative Code Rule 539-4. This is applicable only to people receiving services under the DSPD system.
5. Aspiration or choking which does not result in hospitalization.
6. Evidence of a seizure or seizure like behavior in an individual with no existing seizure diagnosis, except where seizures have been ruled out and seizure like behavior is a behavior identified as a target behavior in a Behavior Support Plan and reported in a monthly behavior summary sent to the appropriate case management/support coordination.
7. Any incident involving the alleged or confirmed waste, fraud or abuse of Medicaid funds by either a provider or a recipient of Medicaid services.
8. Any involvement of an outside entity such as fire department, law enforcement, etc.
9. Attempted escape from a detention or secure facility.
10. Unlawful or unauthorized possession of pornographic material.
11. Any pending litigation that is specifically related to the provider's services or to an individual receiving services.

B. Reporting process and requirements for NCIs:
1. Initial notification shall be made within one business day of the incident to the appropriate case manager, case worker or Support Coordinator. For those serving individuals in the DSPD system, this may be accomplished via entry into USTEPS when applicable. This initial notification shall contain the following information:
• Identification of the individual receiving services involved in the incident
• The date of the incident
• The date the incident was discovered
• A brief description of the occurring incident
2. A full report of the incident shall be submitted to the case manager, case worker or Support Coordinator within 5 business days. This report shall include the following: • The reporting criteria established in Utah Administrative Code, Rule 501-1-9, which are also referenced in section I.C. above. Those providing services to individuals in the DSPD system shall also include any additional criteria set forth in USTEPS.
3. In addition to the initial and full report, providers may be asked to provide additional information if such information is required by DHS, Department of Health or other entity making further inquiry of an incident(s).

The State does not review incident reports/findings differently when a single provider renders both residential and day services.

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.

The State uses a burden of proof standard in regards to allegations of abuse, neglect or exploitation. (The probability that the incident occurred as a result of the alleged/suspected abuse, neglect and/or exploitation is clear and convincing). In general, the State's incident reporting criteria is event based - if the occurrence of a defined criteria is met, the incident must

be reported. The level of investigation/remediation may be altered depending on the severity of incident/likely recurrence/improper safeguards, etc.

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 DHS/DSPD annual Incident Report. If the SMA detects systemic problems either through this reporting mechanism or during the SMA's program review process, DHS/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.

The DHS/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.

Quarterly reports submitted by the OA are reviewed for Level 2 incidents. Level 1 incidents are reported to the SMA upon notification to the OA.

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:0

R539-4-3 Definitions
(n) "Level II Intervention" means intrusive procedures that may be used in pre-approved Behavior Support Plans or as Emergency Behavior Interventions. Approved interventions include Enforced Compliance, Manual Restraint, Exclusionary Time-out, Mildly Noxious Stimuli, and Emergency Rights Restrictions.
(o) "Level III Intervention" means intrusive procedures that are only used in pre-approved Behavior Support Plans. Approved interventions include Time-out rooms, Mechanical Restraint, Highly Noxious Stimuli, overcorrection, Contingent Rights Restrictions, Response Cost, and Satiation
(p) "Manual Restraint" means a Level II Intervention using physical force in order to hold a Person to prevent or limit movement.
(q) "Mechanical Restraint" means a Level III Intervention that is any device attached or adjacent to the Person's body that cannot easily be removed by the Person and restricts freedom of movement. Mechanical restraint devices may include, but are not limited to, gloves, mittens, helmets, splints, and wrist and ankle restraints. For purposes of this Rule, Mechanical Restraints do not include: (i) Safety devices used in typical situations such as seatbelts or sporting equipment. (ii) Medically prescribed equipment used as positioning devices, during medical procedures, to promote healing, or to prevent injury related to a health condition (i.e. helmets used for Persons with severe seizures).

R539-4-4 Levels of Behavior Interventions
(1) The remainder of this rule applies to all Division staff and Providers, but does not apply to employees hired for self-direction.
(8) Level II Interventions may be used in pre-approved Behavior Support Plans or emergency situations.
(9) Level III Interventions may only be used in pre-approved Behavior Support Plans.
(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.
(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-direction may seek State Behavior Review Committee recommendations, if desired.

DHS90743 Contract Scope of Work
Within 30 days of hire, provider employees must be trained in “[t]he use of positive behavior supports as a first response in behavioral crisis prevention and intervention in accordance with

Utah Administrative Code, Rule R539-4." Ensure its staff successfully completes training in one of the following within 180 days of employment if the Person the staff is serving is likely to engage in aggressive, self-injurious, or destructive behavior: a. Supports Options and Actions for Respect ("SOAR"); b. System for Managing Non-Aggressive and Aggressive People ("MANDT"); c. Professional Assault Response Training ("PART"); d. Crisis Prevention Institute ("CPI") or Safety Care; or e. Another intervention-training program with prior written approval from DHS. The staff shall maintain certification in one of the above.

R501-2-7. Behavior Management. (Office of Licensing)
A. The program shall have on file for public inspection, a written policy and procedure for the methods of behavior management. These shall include the following: 1. definition of appropriate and inappropriate behaviors of consumers, 2. acceptable staff responses to inappropriate behaviors, and 3. consequences.
B. The policy shall be provided to all staff, and staff shall receive training relative to behavior management at least annually.
C. No management person shall authorize or use, and no staff member shall use, any method designed to humiliate or frighten a consumer.
D. No management person shall authorize or use, and no staff member shall use nor permit the use of physical restraint with the exception of passive physical restraint. Passive physical restraint shall be used only as a temporary means of physical containment to protect the consumer, other persons, or property from harm. Passive physical restraint shall not be associated with punishment in any way.
E. Staff involved in an emergency safety intervention that results in an injury to a resident or staff must meet with the clinical professional to evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.

Documentation Requirements
Use of Emergency Behavioral Interventions as defined by R539-4-6 and use of restraints or a seclusion room, even when identified in the Person's Behavior Support Plan must be reported as a Level III Incident. Human rights violations that include unauthorized use of physical, mechanical, or chemical restraints, seclusion rooms, and infringement of personal privacy rights experienced by the Person that would otherwise require a human rights review process must be reported as a Level I Critical Incident. Providers must submit notification of an incident within one business day of discovery to the Support Coordinator and the person's guardian. Notification to the Support Coordinator is made through the Utah Provider Interface (UPI). A detailed report must be completed in UPI within 5 days of discovery.

The following information is included in the State's administrative rule regarding behavior interventions (R539-4-3 https://rules.utah.gov/publicat/code/r539/r539-004.htm)
(l) "Highly Noxious Stimuli" means a Level III Intervention applying an extremely undesirable, but not harmful, sensory event that exceeds the criteria of Mildly Noxious Stimuli.
(r) "Mildly Noxious Stimuli" means a Level II Intervention applying a slightly undesirable sensory event such as a verbal startle or loud hand clap.
(m) "Level I Intervention" means positive, unregulated procedures such as prevention strategies, reinforcement strategies, positive teaching and training strategies, redirecting, verbal instruction, withholding reinforcement, Extinction, Non-exclusionary Time-out/Contingent Observation, and simple correction.

State administrative rule R539-4-4 includes the following information:

(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.

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 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.

Office of Quality and Design (OQD) manages all behavior support plans and human rights issues related to incidents and restraints. Office of Licensing (OL) core rule R501-2 governs restraints and behavior management in licensed settings. Investigative teams look into all incidents reported according to rule requirements and note violations as appropriate. OQD is involved to add to any noted violations of contract. Trends and patterns are noted in OL database and DSPD Database (USTEPS).

Unauthorized use, overuse, or inappropriate/ineffective use of restraints must be reported through the critical incident process. Incidents of this nature are considered level one critical incidents, requiring investigation by the SMA to ensure development and implementation of prevention strategies, Support Coordinator follow-up, and State requirements are followed. Additionally, Support Coordinator monthly contact addresses any suspicion of abuse, neglect, or exploitation. Support Coordinators are mandatory reporters and therefore must report any suspicion of abuse, neglect, or exploitation to Adult Protective Services, Child Protective Services, and other authorities as appropriate. Constituent Services within both the SMA and the OA will accept any report of abuse,

neglect, exploitation including unauthorized use, overuse, or inappropriate/ineffective use of restraints. Finally, the Support Coordinator is responsible to review any human rights restriction plans for the individuals they serve to assure the health and welfare of the individual and ensure their human rights are protected.

The OA compiles and analyzes critical incident data at a minimum of quarterly in order to prevent re-occurrence of similar incidents. Critical incident trends are identified for systemic intervention, and targeted improvement strategies are implemented by the OA. Improvement strategies can include interventions targeted toward specific providers, identified provider types, individuals in services, or select groups based on demographics such as regional location, gender, age, sexual orientation; among others. The Quality Improvement Committee which is composed of representatives from the SMA, the Division of Services for People with Disabilities, the Office of Quality and Design, and the Division of Licensing reviews critical incident data and associated improvement strategies at a minimum of quarterly and provides support for collaborative inter-agency improvement strategy implementation. The SMA receives quarterly reports on critical incident data, trends, and prevention strategies.

The State evaluates the following performance measures to support oversight of the operation of the incident management system:
-Number and percentage of quarterly critical incident reports submitted to the SMA which demonstrate how incident data are collected, compiled, and used to prevent re-occurrence.
-Number and percentage of critical incident trends identified for systemic intervention that were implemented.

Data for overseeing the operation of the incident management system are collected using the Utah Provider Interface (UPI) system within USTEPS. Providers and Support Coordinators use UPI to report incidents, document information and follow-up surrounding the incident following its occurrence, provide investigation information, and identify trends for individuals who experience multiple incidents requiring intervention, including those involving unauthorized use of restraints. The OA is responsible to compile and analyze this data at a minimum of quarterly to prevent re-occurrence concerning the unauthorized use of restraints. The SMA and the OA collaborate to implement improvement strategies through quarterly reporting processes, the Quality Improvement Committee, and other efforts as necessary.

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.

R539-4-3 Definitions
(d) "Contingent Rights Restrictions" means a Level III Intervention resulting in the temporary loss of rights based upon the occurrence of a previously identified problem.
(f) "Emergency Rights Restriction" means a Level II Intervention temporarily denying or restricting access to personal property, privacy, or travel in order to prevent imminent injury to the Person, others, or property. Rights are reinStated when immediate danger is resolved. (n) "Level II Intervention" means intrusive procedures that may be used in pre-approved Behavior Support Plans or as Emergency Behavior Interventions. Approved interventions include Enforced Compliance, Manual Restraint, Exclusionary Time-out, Mildly Noxious Stimuli, and Emergency Rights Restrictions.
(o) "Level III Intervention" means intrusive procedures that are only used in pre-approved Behavior Support Plans. Approved interventions include Time-out rooms, Mechanical Restraint, Highly Noxious Stimuli, overcorrection, Contingent Rights Restrictions, Response Cost, and Satiation.

R539-3-4. Human Rights Committee.
(1) This rule applies to the Division, Persons funded by the Division, Providers, Providers' Human Rights Committees, and the Division Human Rights Council.
(2) All Persons shall have access to a Provider Human Rights Committee with the exception of the following: (a) Persons receiving physical disabilities services. (b) Families using the Self-Directed Model. (c) Persons receiving only family supports or respite. (3) The Provider Human Rights Committee approves the services agencies provide relating to rights issues, such as rights restrictions and the use of intrusive behavior supports. In addition, the Committee provides recommendations relating to abuse and neglect prevention, rights training, and supporting people in exercising their rights.
(4) Any interested party may request that the rights of a Person be reviewed by a Provider Human Rights Committee by contacting the Person's Provider agency verbally or in writing.
(5) Any interested party may request an appeal of the Provider Human Rights Committee decision by sending a request to the Division, 195 North 1950 West, Salt Lake City, UT 84116. The Division shall make a decision whether there will be a review and shall notify the Person, Provider, and Support Coordinator concerning the decision within eight business days. The notification shall contain a Statement of the issue to be reviewed and the process and timeline for completing the review.

Documentation Requirements

Human rights violations that include unauthorized use of physical, mechanical, or chemical restraints, seclusion rooms, and infringement of personal privacy rights experienced by the Person that would otherwise require a human rights review process must be reported as a Level I Critical Incident. Providers must submit notification of an incident within one business day of discovery to the Support Coordinator and the person's guardian. Notification to the Support Coordinator is made through the Utah Provider Interface (UPI). A detailed report must be completed in UPI within 5 days of discovery.

All eight elements for modifications, as described in the Settings Rule, will be addressed in the person-centered plan. Answers for each element must be documented in the plan for each modification. The plan requires signed informed consent prior to activation.

Whenever there is discrepancy between it and OL requirements, we defer to OQD to assist in determining course of action. We have proposed the following rule change to assist in processing of incidents moving forward: (3) All occurrences of Emergency Behavior Interventions that are not approved for use in the behavior support plan or resulting in a critical incident in a licensed setting as defined in Licensing Rule 501-1-2 shall be documented by the provider through an incident report as outlined in the provider's service contract and in accordance with Licensing Rule 501-1-9-2 (4) All incident reports shall be reviewed by the Office of Licensing and the person's Support Coordinator. (a) In licensed settings, the Office of Licensing will assess the provider's compliance with Licensing Rules through incident report review and/or incident investigation. (i)the Office of Licensing is responsible for all follow-up action regarding the provider when the provider is licensed. (ii)the Support Coordinator is responsible for all follow up action regarding the person in both licensed and non-licensed settings. (iii) OQD is responsible for investigating non-licensed incidents and managing any contract compliance concerns noted by any entity during the course of the review or investigation.

State administrative rule R539-4 includes the following information:
(b) "Behavior Peer Review Committee" means a group consisting of at least three specialists with experience in the fields of Positive Behavior Supports and applied behavior analysis. One of the three members must be outside the Provider agency. The Committee is primarily responsible for evaluating the quality, effectiveness, and least intrusiveness of the Person's Behavior Support Plan.

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-direction may seek State Behavior Review Committee recommendations, if desired.

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.

Operating Agency is DHS: (OL and DSPD and OQD) all coordinate efforts to manage incidents on an ongoing basis. OQD/DSPD oversee Human Rights committee, Quality Management and compilation of findings/data analysis. OL oversees minimum health and safety standards across all licensed settings (MANY of OL's licenses are not for DSPD recipients, but incident processing and rules were tailored to include all key elements of incidents and processes to satisfy SMA for waiver recipients as well as meet private provider needs.

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.

State administrative rule R539-4-4 includes the following information:
(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.

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.

R539-4-3 Definitions
(n) "Level II Intervention" means intrusive procedures that may be used in pre-approved Behavior Support Plans or as Emergency Behavior Interventions. Approved interventions include Enforced Compliance, Manual Restraint, Exclusionary Time-out, Mildly Noxious Stimuli, and Emergency Rights Restrictions.

(o) "Level III Intervention" means intrusive procedures that are only used in pre-approved Behavior Support Plans. Approved interventions include Time-out rooms, Mechanical Restraint, Highly Noxious Stimuli, overcorrection, Contingent Rights Restrictions, Response Cost, and Satiation

R539-4-4. Levels of Behavior Interventions.
(1) The remainder of this rule applies to all Division staff and Providers, but does not apply to employees hired for self-direction.
(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.
(6) Level I interventions may be used informally, in written support strategies, or in Behavior Support Plans without approval.
(7) Behavior Support Plans that only include Level I Interventions do not require approval or review by the Behavior Peer Review Committee or Provider Human Rights Committee.
(8) Level II Interventions may be used in pre-approved Behavior Support Plans or emergency situations.
(9) Level III Interventions may only be used in pre-approved Behavior Support Plans.
(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.

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-direction may seek State Behavior Review Committee recommendations, if desired. DHS90743 Contract Scope of Work Within 30 days of hire, provider employees must be trained in "[t]he use of positive behavior supports as a first response in behavioral crisis prevention and intervention in accordance with Utah Administrative Code, Rule R539-4."

Documentation Requirements
Use of Emergency Behavioral Interventions as defined by R539-4-6 and use of restraints or a seclusion room, even when identified in the Person's Behavior Support Plan must be reported as a Level III Incident. Human rights violations that include unauthorized use of physical, mechanical, or chemical restraints, seclusion rooms, and infringement of personal privacy rights experienced by the Person that would otherwise require a human rights review process must be reported as a Level I Critical Incident. Providers must submit notification of an incident within one business day of discovery to the Support Coordinator and the person's guardian. Notification to the Support Coordinator is made through the Utah Provider Interface (UPI). A detailed report must be completed in UPI within 5 days of discovery. All eight elements for modifications, as described in the Settings Rule, will be addressed in the person-centered plan. Answers for each element must be documented in the plan for each modification. The plan requires signed informed consent prior to activation.

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 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.

Unauthorized use, overuse, or inappropriate/ineffective use of seclusion must be reported through the critical incident process. Incidents of this nature are considered level one critical incidents, requiring investigation by the SMA to ensure development and implementation of prevention strategies, Support Coordinator follow-up, and State requirements are followed. Additionally, Support Coordinator monthly contact addresses any suspicion of abuse, neglect, or exploitation. Support Coordinators are mandatory reporters and therefore must report any suspicion of abuse, neglect, or exploitation to Adult Protective Services, Child Protective Services, and other authorities as appropriate. Constituent Services within both the SMA and the OA will accept any report of abuse, neglect, exploitation including unauthorized use, overuse, or inappropriate/ineffective use of restraints. Finally, the Support Coordinator is responsible to review any human rights restriction plans for the individuals they serve to assure the health and welfare of the individual and ensure their human rights are protected.

The OA compiles and analyzes critical incident data at a minimum of quarterly in order to prevent re-occurrence of similar incidents. Critical incident trends are identified for systemic intervention, and targeted improvement strategies are implemented by the OA. Improvement strategies can include interventions targeted toward specific providers, identified provider types, individuals in services, or select groups based on demographics such as regional location, gender, age, sexual orientation; among others. The Quality Improvement Committee which is composed of representatives from the SMA, the Division of Services for People with Disabilities, the Office of Quality and Design, and the Division of Licensing reviews critical incident data and associated improvement strategies at a minimum of quarterly and provides support for collaborative inter-agency

improvement strategy implementation. The SMA receives quarterly reports on critical incident data, trends, and prevention strategies

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 Attendant Care, Prevocational Services, and Integrated Community Learning, 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 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. DHS/DSPD certifies new providers before contracting for services. Medication training and competency is part of the certification process. DHS/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 DHS/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 reviews the findings of OA audits and 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. - DHS/DSPD contract analyst reviews staff medication competencies annually. - DHS/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 one business day. 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 DHS/DSPD regarding medication errors and these reports are reviewed by both the DHS 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-direct 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).

Skilled nursing tasks may be delegated by a licensed nurse as established by the Utah Code Annotated § 58-31b, Nurse Practice Act and corresponding Administrative Rule R156-31b. A licensed nurse retains accountability for delegated tasks. A nurse may delegate appropriate tasks in accordance with R156-31b-701a. A responsible caregiver may delegate nursing care in accordance with R156-31b-701c. For all HCBS settings, the standards in Sections R156-31b-701a and R156-31b-701c apply.

In accordance with the DHS Scope of Work for agency providers:
If the Contractor will support Persons in their self-directed, self-administration of prescription medication, the Contractor shall ensure that its policies and procedures address the following:
(1)Ensure medications are properly stored according to the Person's needs and capabilities, as determined by the Person's PCPT;
(2)Prevention of theft and abuse of medication;
(3)Training and explanation to the Person regarding the prescribed medication indication, the correct dose, how to properly administer the medicine, and the schedule for taking the medication according to the prescription and directions of the health care professional;

(4)Supervision of the Person while the Person takes their medication, according to their needs; and
(5)That the staff that observes or assists the Person with medication documents the following in the Person's record: time and date the medication was taken; name of the medication taken; reason the medication was taken if the medication is an "as needed" ("PRN") medication; the route the medication was administered; and the staff that observed the medication administration.
c.If the Contractor has primary responsibility for the Person's medication, the Contractor shall ensure that its policies and procedures also address the following:
(1)The Person's prescription medication must be packaged and dispensed to the Person by a licensed pharmacy using dose packaging when such packaging is available. If dose packaging is not available, the Contractor may provide medication supports with medication that is dispensed in the original and lawful packaging of the medication with prior written approval from the DSPD Director or designee;
(2)Disposal of medications;
(3)Process to ensure the transfer of prescription medication for services provided to the Person by a school or another service provider;
(4)Provisions to report or address the discovery of any prescribed medication errors. Medication errors include a suspected or actual missed dose and misadministration of medication, including taking medication at the wrong time when timing is important in the proper administration of the medicine; and
(5)Enhanced process for monitoring the dispensing, tracking, and written documentation in Person's medical data sheet of Schedule II- IV medication under Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, U.S.C. Title 21, Chapter 13, Subchapter I, Part I, Part B § 812, such as Benzodiazepines, Opiates, and PRN medication. The enhanced process for monitoring must include provisions for ensuring the medication count is accurate, and for theft and abuse prevention.
d.If the Contractor will support Persons in their self-directed, self-administration of prescription medication, the Contractor shall ensure that the Person's record includes: the name and purpose of each medication the Person is taking; instruction regarding routes of administration and dosage for each medication the Person is taking; medication adversities, side effects, and indications of an effect or adverse reaction for each medication, including if there is a possibility that medication taken may contribute to swallowing difficulties or enhance the prospects of choking; and documentation of compliance with medication administration requirements.

In accordance with R539-5-5 SDS Employee Requirements
(3) (SDS) Employees must complete the following prior to working with the Person and receiving payment from the Fiscal Agent:
(g) Complete any screenings and trainings necessary to provide for the health and safety of the Person (i.e., training for any specialized medical needs of the Person).

Under Utah Administrative Code 501-1-2(9) the following is considered a critical incident and must be reported by all contracted providers in accordance with critical incident requirements:
(n) medication errors resulting in impact on client's well-being, medical status or functioning;

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:
	Under Utah Administrative Code 501-1-2-9 Critical incident means an occurrence that involves: (n) medication errors resulting in impact on client's well-being, medical status or functioning.
	(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 one business day of the development of any apparent medical need for the person. Medication overdoses or medication errors reasonably requiring medical intervention must be reported to the DHS Office of Licensing by the provider within one business day.
○	**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. DHS/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. DHS/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.
DHS staff review all client files annually, and compare incidents discovered through this method to incident reports filed in the DHS database. Violations of failure to report are issued when noted.

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 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):*

If 'Other' is selected, specify:

Incidents reports

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

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 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):*

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:*

Performance Measure:	*Number and percentage of suspected abuse, neglect, exploitation and unexpected death incidents referred to Adult Protective Services, Child 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):*	
If 'Other' is selected, specify:	
DSPD records, Participant records, Incident reports, DSPD Annual Incident report	

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

Performance Measure:	*# and % of abuse, neglect, exploitation and unexpected death incidents reported to DSPD within one business day of discovery of occurrence. Numerator is total number of abuse, neglect, exploitation and unexpected death incidents reviewed reported to DSPD within one business day of the discovery of occurrence; 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):*

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*	*x 100% Review*
	x Operating Agency	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	*x Annually*	
		x Continuously and Ongoing	☐ *Stratified: Describe 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 % of abuse, neglect, exploitation & unexpected death incidents for which providers submit incident report in 5 business days of discovery of incident. Numerator is total # of incidents reviewed for which providers submit incident report in 5 business days of discovery of incident; Denominator is total number of abuse, neglect, exploitation & unexpected death incidents reviewed.*
Data Source *(Select one) (Several options are listed in the on-line application):*	
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*	*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*
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 substantiated instances of abuse, neglect, exploitation and unexplained death identified by agency partners that were appropriately reported. Numerator = Number of cases reported; Denominator = number of incidents which should have been reported.*

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

If 'Other' is selected, specify:

Critical Incident reports; Participant Records; Claims Data

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

Performance Measure:	*Number and percentage of quarterly critical incident reports submitted to the SMA which demonstrate how incident data are collected, compiled, and used to prevent reoccurrence. The numerator is the number of reports which demonstrate how incident data are collected, compiled, and used to prevent re-occurrence; the denominator is the total number of reports required.*
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
Participant records, Participant Support 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*	*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*
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 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):*			
If 'Other' is selected, specify:			
Participant records, Participant Support plans, Participant interviews and Provider interviews Responsible			
	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:*	*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: 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:	*# and % incidents identifying unauthorized use of restrictive interventions (including restraints/seclusion) appropriately reported, investigated & for which recommended follow-up was completed. Numerator is total # of these types of incidents reviewed that were appropriately reported, investigated and had recommended follow-up; Denominator is total # of these types of incidents.*

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

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.

Performance Measure:	*Number and percent of participants whose Person Centered Support Plan (PCSP) addresses their health needs. Numerator = Number of participants whose PCSP addresses their health needs. Denominator = Number of PCSPs reviewed.*		
Data Source *(Select one) (Several options are listed in the on-line application):*			
If 'Other' is selected, specify:			
PCSP, Log Notes, 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)*

	☐ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	x Operating Agency	☐ *Monthly*	*x Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	*x Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	*x Annually*	*95% confidence interval, 5% margin of error*
		☐ *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)

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

Referrals are made to Adult Protective Services, Child Protective Services, and/or law enforcement according to State laws. Prevention strategies are developed and implemented, when 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 by DHS/DSPD of a level one critical incident or event.

DHS/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 LSW program performance measures for each of the five waiver years. The SMA reviews findings annually and participates in reviews at its discretion or reviews OA processes and findings. The criteria for the focused reviews will be determined from DHS/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 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, CPS, and/or local law enforcement; or issues involving the State's Medicaid Fraud Control Unit or Office of Inspector General.

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:	☐ **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 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.

Appendix H: Quality Improvement Strategy

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

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

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

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

Quality Improvement Strategy: Minimum Components

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

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

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

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

Additionally, a Quality Improvement Committee which includes representation from the SMA, the Division of Services for People with Disabilities, the Office of Quality and Design, and the Division of Licensing meets at least monthly to review discovery and remediation information, analyze that information, recommend system improvements, and analyze the effectiveness of the improvement initiatives. The Committee may generate or request quality improvement reports to monitor outcomes, evaluate the effectiveness of process and system improvements, and track and trend performance measures. Quality improvement reports which include the above information are compiled 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%. The Committee maintains an accountability tracker to assure designated research and reporting tasks assigned to each agency are completed as required

ii. System Improvement Activities

Responsible Party *(check each that applies):*	**Frequency of monitoring and analysis** *(check each that applies):*
x State Medicaid Agency	☐ **Weekly**
☐ **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, the DSPD waiver manager, the DSPD Quality Team, the Office of Quality and Design, and the Division of Licensing, 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 DSPD web site, and DSPD Board Meetings. 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 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 LSW. Improvements to the QIS will be made at this time and submitted in the following waiver renewal application

H.2 Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the State has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one):*

- No
- xYes *(Complete item H.2b)*

b. Specify the type of survey tool the State uses:

- HCBS CAHPS Survey;
- xNCI Survey;
- NCI AD Survey;
- Other *(Please provide a description of the survey tool used)*:

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. Beyond State and federal laws regarding the submission of independent audits, the State does not require providers to have an independent audit.

The State conducts a single audit in conformance with the Single Audit Act of 1984, Public Law 98-502. The single State audit will be completed by the State Auditor or his designee.

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

The Department of Human Services (DHS), through the Division of Services for People with Disabilities (DSPD) and the DHS Office of Quality and Design (OQD), 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, 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 DSPD.

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

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

As a result of the State's organizational structure described above: 1. All providers participating in this 1915(c) HCBS PD Waiver must: a) Fulfill the DSPD State contracting requirement as one of the waiver provider qualifications related to compliance with State law, and b) agree to bill the MMIS directly or voluntarily reassign payment to DHS/DSPD. 2. The State Medicaid Agency reimburses DSPD for any interim payments that are made for legitimate waiver service claims during the time the clean claim is being processed through the MMIS system. 3. The State Medicaid Agency receives from DSPD the State matching funds associated with the waiver expenditures prior to the State Medicaid Agency drawing down Federal funds. 4. The State Medicaid Agency approves all proposed rules, policies and other documents related to 1915(c) waivers prior to adoption by the DSPD policy board.

SMA ROLE AND PROVIDER CONTRACT REQUIREMENT

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

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

During annual contract reviews, the DHS Quality Management team 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. Through the review of Financial Management Services providers, Personal Attendants are verified to meet the minimum requirements under the waiver.

The Quality Management team at DHS selects two months of data during the past year and compares claims data with supporting documentation at the provider site (attendance records, time sheets, progress notes, etc.) for each client in the sample. If the reviewer notes inconsistencies, an expanded review may be completed. This may involve the expansion of the date range of information for a particular client, or additional clients to be added to the sample. As part of provider reviews, while 100% of providers are reviewed, 10% of the participants served by that provider are reviewed. The claims belonging to the specific provider, for that participant will be reviewed.

Review results are communicated to providers through a draft report of findings. The provider is then given an opportunity to supply evidence to refute the findings cited. Should evidence be supplied, it is considered by the SMA/OA prior to a final report being completed.

When overpayments or other ineligible claims are identified by the OA, the OA works with the SMA to return FFP amounts. The SMA receives the results of all audits performed including the initial presentation of findings to providers (which may include the identification of ineligible or overpayments). These communications include instructions for the provider on how they may refute or accept the findings, and in the case of ineligible or overpayments, how they may return funds to the DSPD or appeal the decision. DSPD will reimburse SMA for all collected ineligible or overpayments as a result of the audit.

Providers are required to develop plans of correction when deficiencies are cited. Should a plan of correction be required by the provider, it is reviewed and approved prior to being implemented. During subsequent reviews, verification of items within the plan are reviewed. Should non-compliance continue, an expanded review may be completed, or a more aggressive plan may be required with more frequent reviews. OA provider contract reviews are conducted separately from post-payment audits completed by the Medicaid agency.

Entities such as DOH Internal Audit, State Office of Inspector General (OIG), Federal OIG, Office of Legislative Auditor General, Medicaid Fraud Control Unit, etc. may engage in additional review activities at their discretion.

For providers of Support Coordination Services, Medicaid recipients are contacted by their Support Coordinators monthly to ensure that service delivery has been in accordance with the amount/frequency/duration listed on their support plans. Support Coordinators are then responsible for either allowing provider payments to be processed or identify any questionable requests for payment to the

OA. JOINT DSPD STATE CONTRACT/SMA PROVIDER AGREEMENT

Upon enrollment into the LSW all participants receiving services through the self-directed 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 DSPD.

INTERAGENCY AGREEMENT FOR OPERATIONS AND ADMINISTRATION OF THE HCBS WAIVER
An interagency agreement between the SMA and DSPD sets forth the respective responsibilities for the administration and operation of this waiver. The agreement delineates the SMA's overall responsibility to provide management and oversight of the waiver including review and approval of all waiver related rules and policies to ensure compliance with Medicaid HCBS waiver rules and regulations. The agreement also delineates DSPD's roles in relation to the statutory responsibilities to develop the State's program for persons with disabilities. The nature of the agreement enhances provider access to the Medicaid program and quality assurance of services as well as defines the fiscal relationship between the two agencies. The major components of the agreement are: 1. Purpose and Scope; 2. Authority; 3. Definitions; 4. Waiver Program Administration and Operation Responsibilities; 5. Claims Processing; 6. Payment for Delegated Administrative Duties (including provisions for State match transfer); 7. Role Accountability and FFP Disallowances; and 8. Coordination of DHS Policy Development as it relates to Implementation of the Medicaid Program.

Electronic Visit Verification (EVV):
In Utah, following consultation with providers, a modified version of the Provider Choice model was selected. In order to validate compliance, the State is using a post-payment methodology to verify claims paid compared to EVV records. Using an approved IAPD, the State will move to more automated processes to compare claims/EVV records and develop exception reports for missing and manual corrections. The current IAPD and State's good faith effort request have a January 1, 2021 anticipated effective date. The following LSW services will be subject to EVV requirements:
• Attendant Care
• Individual and Family Peer Support

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 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 recoupments in a representative sample of participants which are identified & processed correctly through MMIS & have an audit trail of the TCN in error showing overpayments are returned to the federal government within required timeframes. N=total # of recoupments for participants sampled which were identified, processed, & returned correctly; D=total # of recoupments identified in the participant sample.*		
Data Source *(Select one) (Several options are listed in the on-line application):*			
If 'Other' is selected, specify:			
Participant Claims Data, SMA QA Review and CMS 64 Report			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation :*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	x State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	☐ Operating Agency	*☐ Monthly*	*x Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*x Representative Sample; Confidence Interval =*

	☐ *Other Specify:*	*x Annually*		*95% Confidence Level, 5% Margin of Error*
		☐ *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:*

Performance Measure:	*Number and percentage of paid claims in a representative sample of participants for services that use approved waiver codes and rates. The numerator is the total number of paid claims in the participant sample for services that use approved waiver codes and rates; the denominator is the total number of paid claims in the participant sample.*
Data Source *(Select one) (Several options are listed in the on-line application):*	

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 =*
	☐ Other Specify:	*x Annually*	*95% Confidence Level, 5% Margin of Error*
		☐ 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*
	x Other Specify:
	Every two years

Performance Measure:	*Number and percentage of paid claims in a representative sample of participants for services identified on a participant's service plan which in total do not exceed their annual budget. The numerator is the total number of paid claims in the participant sample which did not exceed the annual budget; the denominator is the total number of paid claims in the participant sample.*

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

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 =*
	☐ *Other Specify:*	*x Annually*	*95% Confidence Level, 5% Margin of Error*
		☐ *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:*

Performance Measure:	*Number and percentage of provider claims submitted and processed through the CAPS in a representative sample of participants which match the DSPD claims submitted and processed through the MMIS. N = total number of provider claims in the participant sample which match in CAPS and MMIS; D = total number of provider claims submitted and processed through CAPS in the participant sample.*
Data Source *(Select one) (Several options are listed in the on-line application):*	
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*	*x Representative Sample; Confidence Interval =*
	☐ Other Specify:	*x Annually*	*95% Confidence Level, 5% Margin of Error*
		☐ 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:	*☐ Annually*

	☐ *Continuously and Ongoing*
	x Other *Specify:*
	every two years

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

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):*			
If 'Other' is selected, specify:			
Participant Claims Data, SMA QA Review and CMS 64 Report			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation :*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	x State Medicaid Agency	☐ *Weekly*	*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:*

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 OA conducts an annual review of the LSW program for each waiver year. The comprehensive review will include participant and provider interviews. The sample size for each review will be sufficient to provide a confidence level equal to 95% and a confidence interval equal to 5.
Additional Information on Claims/Participant Sampling:
Individuals who comprise the representative sample for the purposes of review have the entire support plan period analyzed as part of their review. This is completed in order to assure services meet amount/frequency/duration requirements as Stated in the PCSP; that unauthorized billings may be monitored against the individual's budget; that approved waiver codes/rates were used; and that overpayments can be tracked to ensure FFP is correctly returned.

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 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**
		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**
○	**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).

Pricing for services in the Limited Supports Waiver can put into three broad categories. The broad categories are 1) services utilized in the Community Supports Waiver that are being incorporated into the LSW 2) new LSW services that are benchmarked to existing/similar services within Utah's Dept. of Health (DOH), Dept. of Human Services (DHS), and Dept. of Workforce Services (DWS) service systems and 3) new LSW defined goods and services paid to cover/reimburse client specific costs incurred.

The first category consists of relevant services in CSW that are being incorporated into the LSW. These services include transportation services, fiscal management services, environmental accessibility adaptations, and special medical needs services. Pricing above current CSW pricing is proposed for transportation services.

The second category consists of new LSW services that are benchmarked to existing/similar services within the DOH, DHS, and DWS service systems. To determine which service in these systems matches or is most similar to the new LSW service and therefore can be used as a benchmark for the new service, elements such as service descriptions, service requirements, credentialing, and training requirements were considered. The services in this second category include attendant care, behavioral services, employment services, and peer support services.

The third category consists of new LSW purchases of goods and services which are uniquely tailored to each client. These goods and services consist of remote supports, which are acquired through a bid process (where the client care team selects the bid that will be the most beneficial to the client given their current service plan and budget cap); also included are reimbursements for other goods and services purchased on behalf of the client. The rate listed for remote supports services represents an average of the estimated bid amount to be paid.

The rate methodologies employed in the first two categories of services is dependent on 1) the rate methodology used for the service that is being pulled over to the LSW from the CSW or 2) the rate methodology used for whatever service the new LSW service is benchmarked against. Importantly, pricing adjustments beyond the original rate methodology were adopted for some rates in the first two categories based on market research and in some cases a rate increase request that is anticipated in the near term. The third category of services does not have a rate methodology per se, payment is simply based on reimbursement of a purchase amount or on the amount of an accepted bid.

As discussed above, comparative analysis was a primary tool used for rate determination, but a mix of other methodologies were reflected in price determination as well, such as cost survey, component cost analysis, and market research.

As a part of the market research conducted, Utah has compared service requirements and reimbursement to several surrounding States including: Wyoming, Nevada, North Dakota, Oregon, Idaho, Montana, Colorado, Arizona, New Mexico, and Montana. Nearby States are likely to experience similar challenges with respect to urban/rural service delivery, similar labor markets, service descriptions/qualifications, etc. This research helps validate whether payment rates established are reasonable and whether they account for differences which may exist among States such as cost of living, how reimbursement is made (daily, hourly episodic), and provider qualifications. As an example of differences in provider qualifications, a State may require a service to be delivered by a Registered Behavior Technician (registered through a Behavior Analyst Certification Board or BACB) whereas another State may not have that requirement.

Utah's DOH has authority over the final recommendation of the pricing of services in the LSW. The rate setter at DHS makes initial recommendations on the pricing of services and DOH reviews those recommendations and makes any adjustments deemed necessary. The DHS rate setter coordinates with the DOH rate setter over the period pricing recommendations are developed to minimize later adjustments needed to pricing recommendations. The DHS rate setter receives assistance from DSPD and the DHS Office of Quality and Design (OQD) to gain a deeper understanding of the services to be provided; DSPD and OQD also assist with market research and other rate development activities as needed.

As part of the public notice period for review of this waiver application, the public will have a 30-day comment period to review services and rates paid for those services. The standard process required by the Centers for Medicare and Medicaid Services (CMS) will be utilized.

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

For Providers who Voluntarily Reassign Payment to DHS/DSPD:

Requests for payments from the contracted providers are submitted to the Dept of Human Services/DSPD on E-520; payments are then made to the providers. Dept of Human Services/DSPD submits billing claims to DOH for reimbursement.

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

Providers who voluntarily reassign payment to DHS/DSPD reviews and approves the electronic 520 on the DHS/DSPD Payment System.

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:

Step 1: The Provider reviews the payment data for accuracy and completeness. As part of the data submission, the Provider certifies compliance to policies.
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 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 MMIS directly: Providers submit billing prior authorization forms to DHS/DSPD prior to submitting the claims to MMIS. DHS/DSPD will review the billing prior authorization forms submitted by the provider and will authorize the provider to bill the MMIS as long as the claims submitted on the billing prior authorization form are consistent with the service type, amount, frequency and duration as listed on the PCSP and budget.

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

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

Once the DHS/DSPD has approved the billing prior authorization forms, the provider will then submit claims directly through the States' MMIS.

The waiver only pays for Non-Medical transportation and only when in accordance with the written plan of care.

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

2. Post-payment reviews are conducted by the Medicaid agency; reviews of a sample of individual written support plans and Medicaid claims histories to ensure: (1) all of the services required by the individual are identified in the support plan, (2) that the individual is receiving the services identified in the support plan, and (3) that Medicaid reimbursement is not claimed for waiver services which were not included in the support plan. The sample size for each review will be sufficient to provide a confidence level equal to 95% and a confidence interval equal to five.

3. The SMA will perform an annual post payment review of claims that are paid to providers through the CAPS. The review will verify that the rates paid to providers through the CAPS are equal to the rates paid to DSPD through the MMIS

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

APPENDIX I-3: Payment

a. Method of payments — MMIS *(select one)*:

○	**Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
○	**Payments for some, but not all, waiver services are made through an approved MMIS.** Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) how an audit trail is maintained for all State and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.
X	**Payments for waiver services are not made through an approved MMIS.** Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all State and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:
	a) The Waiver services that are not paid through an approved MMIS - Payment for all Waiver services are made through an approved Medicaid Management Information System (MMIS) eventually, but for providers who voluntarily reassign payment to the Department of Human Services (DHS), initially payments for Waiver services are paid to providers through the Department of Human Services (DHS), Contract, Approval and Provider System (CAPS). (b) The process for making such payments and the entity that processes payments- Waiver service providers bill the DHS using an Electronic 520 billing. The Electronic 520 is reviewed and approved by the Support Coordinator and the Payment Technician. Once the Electronic 520 billing is approved, the data is entered into CAPS for payment processing.. 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 DHS with either a paper check or an electronic funds transfer as per the provider's preference. DHS then submits a file of all eligible claims paid through the CAPS to the SMA. The claims are then entered into the MMIS for payment. The SMA makes payment to DHS through the Financial Information Network (FINET) transfer. Each claim is individually identifiable at the level of the participant, provider, HCPCS and units of service paid. (c) How an audit trail is maintained for all State and federal funds expended outside the MMIS- The audit trail outside the MMIS is maintained in CAPS. (d) The basis for the draw of federal funds and claiming of these expenditures on the CMS-64- As Stated previously all Waiver service payments are eventually made through an approved Medicaid Management Information System (MMIS) and this is the basis for the draw of federal funds and claiming of these expenditures on the CMS-64. CAPS along with supporting documentation and claim information processed through MMIS provide audit support. Plans of care including specifications of amount, frequency

	and duration of prescribed services are documented in USTEPS by case managers and result in payment authorizations in CAPS. Payment authorizations result in the generation of provider billings. Provider claims are accompanied by eligibility codes that detail whether services qualify for FFP. Claims for services rendered under Medicaid eligibility are then ported to MMIS where recipient and provider eligibility are verified and claims that are determined to be eligible for FFP result in reimbursement to DHS/DSPD. Participant claim information is documented in MMIS. Utah DOH/DSPD Fund Transfer Process 1. The Department of Health (DOH) estimates the State seed amount for the fiscal year. 2. The DOH sends the request to the Department of Human Services (DHS) for the estimated seed amount. 3. DHS processes the request through FINET transfer. 4. DOH receives the funds before the beginning of the fiscal year. 5. DOH reimburses DHS/DSPD weekly for qualified reimbursements based on the weekly file sent to MMIS. 6. At the end of the quarter, DOH determines the actual seed amount based on the paid claims. 7. The DOH sends the request to the Department of Human Services (DHS) for the seed on the actual paid amount. 8. DHS/DSPD reviews and approves the FINET fund transfer request and DOH receives the funds. 9. DOH refunds the estimated amount to DHS through FINET transfer.
	Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS. Describe how payments are made to the managed care entity or entities:

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

☐	**The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
☐	**The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
x	**The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.** Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and

	the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:
	The DHS/DSPD serves as the governmental entity that pays for Waiver claims for providers who voluntarily reassign payment to DHS/DSPD and DHS/DSPD will pay for all services provided by the Waiver when they are delivered by qualified providers according to the service plan. DHS/DSPD obtains all of the claims for payment for services delivered directly from contract providers on the Electronic 520 billing. Support Coordinators review the claims for accuracy and approval. All approved claims are paid directly to the providers by DHS/DSPD. DHS/DSPD then submits billing claims to the DOH for reimbursement. DHS/DSPD has internal controls in place to assure providers paid through the CAPS system receive payment that is equal to the payment DHS/DSPD receives from DOH including a comparison of DOH's MMIS Reference File rates with DHS/DSPD's CAPS rates for the same service, as per the DOH rate sheet provided each year. A comparison of MMIS HCPCS code/rate information with corresponding CAPS service code/rate information is implemented and documented via screen prints on a copy of a rate chart spreadsheet. This is completed before the beginning of each fiscal year when rates are generally adjusted, but a periodic review of CAPS to MMIS rates is completed throughout the year. Post rate adjustment billing detail is reviewed closely to ensure the agreed rates are correct on the claims submitted for reimbursement, as is the claims reimbursement detail. The SMA will perform an annual post payment review of claims that are paid to providers through the CAPS. The review will verify that the rates paid to providers through the CAPS are equal to the rates paid to DHS/DSPD through the MMIS. During contracting/enrollment with DHS/DSPD, the provider is informed of the ability to bill Medicaid directly for services rendered, or to allow DHS/DSPD to submit for reimbursement on their behalf by completing an optional 'voluntary reassignment of payment' form. Information on billing is also found in the Medicaid provider agreement which is signed by the provider.
☐	**Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.** Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State Plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

x	**No**. **The State does not make supplemental or enhanced payments for waiver services.**

○	**Yes**. **The State makes supplemental or enhanced payments for waiver services.** Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

○	**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 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 through a FINET transfer. The FINET transfer is made to the Medicaid Agency prior to any federal funds being drawn. LOCAL GOVERNMENT OR OTHER SOURCE(S) OF THE NON-FEDERAL SHARE OF COMPUTABLE WAIVER COSTS a.The Utah Transit Authority (UTA), a Utah public transit district, is the local governmental source of the non-federal share of computable waiver costs. b.The source of the funding from UTA is local sales and use taxes. The funds are publicly approved sales tax revenues levied by the cities and counties within UTA's service district. The taxes are collected quarterly from businesses from the sale of retail goods. The sales tax revenues are given to the transit authority for the operation of a local public transportation agency. c.The mechanism that is used to transfer funds from the UTA to the Department of Human Services is through a quarterly check payment

e. Amount of Payment to State or Local Government Providers.

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

x	**The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
○	**The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
○	**The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.** Describe the recoupment process:

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved waiver. *Select one:*

x	**Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
○	**Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.** Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

○	**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 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 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.**
○	**The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.** Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and (d) how payments are made to the health plans.

○	**This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**
○	**This waiver is a part of a concurrent §1115/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1115 waiver specifies the types of health plans that are used and how payments to these plans are made.**

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 appropriated 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 FINET transfer) or check payment, including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:
	The Division of Services for People with Disabilities (DSPD) which resides within the Department of Human Services receives the appropriated funds. DSPD transfers the funds to the State Medicaid Agency via a FINET transfer. This prepayment transfer is based on estimates for the upcoming quarter and takes place approximately 15 days before each new quarter. At the end of each quarter, the State Medicaid Agency will perform a reconciliation of the actual State match obligation and the prepaid amount. State Tax Revenues (general funds) are appropriated directly to the Department of Human Services (DHS) by the legislature. The Division of Services for People with Disabilities (DSPD) which resides within the Department of Human Services (DHS) receives the appropriated funds. DSPD transfers the funds to the State Medicaid Agency via a FINET transfer). 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 a FINET transfer , 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:*	
	☐	**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 a FINET transfer), 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 a FINET transfer), 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 UTAs 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:

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

x	**No services under this waiver are furnished in residential settings other than the private residence of the individual.**
○	**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:

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:

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

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:*

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

Appendix J: Cost Neutrality Demonstration

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

Composite Overview. Complete the 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)*:	ICF/ID/SNF						
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	$16,626.11	$5,154.09	$21,780.19	$82,557.70	$3,520.35	$86,078.05	$64,297.86
2	$17,008.39	$5,154.09	$22,162.47	$82,557.70	$3,520.35	$86,078.05	$63,915.58
3	$17,268.52	$5,154.09	$22,422.61	$82,557.70	$3,520.35	$86,078.05	$63,655.45
4	$17,533.78	$5,154.09	$22,687.87	$82,557.70	$3,520.35	$86,078.05	$63,390.18
5	$17,804.40	$5,154.09	$22,958.49	$82,557.70	$3,520.35	$86,078.05	$63,119.57

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:
		Intermediate Care Facility	Skilled Nursing Facility
Year 1	40	39	1
Year 2	40	39	1
Year 3	40	39	1
Year 4 (only appears if applicable based on Item 1-C)	40	39	1
Year 5 (only appears if applicable based on Item 1-C)	40	39	1

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) = days
Used the average annual LOS count for 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 and methodology for these estimates is as follows:

All calculations are based on the estimated average usage of the maximum budget. This includes
-a maximum annual budget of $16,400
-potential for individuals to utilize the enhanced funding option

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 on the weighted average for actual amounts for FY2018-2019 from the CSW and actual amounts for FY2016-2018 from the ABIW.
- The State utilizes the MMIS Categories of Service and Provider Type functionality to account for and exclude the costs of prescribed drugs from D'

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

- All calculations are based on a weighted average of actual costs from nursing homes cost per day for fiscal years 2017-2019 multiplied by actual CSW waiver LOS, combined with the actual amounts for FY2016-2018 from the ABIW, to get the waiver year 1 base estimate

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

Used actual average nursing home cost per day for fiscal years 2017-2019 and multiplied by actual CSW waiver LOS to get fiscal year 2021 base estimate
- The cost of prescription drugs is excluded from this estimate. All pharmacy claims are assigned a specific category of service in the State's MMIS and explicitly removed from data queries used to calculate these figures.

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	

Applied Behavioral Analysis Therapy (Non-Autism/or ASD Support for Non-EPSDT Eligible Individuals)	BCBA Supervision/Consultation; RBT Direct Service
Attendant Care	Attendant Care I (SDS); Attendant Care II (SDS), Attendant Care Provider Based
Behavior Services	Behavior Support Professional (SDS); Behavior Support Professional (Provider Based); Behavior Service II
Environmental Adaptations - Home	
Environmental Adaptations - Vehicle	
Fiscal Management Services	
Individual and Family Peer Support	
Individual Goods and Services	
Integrated Community Learning	
Prevocational Services	Pre-Employment Skill Building
Remote Support Equipment - Installation	
Remote Support Equipment - Periodic Fee	
Supported Employment	Individual Supported Employment (SDS); Individual Supported Employment (Provider); Job Development Supports
Specialized Medical Equipment/Supplies/Assistive Technology - Periodic Fee	
Specialized Medical Equipment/Supplies/Assistive Technology - Purchase	
Transportation Services (non-medical)	Transportation Supports - Monthly; Transportation Supports - Daily; Transportation Supports - Trip; Utah Transit Authority Route Deviation, Transportation Payment (Mileage Reimbursement)

d. Estimate of Factor D.

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**
Remote Support	Monthly	1	10	$150.00	$1,500.00
Remote Support Installation	Each	1	1	$200.00	$200.00
Applied Behavioral Analysis Therapy – BCBA Supervision	15 Minute	6	114	$9.28	$6,347.52
Applied Behavioral Analysis Therapy – RBT Direct Service	15 Minute	2	132	$22.00	$5,808.00
Attendant Care I	15 Minute	20	1862	$3.07	$114,326.80
Attendant Care II	15 Minute	12	1900	$4.97	$113,316.00
Behavior Support Professional I	15 Minute	8	114	$9.28	$8,463.36
Behavior Service II	15 Minute	3	132	$22.00	$8,712.00
Individual Supported Employment	15 Minute	7	880	$7.68	$47,296.44
Pre-Employment Skill Building	15 Minute	2	200	$9.40	$3,758.40
Job Development Supports	15 Minute	3	200	$9.40	$5,637.60
Integrated Community Learning	Daily	14	104	$103.36	$150,494.12
Transportation Supports - Monthly	Monthly	20	10	$120.75	$24,150.00
Transportation Supports - Trip	Trip	18	116	$4.85	$10,126.80
Transportation Supports - Daily	Daily	10	182	$22.83	$41,550.60
Utah Transit Authority Route Deviation Fee	Trip	10	364	$1.45	$5,278.00
Transportation Payment (Mileage Reimbursement)	Mile	14	5106	$0.42	$30,023.28

Fiscal Management Service	Monthly	32	12	$95.24	$36,572.16
Environmental Accessibility Adaptations - Home	Each	6	1	$4,065.43	$24,392.58
Environmental Accessibility Adaptations - Vehicle	Each	3	1	$4,169.74	$12,509.22
Specialized Medical Needs	Each	2	1	$1,472.32	$2,944.64
Goods and Services	Each	10	2	$500.00	$10,000.00
Peer Support Services	15 Minute	10	12	$13.64	$1,636.80
GRAND TOTAL:					$665,044.32
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					40
FACTOR D (Divide grand total by number of participants)					$16,626.110
AVERAGE LENGTH OF STAY ON THE WAIVER					346

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**
Remote Support	Monthly	4	10	$153.00	$6,120.00
Remote Support Installation	Each	4	1	$200.00	$800.00
Applied Behavioral Analysis Therapy – BCBA Supervision	15 Minute	6	114	$9.28	$6,347.52
Applied Behavioral Analysis	15 Minute	2	132	$22.00	$5,808.00

Therapy – RBT Direct Service					
Attendant Care I	15 Minute	20	1862	$3.13	$116,613.34
Attendant Care II	15 Minute	12	1900	$5.07	$115,582.32
Behavior Support Professional I	15 Minute	8	114	$9.28	$8,463.36
Behavior Service II	15 Minute	3	132	$22.00	$8,712.00
Individual Supported Employment	15 Minute	7	880	$7.83	$48,242.37
Pre-Employment Skill Building	15 Minute	2	200	$9.58	$3,833.57
Job Development Supports	15 Minute	3	200	$9.58	$5,750.35
Integrated Community Learning	Daily	14	104	$105.43	$153,504.00
Transportation Supports - Monthly	Monthly	20	10	$120.75	$24,150.00
Transportation Supports - Trip	Trip	18	116	$4.85	$10,126.80
Transportation Supports - Daily	Daily	10	182	$22.83	$41,550.6
Utah Transit Authority Route Deviation Fee	Trip	10	364	$1.45	$5,278.00
Transportation Payment (Mileage Reimbursement)	Mile	14	5106	$0.42	$30,023.28
Fiscal Management Service	Monthly	32	12	$95.24	$36,572.16
Environmental Accessibility Adaptations - Home	Each	6	1	$4,146.74	$24,880.43
Environmental Accessibility Adaptations - Vehicle	Each	3	1	$4,253.13	$12,759.40
Specialized Medical Needs	Each	2	1	$1,501.77	$3,003.53
Goods and Services	Each	10	2	$500.00	$10,000.00
Peer Support Services	15 Minute	10	12	$13.64	$1,636.80
GRAND TOTAL:					$680,336.31
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					40

FACTOR D (Divide grand total by number of participants)	$17,008.41
AVERAGE LENGTH OF STAY ON THE WAIVER	346

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**
Remote Support	Monthly	4	10	$156.06	$6,242.40
Remote Support Installation	Each	4	1	$200.00	$800.00
Applied Behavioral Analysis Therapy – BCBA Supervision	15 Minute	6	114	$9.28	$6,347.52
Applied Behavioral Analysis Therapy – RBT Direct Service	15 Minute	2	132	$22.00	$5,808.00
Attendant Care I	15 Minute	20	1862	$3.19	$118,945.60
Attendant Care II	15 Minute	12	1900	$5.17	$117,893.97
Behavior Support Professional I	15 Minute	8	114	$9.28	$8,463.36
Behavior Service II	15 Minute	3	132	$22.00	$8,712.00
Individual Supported Employment	15 Minute	7	880	$7.99	$49,207.22
Pre-Employment Skill Building	15 Minute	2	200	$9.78	$3,910.24
Job Development Supports	15 Minute	3	200	$9.78	$5,865.36
Integrated Community Learning	Daily	14	104	$107.54	$156,574.08
Transportation Supports - Monthly	Monthly	20	10	$120.75	$24,150.00
Transportation Supports - Trip	Trip	18	116	$4.85	$10,126.80
Transportation Supports - Daily	Daily	10	182	$22.83	$41,550.6
Utah Transit Authority Route Deviation Fee	Trip	10	364	$1.45	$5,278.00
Transportation Payment (Mileage Reimbursement)	Mile	14	5106	$0.42	$30,023.28
Fiscal Management Service	Monthly	32	12	$95.24	$36,572.16

Environmental Accessibility Adaptations - Home	Each	6	1	$4,229.67	$25,378.04
Environmental Accessibility Adaptations - Vehicle	Each	3	1	$4,338.20	$13,014.59
Specialized Medical Needs	Each	2	1	$1,531.80	$3,063.60
Goods and Services	Each	10	2	$500.00	$10,000.00
Peer Support Services	15 Minute	10	12	$13.64	$1,636.80
GRAND TOTAL:					$690,740.29
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					40
FACTOR D (Divide grand total by number of participants)					$17,268.51
AVERAGE LENGTH OF STAY ON THE WAIVER					346

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**
Remote Support	Monthly	4	10	$159.18	$6,367.25
Remote Support Installation	Each	4	1	$200.00	$800.00
Applied Behavioral Analysis Therapy – BCBA Supervision	15 Minute	6	114	$9.28	$6,347.52
Applied Behavioral Analysis Therapy – RBT Direct Service	15 Minute	2	132	$22.00	$5,808.00
Attendant Care I	15 Minute	20	1862	$3.26	$121,324.51
Attendant Care II	15 Minute	12	1900	$5.27	$120,251.85
Behavior Support Professional I	15 Minute	8	114	$9.28	$8,463.36
Behavior Service II	15 Minute	3	132	$22.00	$8,712.00
Individual Supported	15 Minute	7	880	$8.15	$50,191.36

Employment					
Pre-Employment Skill Building	15 Minute	2	200	$9.97	$3,988.44
Job Development Supports	15 Minute	3	200	$9.97	$5,982.67
Integrated Community Learning	Daily	14	104	$109.69	$159,705.56
Transportation Supports - Monthly	Monthly	20	10	$120.75	$24,150.00
Transportation Supports - Trip	Trip	18	116	$4.85	$10,126.80
Transportation Supports - Daily	Daily	10	182	$22.83	$41,550.6
Utah Transit Authority Route Deviation Fee	Trip	10	364	$1.45	$5,278.00
Transportation Payment (Mileage Reimbursement)	Mile	14	5106	$0.42	$30,023.28
Fiscal Management Service	Monthly	32	12	$95.24	$36,572.16
Environmental Accessibility Adaptations - Home	Each	6	1	$4,314.27	$25,885.60
Environmental Accessibility Adaptations - Vehicle	Each	3	1	$4,424.96	$13,274.88
Specialized Medical Needs	Each	2	1	$1,562.44	$3,124.88
Goods and Services	Each	10	2	$500.00	$10,000.00
Peer Support Services	15 Minute	10	12	$13.64	$1,636.80
GRAND TOTAL:					$701,352.34
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					40
FACTOR D (Divide grand total by number of participants)					$17,533.81
AVERAGE LENGTH OF STAY ON THE WAIVER					346

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**
Remote Support	Monthly	4	10	$162.36	$6,494.59
Remote Support Installation	Each	4	1	$200.00	$800.00
Applied Behavioral Analysis Therapy – BCBA Supervision	15 Minute	6	114	$9.28	$6,347.52
Applied Behavioral Analysis Therapy – RBT Direct Service	15 Minute	2	132	$22.00	$5,808.00
Attendant Care I	15 Minute	20	1862	$3.32	$123,751.01
Attendant Care II	15 Minute	12	1900	$5.38	$122,656.88
Behavior Support Professional I	15 Minute	8	114	$9.28	$8,463.36
Behavior Service II	15 Minute	3	132	$22.00	$8,712.00
Individual Supported Employment	15 Minute	7	880	$8.31	$51,195.19
Pre-Employment Skill Building	15 Minute	2	200	$10.17	$4,068.21
Job Development Supports	15 Minute	3	200	$10.17	$6,102.32
Integrated Community Learning	Daily	14	104	$111.88	$162,899.67
Transportation Supports - Monthly	Monthly	20	10	$120.75	$24,150.00
Transportation Supports - Trip	Trip	18	116	$4.85	$10,126.80
Transportation Supports - Daily	Daily	10	182	$22.83	$41,550.6
Utah Transit Authority Route Deviation Fee	Trip	10	364	$1.45	$5,278.00
Transportation Payment (Mileage Reimbursement)	Mile	14	5106	$0.42	$30,023.28
Fiscal Management Service	Monthly	32	12	$95.24	$36,572.16
Environmental Accessibility Adaptations - Home	Each	6	1	$4,400.55	$26,403.31
Environmental Accessibility Adaptations - Vehicle	Each	3	1	$4,513.46	$13,540.38
Specialized Medical Needs	Each	2	1	$1,593.69	$3,187.37
Goods and Services	Each	10	2	$500.00	$10,000.00
Peer Support Services	15 Minute	10	12	$13.64	$1,636.80

GRAND TOTAL:					$712,176.63
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					40
FACTOR D (Divide grand total by number of participants)					$17,804.42
AVERAGE LENGTH OF STAY ON THE WAIVER					346

ii. Estimate of Factor D – Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. 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						
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col.6	Col. 7
Waiver Service / Component	**Check if included in capitation**	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Component Cost**	**Total Cost**

	☐						
GRAND TOTAL:							
Total: Services included in capitation							
Total: Services not included in capitation							
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)							
FACTOR D (Divide grand total by number of participants)							
Services included in capitation							
Services not included in capitation							
AVERAGE LENGTH OF STAY ON THE WAIVER							

	Waiver Year: Year 2						
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7
Waiver Service / Component	**Check if included in capitation**	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Component Cost**	**Total Cost**

GRAND TOTAL:							
Total: Services included in capitation							
Total: Services not included in capitation							
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)							
FACTOR D (Divide grand total by number of participants)							
Services included in capitation							
Services not included in capitation							
AVERAGE LENGTH OF STAY ON THE WAIVER							

	Waiver Year: Year 3						
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7
Waiver Service / Component	**Check if included in capitation**	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Component Cost**	**Total Cost**

GRAND TOTAL:							
Total: Services included in capitation							
Total: Services not included in capitation							
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)							
FACTOR D (Divide grand total by number of participants)							
Services included in capitation							
Services not included in capitation							
AVERAGE LENGTH OF STAY ON THE WAIVER							

	Waiver Year: Year 4 (only appears if applicable based on Item 1-C)						
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7
Waiver Service / Component	**Check if included in capitation**	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Component Cost**	**Total Cost**

GRAND TOTAL:							
Total: Services included in capitation							
Total: Services not included in capitation							
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)							
FACTOR D (Divide grand total by number of participants)							
Services included in capitation							
Services not included in capitation							
AVERAGE LENGTH OF STAY ON THE WAIVER							

	Waiver Year: Year 5 (only appears if applicable based on Item 1-C)						
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7
Waiver Service / Component	**Check if included in capitation**	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Component Cost**	**Total Cost**

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							