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

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

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

1. Request Information

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

B. Program Title:
Acquired Brain Injury

C. Waiver Number:UT.0292
Original Base Waiver Number: UT.0292.

D. Amendment Number:UT.0292.R06.01

E. Proposed Effective Date: (mm/dd/yy)
~~05/01/25~~7/1/2026
Approved Effective Date: 05/01/25
Approved Effective Date of Waiver being Amended: 07/01/24

2. Purpose(s) of Amendment

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

-Increase the rate for Massage Therapy services
-Modification to Supported Employment Services

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☐ Waiver Application	

☐ Appendix A - Waiver Administration and Operation	

Component of the Approved Waiver	Subsection(s)
☐ Appendix B - Participant Access and Eligibility	
☐ Appendix C - Participant Services	
☐ Appendix D - Participant Centered Service Planning and Delivery	
☐ Appendix E - Participant Direction of Services	
☐ Appendix F - Participant Rights	
☐ Appendix G - Participant Safeguards	
☐ Appendix H	
☐ Appendix I - Financial Accountability	
☐ Appendix J - Cost-Neutrality Demonstration	

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

☐ **Modify target group(s)**

☐ **Modify Medicaid eligibility**

☐ **Add/delete services**

☐ **Revise service specifications**

☐ **Revise provider qualifications**

☐ **Increase/decrease number of participants**

☐ **Revise cost neutrality demonstration**

☐ **Add participant-direction of services**

☐ **Other**

Specify:

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

1. Request Information (1 of 3)

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

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

Acquired Brain Injury

C. Type of Request: amendment

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: UT.0292
Waiver Number:UT.0292.R06.01
Draft ID: UT.006.06.01

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/24
Approved Effective Date of Waiver being Amended: 07/01/24

PRA Disclosure Statement

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: July 31, 2027). The time required to complete this information collection is estimated to average 163 hours per response for a new waiver application and 78 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR § 440.160**

☒ **Nursing Facility**

Select applicable level of care

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

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of section 1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under section 1915(b) of the Act.**

Specify the section 1915(b) waiver program and indicate whether a section 1915(b) waiver application has been submitted or previously approved:

Specify the section 1915(b) authorities under which this program operates *(check each that applies):*

☐ **section 1915(b)(1) (mandated enrollment to managed care)**

☐ **section 1915(b)(2) (central broker)**

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

☐ **section 1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under section 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 section 1915(i) of the Act.**

☐ **A program authorized under section 1915(j) of the Act.**

☐ **A program authorized under section 1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

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

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

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

3. Components of the Waiver Request

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

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

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

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

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

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

◉ **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 section 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 section 1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ○ **Not Applicable**
- ○ **No**
- ◉ **Yes**

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

- ◉ **No**
- ○ **Yes**

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

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

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

5. Assurances

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

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

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

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

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

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the

Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

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

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

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

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

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

The SMA together with the Division of Services for People with Disabilities (DSPD) prepared an initial draft of the waiver renewal in August 2023. The SMA and DSPD then convened a workgroup consisting of advocates, providers, parents, ABI Waiver participants and others to discuss potential improvements and updates to the Waiver program. Updates to the renewal application were then crafted based on feedback from the workgroup.

Public comment on the waiver changes was solicited in the following ways:
Beginning February 29, 2024, and for 30 days thereafter, a copy of the draft State Implementation Plan was posted online at https://medicaid.utah.gov/ltc. Public comment was accepted by mail, fax and online submission. In addition, the State presented information on the waiver renewal to the Utah Indian Health Advisory Board (UIHAB) at their March meeting. The UIHAB represents all federally recognized Tribal Governments within the State. Additionally, information regarding the changes was supplied to the Medical Care Advisory Committee (MCAC) via email. Information on the amendment was published in the newspaper with instructions on how a copy of the implementation plan could be requested and how comment may be submitted. Hard copies were also made available at the Department of Health and Human Services upon request. The State did not receive any comments.

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

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

7. Contact Person(s)

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

Last Name: Ambrenac

First Name: Josip

Title: Director, Office of Long Term Services and Supports

Agency: Department of Health and Human Services, Division of Integrated Healthcare

Address: 288 N 1460 W

Address 2: PO Box 143112

City: Salt Lake City

State: **Utah**

Zip: 84114

Phone: (385) 251-5541 **Ext:** ☐ **TTY**

Fax: (801) 323-1588

E-mail: jambrena@utah.gov

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

Last Name: Pinna

First Name: Angie

Title: Division Director

Agency: Department of Health and Human Services, Division of Services for People with Disabilities

Address: 288 N 1460 W

Address 2: PO Box 145145

City: Salt Lake City

State: Utah

Zip: 84114

Phone: (801) 448-1782 **Ext:** ☐ **TTY**

Fax: (801) 538-4279

E-mail: apinna@utah.gov

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under section 1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature: Brian Roach

State Medicaid Director or Designee

Submission Date: Jun 20, 2025

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

Last Name: Strohecker

First Name: Jennifer

Title: Director, Division of Integrated Healthcare

Agency: Utah Department of Health and Human Services

Address: 288 N 1460 W

Address 2:

City:

Salt Lake City

State: **Utah**

Zip:

84015

Phone:

(801) 538-6293 **Ext:** ☐ **TTY**

Fax:

(801) 538-6860

E-mail:

jstrohecker@utah.gov

Attachments

Attachment #1: Transition Plan

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

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

☐ **Combining waivers.**

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

☐ **Eliminating a service.**

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

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

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

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

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

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

Specify the transition plan for the waiver:

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).

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

Specify the division/unit name:

The Division of Services for People with Disabilities

In accordance with 42 CFR § 431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

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

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

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

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

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

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

Oversight frequency will depend on the nature of the task/activity. For example, waiver alteration/amendments, rate setting, document/policy adjustments, and critical incident monitoring would happen on an ad hoc basis when required. In addition, other activities occur on a scheduled basis such as the review of level 2 incidents which occurs quarterly as well as the annual aggregation and review of established performance measures.

Appendix A: Waiver Administration and Operation

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

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

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

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

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

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the state

and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
As indicated in sections 3 and 4 of this appendix, no non-Medicaid or non-State agency performs waiver administration. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
As indicated in sections 3 and 4 of this appendix, no non-Medicaid or non-State agency performs waiver administration. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the 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:
 # and percentage % of participants who have a) had a reduction/denial of a waiver service; b) been denied choice of provider if more than one was available; or c) been determined ineligible when previously receiving services, who were provided timely notice of appeal rights. N = # of compliant cases in compliance; D = total # of cases with or without timely notification requiring notification.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Participant records/USTEPS

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

Data Aggregation and Analysis:

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

Performance Measure:
 # and % 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):
Record reviews, on-site
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):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

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

Data Aggregation and Analysis:

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

Performance Measure:
Number & percentage of individuals enrolled in the waiver in accordance with the SIP. Numerator is the number of individuals enrolled appropriately; Denominator is the total number of individuals either enrolled or denied either correctly or inappropriately.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Provider enrollment records

Responsible Party for data	**Frequency of data**	**Sampling Approach***(check*

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

Data Aggregation and Analysis:

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

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

Performance Measure:
 # and % 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 number of newly enrolled waiver providers with approved Medicaid provider agreements in place prior to receiving reimbursement;denominator is the total number of newly enrolled waiver providers receiving reimbursement.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
 # & % of applicants who did not meet the LOC at the time of application and were provided timely notice of appeal rights. Numerator is the total number of applicants who did not meet the LOC at the time of application and received a timely notice of appeal rights; denominator is the total number of applicants who did not meet LOC at the time of application.

Data Source (Select one):
Other
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**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

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

Data Aggregation and Analysis:

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

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

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

assistance to DSPD and other entities within the state that affect the operation of the waiver program.

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

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

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

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

ii. Remediation Data Aggregation

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

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target Sub Group	Minimum Age			Maximum Age			
						Maximum Age Limit			No Maximum Age Limit
☐ Aged or Disabled, or Both - General									
	☐	Aged							☐
	☐	Disabled (Physical)							
	☐	Disabled (Other)							
☒ Aged or Disabled, or Both - Specific Recognized Subgroups									
	☒	Brain Injury		18					☒
	☐	HIV/AIDS							☐
	☐	Medically Fragile							☐
	☐	Technology Dependent							☐
☐ Intellectual Disability or Developmental Disability, or Both									
	☐	Autism							☐
	☐	Developmental Disability							☐
	☐	Intellectual Disability							☐
☐ Mental Illness									
	☐	Mental Illness							☐
	☐	Serious Emotional Disturbance							

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

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

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

3. Individual must score between 36 and 136 on the Comprehensive Brain Injury Assessment (CBIA) form as outlined in R539-1-6(2)(d), UAC.
asd
4. This waiver is not available to individuals who have suffered congenital brain injury or brain injuries induced by birth trauma.

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

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

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

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Specify the percentage: [ ]

○ **Other**

Specify:

○ **Institutional Cost Limit.** Pursuant to 42 CFR § 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

○ **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

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

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	164
Year 2	164
Year 3	164
Year 4	164
Year 5	164

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

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

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

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	157
Year 2	157
Year 3	157
Year 4	157
Year 5	157

Appendix B: Participant Access and Eligibility

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

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

◉ **Not applicable. The state does not reserve capacity.**

○ **The state reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

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

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

◉ **The waiver is not subject to a phase-in or a phase-out schedule.**

○ **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

◉ **Waiver capacity is allocated/managed on a statewide basis.**

○ **Waiver capacity is allocated to local/regional non-state entities.**

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

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

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

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

2. Miller Trust State.

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

- ◉ **No**
- ○ **Yes**

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

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

- ☐ **Parents and Other Caretaker Relatives (42 CFR § 435.110)**
- ☐ **Pregnant Women (42 CFR § 435.116)**

☐ **Infants and Children under Age 19 (42 CFR § 435.118)**

☒ **SSI recipients**

☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR § 435.121**

☒ **Optional state supplement recipients**

☒ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

◉ **100% of the Federal poverty level (FPL)**

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

Specify percentage:

☒ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in section 1902(a)(10)(A)(ii)(XIII)) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in section 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 section 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 section 1902(e)(3) of the Act)**

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

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

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

Specify:

42 CFR 435.135
1634(c)/1634(d)
1902(a)(10)(A)(i)(II)

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

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

Select one:

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

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

Specify percentage:

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

Specify dollar amount:

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

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

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

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

Select one:

○ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR § 435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR § 435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under section 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 section 1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or section 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 period after September 30, 2027 (or other date as required by law).

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law) (select one).

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

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

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

○ **Use regular post-eligibility rules under 42 CFR § 435.726 (Section 1634 State/SSI Criteria State) or under § 435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under section 1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

b. Regular Post-Eligibility Treatment of Income: Section 1634 State and SSI Criteria State after September 30, 2027 (or other date as required by law).

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

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

○ **The following standard included under the state plan**

Select one:

○ **SSI standard**
○ **Optional state supplement standard**
○ **Medically needy income standard**
○ **The special income level for institutionalized persons**

(*select one*):

○ **300% of the SSI Federal Benefit Rate (FBR)**
○ **A percentage of the FBR, which is less than 300%**

Specify the percentage: [ ]

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

Specify dollar amount: [ ]

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

Specify percentage: [ ]

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

Specify:

[ ]

○ **The following dollar amount**

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

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

Specify:

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

○ **Other**

Specify:

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

◉ **Not Applicable**

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

Specify:

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

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

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

○ **Not Applicable (see instructions)**

○ **AFDC need standard**

◉ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR § 435.811 for a family of the same size. If this amount

changes, this item will be revised.

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

Specify:

○ **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR § 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

○ **Not Applicable (see instructions)** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

○ **The state does not establish reasonable limits.**

◉ **The state establishes the following reasonable limits**

Specify:

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

c. Regular Post-Eligibility Treatment of Income: 209(b) State or after September 30, 2027 (or other date as required by law).

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules after September 30, 2027 (or other date as required by law)

The state uses the post-eligibility rules of section 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 section 1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ○ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

  Specify percentage:
- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised
- ◉ **The following formula is used to determine the needs allowance:**

  Specify formula:

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

  Specify:

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

Select one:

- ◉ **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 or 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 selected.*
- ○ **The state does not establish reasonable limits.**
- ◉ **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

e. Regular Post-Eligibility Treatment of Income: Section 1634 State or SSI Criteria State – January 1, 2014 through September 30, 2027 (or other date as required by law).

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

f. Regular Post-Eligibility Treatment of Income: 209(b) State – January 1, 2014 through September 30, 2027 (or other date as required by law).

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules – January 1, 2014 through September 30, 2027 (or other date as required by law).

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

- ( ) **Directly by the Medicaid agency**
- (●) **By the operating agency specified in Appendix A**
- ( ) **By an entity 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:

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

Qualified support coordinators shall possess at least a Bachelor's degree in nursing, behavioral science, or a human services related field such as social work, sociology, special education, rehabilitation counseling, or psychology and demonstrate competency relating to the planning and delivery of health services to the Acquired Brain Injury population through successful completion of a training and testing program approved by the State Medicaid Agency. Although a variety of degrees may satisfy the requirements, majors such as geology and chemical engineering are not acceptable.

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

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

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

(2) The attending physician has determined that the applicant's level of dysfunction in orientation to person, place, or time requires nursing facility care; or equivalent care provided through a Medicaid Home and Community- Based Waiver program; or

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

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

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

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

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

The primary instrument used to determine level of care in nursing facilities is the Minimum Data Set (MDS) assessment. Because this assessment was designed to determine the needs of individuals residing in facility based settings, the state utilizes a tool that assesses the same elements, but that is geared toward assessing a person's needs and abilities in a community based setting. The Comprehensive Brain Injury Assessment (CBIA) serves as the standard comprehensive assessment instrument for this waiver and includes all the data fields necessary to measure the individual's level of care as defined in the state's Medicaid nursing facility admission criteria. It contains a thorough assessment of the individual's diagnostic and other health considerations, the individual's ability to complete activities of daily living and instrumental activities of daily living, and to assess additional services needed.

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

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

The CBIA is an assessment that is administered solely by Acquired Brain Injury Waiver support coordinators (ABISC) meeting the requirements described in B-6-c and who are employees of the operating agency, the Division of Services for People with Disabilities (DSPD), a governmental entity. DSPD developed the requirements, rules, and policies operationalized by the CBIA which were reviewed and approved by the State Medicaid Agency (SMA). Any revisions would similarly be reviewed and approved by the SMA.

CBIA findings identify a person's functional limitations and abilities. Findings inform decisions about the type, intensity, and duration of services that meet the person's support needs and goals. The CBIA shall be completed during intake for each person applying for brain injury services. For a person in service, the CBIA shall be administered annually; and when needed for a second opinion, after an institutional stay, and after a significant change in health status.

g. Reevaluation Schedule. Per 42 CFR § 441.303(c)(4), reevaluations of the level of care required by a participant are

conducted no less frequently than annually according to the following schedule *(select one)*:

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

Specify the other schedule:

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

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

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**

Specify the qualifications:

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

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

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

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

Appendix B: Evaluation/Reevaluation of Level of Care

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.***

Performance Measures

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

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

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

Performance Measures

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

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

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the state to

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

Performance Measure:
Number and percentage of 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):
Other
If 'Other' is selected, specify:
Participant records, CBIA 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):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence Level, 5% Margin of Error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percentage of initial Level of Care evaluations performed by an ABI support coordinator certified by DSPD. The numerator is the number of initial Level of Care evaluations which were performed by a certified ABI support coordinator; the denominator is the total number of initial Level of Care evaluations which were performed and reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Participant records, USTEPS

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

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

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Individual issues regarding the accuracy of level of care determination are addressed and corrected immediately by DSPD to assure that all participants meet nursing facility level of care. Plans of correction such as additional training may be required to assure future compliance. To assure all issues have been addressed, DSPD is required to report back to the SMA on the results of their interventions within the time frame stipulated in standard operating procedures and protocols or are stipulated on a case by case basis depending on the nature of a specific issue. Results of the reviews will be documented in the SMA's Final Reports which 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)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Every 2 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 Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

Freedom of Choice is documented on the Form 818b.

Freedom of choice procedures:

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

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access

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

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

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

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

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

Appendix C: Participant Services

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

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service
Statutory Service	**ABI Waiver Support Coordination**
Statutory Service	**Center-Based Prevocational Services**
Statutory Service	**Day Supports**
Statutory Service	**Homemaker**
Statutory Service	**Residential Habilitation**
Statutory Service	**Respite**
Statutory Service	**Supported Employment**
Supports for Participant Direction	**Consumer Preparation Services**
Supports for Participant Direction	**Financial Management Services**
Other Service	**Behavior Consultation I**
Other Service	**Behavior Consultation II**
Other Service	**Behavior Consultation III**
Other Service	**Chore Services**
Other Service	**Community Transition Service**
Other Service	**Companion Services**
Other Service	**Environmental Adaptations - Home**
Other Service	**Environmental Adaptations - Vehicle**
Other Service	**Extended Living Supports**
Other Service	**Massage Therapy**
Other Service	**Personal Budget Assistance**
Other Service	**Personal Emergency Response System**
Other Service	**Professional Medication Monitoring**
Other Service	**Specialized Medical Equipment/Supplies/Assistive Technology - Purchase**
Other Service	**Specialized Medical Equipment/Supplies/Assistive Technology- Monthly Fee**
Other Service	**Supported Living**
Other Service	**Transportation Services (non-medical)**

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

ABI Waiver Support Coordination

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)*:

ABI Waiver Support Coordination serves the purpose of: (a) establishing and maintaining the individual in the support system and the Home and Community-Based Services Waiver in accordance with program requirements and the individual's assessed support needs and (b) coordinating the delivery of quality waiver services.
Support Coordination assists individuals to: (a) establish Medicaid financial and categorical eligibility, (b) identify the supports necessary to insure the individual's health and safety, (c) write, coordinate, integrate, and assure the implementation of the individual's support plan, (d) gain access to waiver supports, State Plan services, medical, social, and educational assessments and services, and any other services, regardless of the funding source, and (e) develop a personal budget as a component of the individual support plan.
Support Coordination also involves activities to: (f) provide an initial assessment and ongoing reassessment of the individual's level of care determination, (g) facilitate a person-centered plan, (h) review the individual's support plan at such intervals as are specified in the Waiver Application document, (i) write and update personal social history, (j) provide ongoing monitoring to assure the provision and quality of the supports identified in the individual's support plan, (k) instruct the individual/legal representative/family how to independently obtain access to services and supports, regardless of funding source, (l) provide discharge planning services up to 90 days immediately prior to the date an individual living in a Nursing Facility is transitioned to the waiver, and (m) provide discharge planning services up to 90 days immediately prior to the date an individual is dis-enrolled from the waiver.

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

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Individual Medicaid Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: ABI Waiver Support Coordination

Provider Category:

Agency

Provider Type:

Individual Medicaid Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified by DSPD as an Acquired Brain Injury Support Coordinator (ABISC). The ABISC certification process is an internal process offered through DSPD.

Other Standard *(specify):*

Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Qualified support coordinators shall possess at least a Bachelor's degree in nursing, behavioral science or a human services related field such as social work, sociology, special education, rehabilitation counseling, or psychology and demonstrate competency relating to the planning and delivery of health services to the Acquired Brain Injury population through successful completion of a core curriculum and testing program approved by the State Medicaid Agency, leading towards certification of an Acquired Brain Injury Support Coordinator (ABISC). The certification process is an internal process offered through DSPD.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Services for People with Disabilities:

ABI Support Coordinators are monitored and evaluated on an ongoing basis by:
A) their DSPD Supervisors,
B) the ABI Program Manager, and
C) by the internally operated DSPD quality enhancement team

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

Center-Based 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 (Center-based prevocational services) provide learning and work experiences, including volunteer work, where the participant can develop general strengths and skills that contribute to employability in paid employment in integrated community settings. Prevocational services may be provided in a small group and/or on an individual basis. Prevocational activities are not primarily directed at teaching skills to perform a particular job, but are primarily directed at underlying habilitative goals that are associated with building skills necessary to perform work and optimally to perform competitive, integrated employment. Services occur over a defined period of time and with specific outcomes to be achieved, as determined by the participant and his/her service and supports planning team through the person-centered planning process.

Participants receiving prevocational services have employment-related goals in their person-centered service plan and the general service activities are designed to support such employment goals. Competitive, integrated employment in the community for which a participant is 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 is considered to be the optimal outcome of prevocational services.

Prevocational services should enable each participant to attain the highest level of work in the most integrated setting and with the job matched to the participant's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines. Services are intended to develop and teach general skills; Examples include, but are not limited to: ability to communicate effectively with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; general workplace safety and mobility training.

Prevocational services are provided in a hub and spoke model where services are delivered in both integrated community

settings and site-based settings. Participation in integrated community settings must be individualized according to the choices and needs of the participant and providers will be monitored to confirm a person-centered approach to community integration is maintained. Providers will be required to assure at least 20% of the time spent in this service on a monthly basis occurs in the community. Exceptions require an approved modification. Individuals participating in work as part of prevocational services are compensated in accordance with applicable state and Federal laws and regulations. The 20% will be evaluated during compliance monitoring over a 3 month period. Exceptions to the integration requirement will be evaluated by the individual's care planning team and reviewed by the provider's Human Rights Committee.

The level of community integration will be monitored throughout service delivery including review by the individual's Support Coordinator, during Quality Assurance monitoring, and with the authorization of the service during the development of the Person-Centered Service Plan (PCSP). Exceptions to the integration requirement may be considered for pre-approved health and safety concerns. The request/review for an exception will occur during the service authorization request process that is part of the PCSP development. The provider will be responsible to demonstrate what job skill requires development, opportunities for competitive integrated employment that had been explored, and what activities took place as part of required community integration. The State does not seek to authorize exceptions routinely, but only when a documented need can be supported.

Participants may also receive supported employment and/or day support services in conjunction with prevocational services according to the person centered plan, but they may not be billed during the same period of the day. Participation in prevocational services is not a required prerequisite for supported employment services and persons may pursue employment opportunities at any time.

Transportation at the start/end of the service encounter may be billed separately; transportation furnished during the provision of the service is included in the rate paid.

Pre-vocational services are limited to supporting or addressing the goals described in the individual's person centered services and supports plan and are designed to teach skills that will lead to integrated competitive employment.

All prevocational services and/or goals are 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.

Services that teach job task specific skills required by a participant for the primary purpose of completing those tasks for a specific facility based job and are not delivered in an integrated work setting through supported employment are not reimbursed.

Activities of Daily Living may be a component part of this service but cannot comprise the entirety of the service. The services under the Acquired Brain Injury Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Services may be provided 1:1 or in small groups to account for individuals coming/going throughout the day as they engage in other activities such as school, employment, day supports, or possibly when engaging in activities intended for community integration depending on the needs/desires of the individual. Group sizes are recommended to be 4 or under.

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

Limitations: Prevocational services are generally limited to 24 consecutive months except with an approved modification that is aligned with the person-centered support plan. Participants may return to additional 24-month periods of prevocational services with the same stipulations after an interruption without a lifetime limit.

Payment will only be made for adaptations, supervision and training required by an individual 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 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. 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.

Pre-vocational services are limited to supporting or addressing the goals described in the individual's person centered services and supports plan and are designed to teach skills that will lead to integrated competitive employment.

All prevocational services and/or goals are 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.

Services that teach job task specific skills required by a participant for the primary purpose of completing those tasks for a specific facility based job and are not delivered in an integrated work setting through supported employment are not reimbursed.

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Employment Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Center-Based Prevocational Services

Provider Category:

Agency

Provider Type:

Supported Employment Provider

Provider Qualifications

License *(specify)*:

Current Business License

Certificate *(specify)*:

Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Other Standard *(specify)*:

Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Enrolled as a Medicaid provider

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

Entity Responsible for Verification:

Division of Services for People with Disabilities

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

Day Supports

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):*

Day Supports provide assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that build interpersonal competence, independence, and personal choice. Services are most commonly provided in integrated community settings with individuals without disabilities (not including staff paid to support the person), with some services provided in a combination of integrated community settings with a licensed day support setting or the person's residence functioning as a hub according to individual choice and needs. This service may also include training and supports designed

to maintain skills and functioning rather than acquiring new skills or improving skills.
Services shall normally be furnished on routine workdays on a regularly scheduled basis.

Day supports shall focus on enabling the individual to attain or maintain their maximum functional level and increase community connections, integration, and personal choice. Day supports are offered on a 15-minute unit and intermittent basis as well as on a daily basis. It may be provided individually or in small groups. The nature of the Day Supports services offered to each individual is based upon an assessment of the needs of the individual at the time and may change over time.

Elements of Day Supports:
Site Based Day Supports – services provided in a licensed setting in which 4 or more individuals attend.
Non-Site Based Day Supports – designed to take place in the community and are driven by the individual's preferences.
Senior Supports – designed for individuals who have needs that closely resemble those of older persons who desire a lifestyle consistent with that of the community's population of similar age or circumstances. The support is intended to facilitate independence, promote community inclusion and prevent isolation.

Assistance with activities of daily living may occur during the provision of this service. Transportation at the start/end of the service encounter may be billed separately. Transportation furnished during the provision of the service is included in the rate paid.

Activities of Daily Living may be a component part of this service but cannot comprise the entirety of the service. The services under the Acquired Brain Injury Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

Limitations: Individuals receiving Day Supports are not eligible to receive separate, individual waiver services in addition to this service if the separate service is essentially duplicative of the tasks defined in Day Supports. Individuals receiving Day Supports services may not receive the Extended Living service simultaneously. This service is not available to individuals eligible to receive this service through the Medicaid State Plan or other funding source. Day Supports may not provide for the payment of services that are vocational in nature. (i.e., for the primary purpose of producing goods or performing services.)

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Day Supports Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Supports

Provider Category:

Agency

Provider Type:

Day Supports Provider

Provider Qualifications

License *(specify):*

Site based:
R501-2, UAC
R539-6, UAC
R539-7, UAC
(4 or more individuals)

Certificate *(specify):*

Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Other Standard *(specify):*

Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Enrolled as a Medicaid provider

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Services for People with Disabilities

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

Service Definition *(Scope):*

Homemaker services consist of the performance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.

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

Limitations: These services will be provided only in the case where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision. Homemaker Services are not available to individuals receiving other waiver services in which the services are essentially duplicative of the tasks defined in Homemaker Services.

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.

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency Based--Homemaker
Individual	Self-directed --Homemaker

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Agency Based--Homemaker

Provider Qualifications

License *(specify):*

Current business license.

Certificate *(specify):*

Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Other Standard *(specify):*

Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Enrolled as a Medicaid provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Services for People with Disabilities.

Frequency of Verification:

Annually.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Individual

Provider Type:

Self-directed --Homemaker

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Other Standard *(specify):*

Under state contract with 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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Services for People with Disabilities

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

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

Service Definition *(Scope):*

Residential Habilitation means individually tailored supports that assist with acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Residential habilitation also includes personal care and protective oversight and supervision.

Residential Habilitation Settings:

Group Homes - Licensed facilities in which 4 or more individuals reside

Supervised Private Residences - Individual supervised apartments or home settings in which 3 individuals or less reside

Host Homes - Supervised Private Residences for 3 or less individuals.

On average, daily services/rates are rendered for 18 hours during the week when in school or at work and for 24 hours during the weekend or holidays.

Activities of Daily Living may be a component part of this service but cannot comprise the entirety of the service. The services under the Acquired Brain Injury Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

Limitations: Payment is not made for the cost of room and board, the cost of building maintenance, upkeep and improvement, or to meet the requirements of the applicable life safety code. Payment is not made, directly or indirectly, to members of the individual's immediate family. Payment for this service is also unavailable to those who are simultaneously receiving any other services within this waiver that would be duplicative or overlapping in nature of the services contained within this service definition.

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.

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Residential Habilitation Services

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

Residential Habilitation Services

Provider Qualifications

License *(specify):*

R501-2 UAC,
R539-6 UAC
(4 or more individuals)

Certificate *(specify):*

Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Other Standard *(specify):*

Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Enrolled as a Medicaid provider

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Services for People with Disabilities

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

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):*

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

Daily services/rates are rendered for six hours or more per day.

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

Limitations: Payments for respite services are not made for room and board except when provided as a part of respite care in a setting, approved by the State that is not the individual's private residence. In the case of respite care services that are rendered out of the consumer's private residence in a setting approved by the State for a period of six hours or more, this service will be billed under a specific Respite Care-Out of the home/Room and Board included billing code.

In the case of services contained within this definition provided in the provider's or the consumer's home, in no case will more than four (4) individuals be served by the provider at any one time, except that the provider's children over the age of 14 will not be counted toward the limit of four. In the case of services included in this definition provided by a facility-based program, staff to client ratios maintained by providers must fully conform to all relevant specifications in applicable licensing statutes or administrative rule. Individuals receiving services within the Day Supports or Supported Living services may receive Respite Care-Routine services only on an hourly and not a daily basis and only during times that they are not receiving Day Supports or Supported Living services, when the need exists and approval has been granted in advance for the utilization of this service by the appropriate DSPD designee.

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.

This service is not for ongoing daycare nor is this service intended to supplant resources otherwise available for child-care.

Respite care may not be offered at the same time as the person is receiving any other service, either contained within this Home and Community-Based Services waiver or from other sources including the Medicaid State Plan that will afford the person with care and supervision. Respite care may not be offered for relief or substitution of staff paid to provide care and supervision to persons as part of the residential or day habilitation services they receive in this Home and Community-Based Services waiver.

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Self-directedRespite
Agency	Agency based--Respite

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Self-directedRespite

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Other Standard *(specify)*:

Under state contract with 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

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Services for People with Disabilities

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Agency based--Respite

Provider Qualifications

License *(specify):*

Licensed by the State of Utah as a specific category of facility/agency as follows:

Licensed Residential Treatment Programs R501-19, UAC
Licensed Residential Support Programs R501-22, UAC
Nursing Facility: R432-150, UAC
Assisted Living Facility: R432-270, UAC

Certificate *(specify):*

Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Other Standard *(specify):*

Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Enrolled as a Medicaid provider

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Services for People with Disabilities

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

Service Definition *(Scope):*

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

Supported Employment can be provided to an individual who is employed in either full or part time employment and occurs in a work setting where the individual works with individuals without disabilities (not including staff or contracted co-workers paid to support the individual). Supported Employment may occur anytime during a twenty-four hour day and supports are made available in such a way as to assist the individual 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). Individuals in Supported Employment are supported and employed consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individual as indicated in the individual's support plan. An individual may be supported individually or in a group. Supported Employment may also include activities and supports designed to assist individuals who are interested in creating and maintaining their own business enterprises.

These are services provided to maintain integrated and competitive employment. Any of the following activities may be included:

- Job coaching- initial and ongoing:
• 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

Supports to Obtain Employment

Leading up to job placement, the provider's duties may include, but are not limited to, the following:

-Job Development:

- Vocational Assessment
- Identify potential employers and job opportunities
- Networking with potential employers
- Develop, implement, and train on job strategies
- Job site analysis
- Job shadowing
- Paid Internships
- Mock Interviews
- Local Business visits
- 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.)
- 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).

Job Development- Participants receive support to achieve Competitive Integrated Employment that is based on the Person's strengths and interests.

Elements of Supported Employment Services:

Supported Employment Co-Worker Services - provider contracts with a co-worker to provide additional support under the direction of a job coach as a natural extension of the workday.
Supported Employment Enclave/Mobile Work Crew - A small crew of waiver participants, or enclave are trained and supervised amongst employees without disabilities at the host company's worksite, or the crew may operate a self-contained business that operates at multiple locations within the community, under the supervision of a job coach.
Supported Employment - Customized Employment - Individuals desiring to create and implement their own business enterprises receive training, instruction and coaching from a provider in such topics as: creating a business plan, conducting a market analysis, obtaining business financing, implementing the business and managing financial accounts.

Daily services/rates are rendered when Supported Employment services are provided for six hours or more per day by a provider.

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 an individual as a result of the individual'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.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Employment Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

Supported Employment Provider

Provider Qualifications

License *(specify):*

Current Business license

Certificate *(specify):*

Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Other Standard *(specify):*

Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Enrolled as a Medicaid provider

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Services for People with Disabilities

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Other Supports for Participant Direction

Alternate Service Title (if any):

Consumer Preparation Services

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*

Consumer Preparation Services ensure that waiver recipients are prepared to supervise and direct their self-administered services providers. Consumer Preparation Services includes: (a) instruction in methods of identifying need and effectively communicating those needs to service providers; (b) instruction in management of provider(s) including interviewing, selecting, scheduling, termination, time sheeting, evaluating performance, back up coverage; (c) instruction in addressing problems such as changing levels of personal needs, grievance procedures, emergency coverage, exploitation and abuse. Consumer Preparation Services do not include educational, vocational or prevocational components.

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

Limitations: Limits on the amount, frequency and/or duration are specified on the individual's plan of care and based on assessed need.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency-based Consumer Preparation Services Provider

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Consumer Preparation Services

Provider Category:

Agency

Provider Type:

Agency-based Consumer Preparation Services Provider

Provider Qualifications

License *(specify):*

Current business license

Certificate *(specify):*

Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Other Standard *(specify):*

Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Enrolled as a Medicaid provider

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Services for People with Disabilities

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

HCBS Taxonomy:

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

Service Definition *(Scope):*

Financial Management Services is offered in support of the self-administered services delivery option. Services rendered under this definition include those to facilitate the employment of personal attendants or assistants by the individual or

designated representative including:
a) Provider qualification verification;
b) Employer-related activities including federal, state, and local tax withholding/payments, unemployment compensation fees, wage settlements, fiscal accounting and expenditure reports;
c) Medicaid claims processing and reimbursement distribution; and
d) Providing monthly accounting and expense reports to the consumer.

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

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

☐ **Participant-directed as specified in Appendix E**
☒ **Provider managed**
☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Public Accounting Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Licensed Public Accounting Agency

Provider Qualifications

License *(specify)*:

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

Certificate *(specify)*:

Certified by the DSPD as an authorized provider of services and supports.

Other Standard *(specify)*:

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

provider/employee file.

Act on behalf of the person receiving supports and services for the purpose of payroll reporting.

Develop and implement an effective payroll system that addresses all related tax obligations.

Make related payments as approved in the persons budget, authorized by the case management agency.

Generate payroll checks in a timely and accurate manner and in compliance with all federal and state regulations pertaining to domestic service workers.

Conduct background checks as required and maintain results in employee file.

Process all employment records.

Obtain authorization to represent the individual/person receiving supports.

Prepare and distribute an application package of information that is clear and easy for the individuals hiring their own staff to understand and follow.

Establish and maintain a record for each employee and process employee employment application package and documentation.

Utilize and accounting information system to invoice and receive Medicaid reimbursement funds.

Utilize and accounting and information system to track and report the distribution of Medicaid reimbursement funds.

Generate a detailed Medicaid reimbursement funds distribution report to the individual Medicaid recipient or representative semi-annually.

Withhold, file and deposit FICA, FUTA and SUTA taxes in accordance with federal IRS and DOL, and state rules.

Generate and distribute IRS W-2s. Wage and Tax Statements and related documentation annually to all support workers who meet the statutory threshold earnings amounts during the tax year by January 31st.

File and deposit federal and state income taxes in accordance with federal IRS and state rules and regulations.

Assure that employees are paid established unit rates in accordance with the federal and state Department of Labor Fair Labor Standards Act (FLSA)

Process all judgments, garnishments, tax levies or any related holds on an employees funds as may be required by local, state or federal laws.

Distribute, collect and process all employee time sheets as summarized on payroll summary sheets completed by the person or his/her representative.

Prepare employee payroll checks, at least monthly, sending them directly to the employees.

Keep abreast of all laws and regulations relevant to the responsibilities it has undertaken with regard to the required federal and state filings and the activities related to being a Fiscal/Employer Agent.

Establish a customer service mechanism in order to respond to calls from individuals or their representative employers and workers regarding issues such as withholding and net payments, lost or late checks, reports and other documentation.

Customer service representatives are able to communicate effectively in English and Spanish by voice and TTY with people who have a variety of disabilities.

Have a Disaster Recovery Plan for restoring software and master files and hardware backup if management information systems are disabled so that payroll and invoice payment systems remain intact.

Regularly file and perform accounting auditing to ensure system accuracy and compliance with general accounting practice.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Division of Services for People with Disabilities

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Behavior Consultation I

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):*

Behavior Consultation I
Includes the provision of generally accepted educational procedures and techniques that are designed to decrease problem behavior and increase appropriate replacement behaviors. This service is intended to assist individuals in acquiring and maintaining the skills necessary for the capacity to live independently in their communities and avoid placement in a Nursing Facility (NF) and therefore, this service is intended to be habilitative in nature. Consultations are based upon the well-known and widely regarded principles of applied behavior coaching and focus on positive behavior supports. Behavioral consultants provide services to individuals whose behavior problems may be emerging, annoying, worrisome, objectionable, singular but not dangerous, and may interfere with learning or social relationships. The behaviors of the person shall not constitute an impending crisis, nor shall they be assessed as constituting a serious problem. The family and/or support staff with whom the consultant is working will have no special needs/issues beyond consultation and skill training and will be capable of coordinating with schools, agencies, and others as needed. Consultation may include the development of a behavior program which employs widely accepted principles of applied behavior analysis that are applicable to many and which focus on the provision of positive behavioral supports (and which does not include any intrusive interventions). Services are to be provided in the person's residence or other naturally occurring environment in the community.

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

Limitations: This service will not be available to individuals who might otherwise receive this service through the Medicaid State Plan or any other funding source.

The services under Behavioral Consultation I, II, III are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency-basedBehavior Consultation Service I
Individual	Behaviorist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Consultation I

Provider Category:

Agency

Provider Type:

Agency-basedBehavior Consultation Service I

Provider Qualifications

License *(specify):*

Current business license

Certificate *(specify):*

Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Other Standard *(specify):*

Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA
Training and experience in the field of acquired brain injuries of at least one years length; completion of a training course in positive behavioral supports prescribed by DSPD and approved by the SMA and the successful completion of a learning assessment at the conclusion of the course.

Enrolled as a Medicaid provider

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Services for People with Disabilities

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Consultation I

Provider Category:

Individual

Provider Type:

Behaviorist

Provider Qualifications

License *(specify):*

Current business license

Certificate *(specify):*

Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Other Standard *(specify):*

Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA

Training and experience in the field of acquired brain injuries of at least one years length; completion of a training course in positive behavioral supports prescribed by DSPD and approved by the SMA and the successful completion of a learning assessment at the conclusion of the course.
Enrolled as a Medicaid provider

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Services for People with Disabilities

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Behavior Consultation II

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):*

Behavior Consultation II includes the provision of educational procedures and techniques that are designed to decrease

problem behavior and increase appropriate replacement behaviors. This service is intended to assist individuals in acquiring and maintaining the skills necessary for the capacity to live independently in their communities and avoid placement in a Nursing Facility (NF) and therefore, this service is intended to be habilitative in nature. Interventions are based upon the principles of applied behavior analysis and focus on positive behavior supports. Behavior consultants provide individual behavior consultation to families and/or staff who support individuals with serious though not potentially life threatening behavioral problems that may be complicated by medical or other factors. Problems addressed by behavior consultants are identified as serious, but have not been judged to be treatment resistant or refractory. Consultation shall include designing the behavior support plan and training the family and/or support staff on a behavior support plan developed specifically for the person being served. Services are to be provided in the person's residence or other naturally occurring environment in the community. This service is consultative in nature and does not include the provision of any direct services to consumers.

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

Limitations: 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. No direct care services can be provided under this service definition. This service is not available to individuals eligible to receive this service through the Medicaid State Plan or other funding source.

The services under Behavioral Consultation I, II, III are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency-basedBehavior Consultation Service II
Individual	Behaviorist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Consultation II

Provider Category:

Agency

Provider Type:

Agency-basedBehavior Consultation Service II

Provider Qualifications

License *(specify):*

Current business license

Certificate *(specify):*

Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Other Standard *(specify):*

Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance

with 62A-5-103, UCA
Board Certified Associate Behavior Analysts (BCABA); or proof of achievement of a post-graduate degree of at least a Masters in a behaviorally-related field as well as experience of at least one year working in the field of brain injury or other related conditions.
Completion of a training course in positive behavioral supports prescribed by DSPD and approved by the SMA and the successful completion of a learning assessment at the conclusion of the course.

Enrolled as a Medicaid provider

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Services for People with Disabilities

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Consultation II

Provider Category:

Individual

Provider Type:

Behaviorist

Provider Qualifications

License *(specify):*

Current business license

Certificate *(specify):*

Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Other Standard *(specify):*

Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA
Board Certified Associate Behavior Analysts (BCABA); or proof of achievement of a post-graduate degree of at least a Masters in a behaviorally-related field as well as experience of at least one year working in the field of brain injury or other related conditions.
Completion of a training course in positive behavioral supports prescribed by DSPD and approved by the SMA and the successful completion of a learning assessment at the conclusion of the course.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Services for People with Disabilities

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Behavior Consultation III

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):*

Behavior Consultation III includes the provision of educational procedures and techniques that are designed to decrease problem behavior and increase appropriate replacement behaviors. This service is intended to assist individuals in acquiring and maintaining the skills necessary for the capacity to live independently in their communities and avoid placement in a Nursing Facility (NF) and therefore, this service is intended to be habilitative in nature. Interventions are based upon the principles of applied behavior analysis and focus on positive behavior supports. Behavioral consultants provide individual behavioral consultation to families and/or staff who support individuals with the most involved, complex, difficult, dangerous, potentially life threatening and resistant to change behavioral problems. The serious behavioral problems may be complicated by medical or other factors. In addition, eligible persons must have failed alternative interventions and are severely limited in their activities and opportunities due to their behavioral problems. Consultation shall include designing and training the family and/or support staff on a behavior support plan developed specifically for the person being served. Services are to be provided in the person's residence or other naturally occurring environment in the community. This service is consultative in nature and does not include the provision of any direct services to consumers.

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

Limitations: 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. No direct care services can be provided under this service definition. This service is not available to individuals eligible to receive this service through the Medicaid State Plan or other funding source.

The services under Behavioral Consultation I, II, III are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Behaviorist
Agency	Agency-based-- Behavior Consultation Service III Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Consultation III

Provider Category:

Individual

Provider Type:

Behaviorist

Provider Qualifications

License *(specify)*:

Current business license

Certificate *(specify)*:

Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Other Standard *(specify)*:

Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA

Board Certified Behavior Analysts (BCBA); or proof of achievement of a post-graduate degree of a doctoral level in a behaviorally related field and a combination of training and experience equivalent to that required for certification as a Board Certified Behavior Analysts.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Services for People with Disabilities

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Consultation III

Provider Category:

Agency

Provider Type:

Agency-based-- Behavior Consultation Service III Provider

Provider Qualifications

License *(specify):*

Current business license

Certificate *(specify):*

Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Other Standard *(specify):*

Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA

Board Certified Behavior Analysts (BCBA); or proof of achievement of a post-graduate degree of a doctoral level in a behaviorally related field and a combination of training and experience equivalent to that required for certification as a Board Certified Behavior Analysts.

Enrolled as Medicaid provider

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Services for People with Disabilities

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Chore Services

HCBS Taxonomy:

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

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

Service Definition *(Scope):*

Chore Services serve the purpose of maintaining a clean, sanitary and safe living environment in the individual's residence.

Chore Services involve heavy household tasks such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress.

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

Limitations: These services will be provided only in cases where the individual lacks the ability to perform or financially provide for the services, and no other relative, caregiver, landlord, community/volunteer agency, third party payer, or other informal support system is capable of or responsible to perform or financially provide for the services. In the case of rental property, the responsibility of the landlord, pursuant to the lease arrangement, will be examined prior to any authorization of service.

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency-basedChore Services
Individual	Self-directed--Chore Services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore Services

Provider Category:

Agency

Provider Type:

Agency-basedChore Services

Provider Qualifications

License *(specify):*

Current business license

Certificate *(specify):*

Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Other Standard *(specify):*

Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Enrolled as a Medicaid provider

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Services for People with Disabilities

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore Services

Provider Category:

Individual

Provider Type:

Self-directed--Chore Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA and R539-5.

Other Standard *(specify):*

Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Completed Provider Agreement

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Services for People with Disabilities

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Transition Service

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):*

Community Transitions Services are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. This service provides set-up expenses/allowable expenses that are necessary to enable a person to establish a basic household that do not constitute room and board and may include a bed, a table, chairs, bathroom/bedroom linens, pots, pans, storage containers needed for food preparation, utensils, plates, dishes, bowls, cups, non-refundable set-up fees or deposits for utility or service access (e.g. telephone, electricity, heating).

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

Limitations: Reimbursement for the cost of rent or food is not a covered expense under this service. Reimbursable items are limited to only those household items that are essential. Reimbursement for entertainment and diversional items such as televisions, stereos, DVD players, VCRÂs, CD players, or gaming systems, etc. is prohibited. Reimbursement for the cost of refundable fees or deposits is not a covered expense under this service.

This service requires prior authorization by a Division of Services for People with Disabilities designee and is only available to those transitioning from a more restrictive living arrangement to a less restrictive living arrangement. (Federal matching funds will not be claimed for those moving from facility-based care until the individual is enrolled in the waiver.) This service is available only after attempts to access start-up items from all alternative sources have been exhausted. Efforts to access alternative sources must be documented in the individualÂs case file. Copies of this documentation must be submitted to the Division of Services for People with Disabilities prior authorization designee for review. This service is only available for assisting individuals in transitioning to a living arrangement in a private residence where the person is responsible for his or her living expenses.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Living Start-up Costs Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Service

Provider Category:

Agency

Provider Type:

Living Start-up Costs Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Enrolled as a Medicaid provider

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Services for People with Disabilities

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Companion 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):*

Companion Services involve non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the Individual Support Plan, and is not purely diversional in nature.

Daily services/rates are rendered for six hours or more per day.

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

Limitations: Companion Services are not available to individuals receiving other waiver services in which the services are essentially duplicative of the tasks defined in Companion Services. Individuals receiving services within the Day Supports or Supported Living may receive Companion Services only in 15 minute increments and not a daily basis, when the need exists and approval has been granted by DSPD in advance for the utilization of this service.

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.

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

☒ **Participant-directed as specified in Appendix E**
☒ **Provider managed**
☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency-basedCompanion Services Provider
Individual	Self-directed--Companion Services Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Companion Services

Provider Category:

Agency

Provider Type:

Agency-basedCompanion Services Provider

Provider Qualifications

License *(specify):*

Current business license

Certificate *(specify):*

Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Other Standard *(specify):*

Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA

Enrolled as a Medicaid provider

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Services for People with Disabilities

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Companion Services

Provider Category:

Individual

Provider Type:

Self-directed--Companion Services Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Other Standard *(specify):*

Under state contract with 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

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Services for People with Disabilities

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental 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 for the home involve equipment and/or physical adaptations to the individual's residence 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. 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 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 home, which are of general utility, and are not of direct medical or remedial benefit to the individual. General household repairs are not included but repairs to housing 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). All services shall be provided in accordance with applicable State or local building codes.

Home accessibility 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.

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

☐ **Participant-directed as specified in Appendix E**
☒ **Provider managed**
☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Environmental Adaptations Supplier

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Adaptations - Home

Provider Category:

Agency

Provider Type:

Environmental Adaptations Supplier

Provider Qualifications

License *(specify):*

Current business license.
(and Contractors license when applicable)

Certificate *(specify):*

Other Standard *(specify):*

Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Services for People with Disabilities

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental 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). 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.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Vehicle Environmental Adaptations Suppliers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Adaptations - Vehicle

Provider Category:

Agency

Provider Type:

Vehicle Environmental Adaptations Suppliers

Provider Qualifications

License *(specify):*

Current business license.
(and Contractors license when applicable)

Certificate *(specify):*

Other Standard *(specify):*

Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Services for People with Disabilities

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Extended Living Supports

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):*

Extended Living Supports provides supervision, socialization, personal care and supports for persons who reside in a community living setting during the period of time they would normally be attending an employment, day or school program. Extended living supports are intended to be utilized for short periods of time, such as illness, recovery from surgery and/or transition between service providers and are not intended for long term use in lieu of supported employment, day supports or school programs.

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

Limitations: Individuals receiving Extended Living Supports may not receive Day Supports Services simultaneously.

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Extended Living Supports Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Extended Living Supports

Provider Category:

Agency

Provider Type:

Extended Living Supports Provider

Provider Qualifications

License *(specify)*:

R501-2 UAC,
R539-6 UAC
(4 or more individuals)

Certificate *(specify)*:

Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Other Standard *(specify)*:

Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Enrolled as Medicaid provider

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Services for People with Disabilities

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Massage Therapy

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):*

Massage Therapy is the provision of therapeutic services delivered by licensed massage therapists intended to provide comfort, stress and tension relief and reduction, and other health-related benefits consistent with the practice of massage therapy. This service is intended to accomplish a clearly defined outcome that is outlined in the person centered support plan.

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

The amount, frequency and duration provided will be reflective of the prescription completed by a medical professional for medical benefit to the person. This service is only available after all other funding sources have been exhausted.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Massage Therapy Provider
Individual	Licensed Massage Therapist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Massage Therapy

Provider Category:

Agency

Provider Type:

Massage Therapy Provider

Provider Qualifications

License *(specify):*

Current business license

Certificate *(specify):*

Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Other Standard *(specify):*

Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Enrolled as a Medicaid provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Services for People with Disabilities

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Massage Therapy

Provider Category:

Individual

Provider Type:

Licensed Massage Therapist

Provider Qualifications

License *(specify):*

Sec. 58-47b, UCA and R156-47b, UAC

Certificate *(specify):*

Other Standard *(specify):*

Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Enrolled as a Medicaid provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Services for People with Disabilities

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Budget Assistance

HCBS Taxonomy:

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

Service Definition *(Scope):*

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

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

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency-based - Personal Budget Assistance Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Budget Assistance

Provider Category:

Agency

Provider Type:

Agency-based - Personal Budget Assistance Provider

Provider Qualifications

License *(specify):*

Current business license

Certificate *(specify):*

Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Other Standard *(specify):*

Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Enrolled as a Medicaid provider

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Services for People with Disabilities

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response System

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):*

Personal Emergency Response Systems serve the purpose of enabling the individual who has the skills to live independently or with minimal support to summon assistance in case of an emergency.

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

Elements of Personal Emergency Response System:
Installation and testing of the Personal Emergency Response System
Monthly Fee is the periodic service fees (e.g., monthly) for ongoing support services and or rental associated with the Personal Emergency Response System
Purchase of Personal Emergency Response System

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

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Emergency Response System Installer
Agency	Emergency Response System Supplier
Agency	Personal Emergency Response Center

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System

Provider Category:
Agency

Provider Type:

Personal Emergency Response System Installer

Provider Qualifications

License *(specify):*

Current business license

Certificate *(specify):*

Other Standard *(specify):*

Demonstrated ability to properly install and test specific equipment being handled. Medicaid provider enrolled to provide personal emergency response system services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Services for People with Disabilities

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System

Provider Category:

Agency

Provider Type:

Emergency Response System Supplier

Provider Qualifications

License *(specify):*

Current business license

Certificate *(specify):*

Other Standard *(specify):*

FCC registration of equipment placed in individuals home.

Enrolled with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Enrolled as a Medicaid provider

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Services for People with Disabilities

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System

Provider Category:

Agency

Provider Type:

Personal Emergency Response Center

Provider Qualifications

License *(specify):*

Current business license

Certificate *(specify):*

Other Standard *(specify):*

24 hour per day operation, 7 days per week. Medicaid provider enrolled to provide personal emergency response system services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Services for People with Disabilities

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Professional Medication Monitoring

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):*

Professional Medication Monitoring provides testing and nursing services necessary to provide medication management to assure the health and welfare of the person. This service includes regularly scheduled, periodic visits by a nurse in order to conduct an assessment of the individual with regard to their health and safety particularly as it is affected by the maintenance medication regimen that has been prescribed by their physician, to review and monitor for the presence and timely completion of necessary laboratory testing related to the medication regimen, and to offer patient instruction and education regarding this medication regimen. Nurses will also provide assistance to the individual by ensuring that all pill-dispensing aids are suitably stocked and refilled.

This service may be available to waiver participants with an assessed need, including those receiving residential habilitative supports as the scope may not consider clinical oversight and monitoring of an individual's medication regimen.

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

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

The services under Professional Medication Monitoring are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Professional Medication Monitoring Provider
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Professional Medication Monitoring

Provider Category:

Individual

Provider Type:

Professional Medication Monitoring Provider

Provider Qualifications

License *(specify):*

RN and LPN:
Sec. 58-31b, UCA and R156-31b UAC

Certificate *(specify):*

Other Standard *(specify):*

Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Enrolled as a Medicaid provider

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Services for People with Disabilities

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Professional Medication Monitoring

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Licensed Home Health Agency

Certificate *(specify):*

Certified Home Health Agency

Other Standard *(specify):*

Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Services for People with Disabilities

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Medical Equipment/Supplies/Assistive Technology - 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 individuals 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 individual. 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 individual's PCSP.

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

Limitations: Expenditures for specialized medical equipment and supplies will be in accordance with Division of Services for People with Disabilities policy and all purchases will comply with State procurement requirements. Each item of specialized medical equipment and medical supplies must be prior approved based on a determination of medical necessity and a determination that the item is not available as a Medicaid State Plan service, or may not be considered through EPSDT for those who meet age criteria.

Home accessibility adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.

The services under Medical Equipment and Supplies, Assistive Technology and Home Accessibility Adaptations are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medical equipment and supply suppliers
Individual	Automated Medication Dispensary Equipment and Supply Suppliers

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Medical equipment and supply suppliers

Provider Qualifications

License *(specify):*

Current business license

Certificate *(specify):*

Other Standard *(specify):*

Enrolled with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Enrolled as a Medicaid provider

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Services for People with Disabilities

Frequency of Verification:

Annually

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Automated Medication Dispensary Equipment and Supply Suppliers

Provider Qualifications

License *(specify):*

Current business license

Certificate *(specify):*

Other Standard *(specify):*

FCC registration of equipment placed in individuals home.
Enrolled with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.
Enrolled as a Medicaid provider.
Automated Medication Dispensary Device Installer - Demonstrated ability to properly install and test specific equipment being handled.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Services for People with Disabilities

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Medical Equipment/Supplies/Assistive Technology- Monthly 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 - Monthly Fee includes 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 individuals 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 individual. 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 individual's PCSP.

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

Limitations: Expenditures for specialized medical equipment and supplies will be in accordance with Division of Services for People with Disabilities policy and all purchases will comply with State procurement requirements. Each item of specialized medical equipment and medical supplies must be prior approved based on a determination of medical necessity, a determination that the item is not available as a Medicaid State Plan service, or may not be considered through EPSDT for those who meet age criteria, and a determination that rental or payment of a monthly fee for equipment or supplies is a more cost effective than purchasing the equipment outright.

Home accessibility adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.

The services under Medical Equipment and Supplies, Assistive Technology and Home Accessibility Adaptations are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Automated Medication Dispensary Equipment and Supply Suppliers
Agency	Medical equipment and supply suppliers

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Automated Medication Dispensary Equipment and Supply Suppliers

Provider Qualifications

License *(specify):*

Current business license

Certificate *(specify):*

Other Standard *(specify):*

FCC registration of equipment placed in individuals home.

Enrolled with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Enrolled as a Medicaid provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Services for People with Disabilities

Frequency of Verification:

Annually

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Medical equipment and supply suppliers

Provider Qualifications

License *(specify):*

Current business license

Certificate *(specify):*

Other Standard *(specify):*

Enrolled with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Enrolled as a Medicaid provider

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Services for People with Disabilities

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Supported Living

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 Living constitutes individually tailored hourly support, supervision, training and assistance for people to live as independently as possible in their own homes, family homes and apartments. Supported living is available to those who live alone, with family or with roommates. For individuals residing with families, Supported Living is intended to provide support to the individual and the family to allow the family to continue providing naturals supports and to avoid unwanted out of home placement. Supported living activities are prioritized based upon the individual's assessed needs, but may include maintenance of individual health and safety, personal care services, homemaker, chore, attendant care, medication observation and recording, advocacy, communication, assistance with activities of daily living, instrumental activities of daily living, transportation to access community activities, shopping and attending doctor appointments, 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. This service may also include behavioral plan implementation by direct care staff.

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

Limitations: Individuals receiving Supported Living are not eligible to receive separate individual waiver services in

addition to Supported Living if the separate services are essentially duplicative of the tasks defined in Supported Living.

Individuals receiving Supported Living may not receive Residential Habilitation; however, they may receive Day Support Services as long as these services are not provided nor billed for times when the individual is receiving Supported Living services

Spouses providing Supported Living services through self-direction are limited to a maximum of 40 hours per week.

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☒ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency-basedSupported Living
Individual	Self-directedSupported Living

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Living

Provider Category:

Agency

Provider Type:

Agency-basedSupported Living

Provider Qualifications

License *(specify):*

Current business license

Certificate *(specify):*

Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Other Standard *(specify):*

Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.
Enrolled as a Medicaid provider

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Services for People with Disabilities

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Living

Provider Category:

Individual

Provider Type:

Self-directedSupported Living

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Other Standard *(specify):*

Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA and R539-5.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Services for People with Disabilities

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Transportation Services (non-medical)

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Transportation Services serves the purpose of allowing the individual access to other waiver supports necessary to live an inclusive community life. Individuals receiving services are trained, assisted and provided opportunities to use regular transportation services available to the general public in their community. If regular transportation services are not available or do not meet the needs of the waiver enrollee, waiver non-medical transportation becomes an option.

Transportation Supports 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.

Elements of Transportation Services:
The Transportation Services category consists of elements for enrollee/family arranged transportation, for transportation by an agency-based provider and for public/para-transit bus trip fares.

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 individuals to medical services that are covered by the State Plan. In addition, Medicaid payment is not available for any other transportation available thru 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 personÃÂÃÂs residence to the site(s) of a day program when payment for transportation is included in the established rate paid to the provider.

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.

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency-based Non-Medical Transportation
Individual	Self-directed--Non-Medical Transportation

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation Services (non-medical)

Provider Category:

Agency

Provider Type:

Agency-based Non-Medical Transportation

Provider Qualifications

License *(specify):*

Licensed public transportation carrier
OR
Individual with drivers license and registered vehicle, per 53-3-202, UCA and 41-12a-301 through 412, UCA

Current business license

Certificate *(specify):*

Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Other Standard *(specify):*

Under state contract with 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

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Services for People with Disabilities

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation Services (non-medical)

Provider Category:

Individual

Provider Type:

Self-directed--Non-Medical Transportation

Provider Qualifications

License *(specify):*

Individual with drivers license and registered vehicle, per 53-3-202, UCA and 41-12a-301 through 412, UCA

Certificate *(specify):*

Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Other Standard *(specify):*

Under state contract with 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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Services for People with Disabilities

Frequency of Verification:

Annually

Appendix C: Participant Services

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

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

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management).** *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 and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

d. Remote/Telehealth Delivery of Waiver Services. Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

No services selected for remote delivery

Appendix C: Participant Services

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

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

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to

CMS upon request through the Medicaid or the operating agency (if applicable):

UCA 62A-2-120 and R501-14 of the Utah Human Services Administration require that all persons having direct access to children or vulnerable adults must undergo a criminal history/background investigation.

The Office of Licensing, an agency within the Utah Department of Human Services, has the responsibility of conducting background screenings on all direct care workers who provide waiver services. The scope of the investigation includes a check of the State's child and adult abuse registries, a check of State and regional criminal background databases, a review of the State's juvenile court records and a criminal history search of applicable national criminal background databases. If a person has spent time outside of the United States and its territories during the last five years, submission of additional documentation may be required to establish whether there was a conviction of a crime during that time period.

For providers under the Self-Administered Service Model, the state will withhold payments for services for anyone who has not completed a background screening within the first 30 days of being hired. DSPD has the ability to view the database of the Office of Licensing in regards to the status of employees hired under the self-administered model. All employees are required to have a current background screening approval and must submit their renewal application no more than one year from the date the previous background screening was approved.

Background screening approvals are issued by the Office of Licensing in accordance with UCA 62A-2-120 and R501-14. Providers on the Office of Inspector General List of Excluded Individuals and Entities (LEIE) are not eligible to render waiver services.

The health and safety of participants are ensured by routinely scheduled face-to-face visits by support coordinators and by quality monitoring reviews performed by both DSPD and the SMA.

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

- ○ **No. The state does not conduct abuse registry screening.**
- ◉ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

UCA 62A-2-120 and R501-14 require that all persons having direct access to children or vulnerable adults must undergo an abuse screening.

Designated staff within DHHS, Office of Licensing, complete all screenings. DSPD maintains a database on all approved employees. DSPD will not approve payments if the required screenings have not been completed.

During contract reviews, samples of staff files are pulled to validate that abuse registry screenings are completed annually for selected staff.

Appendix C: Participant Services

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

Note: Required information from this page is contained in response to C-5.

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *Select one*:

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

Specify: (a) the types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is ***"extraordinary care"***, exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

(a) Caregiver, defined as spouses, legal guardians and parents of waiver participants may be eligible to perform Supported Living in accordance with the definition for extraordinary care below and per the CMS Technical Guide, Version 3.6
(b) To ensure the use of a caregiver to provide services is in the best interest of the participant, the following criteria must be met and documented in the participant's Person-Centered Support/Service Plan/Comprehensive Care Plan:
1. Choice of the caregiver to provide waiver services truly reflects the participant's wishes and desires;
2. The provision of services by the caregiver is in the best interests of the participant and his or her family;
3. The provision of services by the caregiver is appropriate and based on the participant's identified support needs;
4. The services provided by the caregiver will increase the participant's independence and community integration;
5. There are documented steps in the PCSP that will be taken to expand the participant's circle of support so that he or she is able to maintain and improve his or her health, safety, independence, and level of community integration on an ongoing basis should the caregiver acting in the capacity of employee no longer be available;
6. The caregiver must sign a service agreement to provide assurances to the State/OA that he or she will implement the service plan and provide the services in accordance with applicable federal and State laws and regulations governing the program.
From a financial perspective, the prior authorization of monthly rate and coordination with FMS agencies or providers will be used as a control. In addition, set monthly tier rates will be established using assessment data to determine the need for extraordinary care. State staff members will provide additional oversight and coordinate with Case Managers/Support Coordinators to ensure health and safety objectives are maintained, both for the waiver participant and the caregiver rendering care.

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

The State uses the following definition for Extraordinary Care:

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

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

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

On an ongoing basis, the Support Coordinator will verify that services provided are appropriate and furnished in the best interest of the recipient at the time a formal review of the care plan is completed, completed, at least annually or more frequently as necessary to ensure services continue to meet the needs of the waiver participant. Additionally,

on an annual basis, a sample review of claims for waiver services rendered to verify the service was authorized and did not exceed the amounts authorized in the care plan.
The State will use the sampling methodology required by CMS when calculating sample sizes. (Currently a 95% confidence interval, 5% margin of error and 50% response distribution). Care plans for those individuals will be compared to actual claims billed and recoupments initiated for those who had utilization exceeded authorized amounts.
Payment for services is restricted to Supported Living Services. The amount of services is limited to the overall tier level established in the service plan.

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

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

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

Specify the types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

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

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

Relatives may not provide services to multiple participants at the same time, but relatives may provide more than one service to a participant with the limitation that the services may not be provided at the same time. For example, a relative may be a provider of both personal care and respite services, but they would not be eligible to bill for both services concurrently.

For Relatives: Support Coordinators conduct monthly reviews of all services provided before claims are paid. Support Coordinators monitor the use of services as defined in the Care Plan. DSPD conducts random sample audits each year on the SAS programs that focus on service usage and interviews with clients and employees about service utilization. DSPD monitors service utilization each month and notifies the contract monitoring units if there is any indication of fraud or abuse of funds - for more in-depth audits to be completed.

Relatives may include immediate family such as brothers or sisters, or extended family such as aunts/uncles/cousins. It is not the intention to limit any familial relationships provided the needed services can be safely performed by the prospective provider.

The State also allows payments to relatives when the relative is qualified to provide services as specified in Appendix C-3. The State will not pay non-legally responsible caregivers to provide waiver services when they are already being paid by another source to care for the recipient (i.e., foster parents).

On an ongoing basis, the Support Coordinator will verify that services provided are appropriate and furnished in the best interest of the recipient at the time a formal review of the care plan is completed, at least annually or more frequently as necessary to ensure services continue to meet the needs of the waiver participant. Additionally, on an annual basis, a sample review of claims for waiver services rendered to verify the service was authorized and did not exceed the amounts authorized in the care plan.

The State will use the sampling methodology required by CMS when calculating sample sizes. (Currently a 95% confidence interval, 5% margin of error and 50% response distribution). Care plans for those individuals will be compared to actual claims billed and recoupments initiated for those who had utilization exceeded authorized amounts.

While spouses and parents/guardians are limited to providing Supported Living Services, other relatives may be providers of any waiver service they meet the qualifications for.

Whenever a legally responsible individual or relative/legal guardian is paid for the provision of a waiver service, the person must meet the provider qualifications that apply to a service and there must be a properly executed provider agreement, or employment facilitated through self-administered services as outlined in Appendix E.

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

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

g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act. Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one*:

- ○ **No, the state does not choose the option to provide HCBS in acute care hospitals.**
- ○ **Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions.** *By checking the boxes below, the state assures:*
  - ☐ **The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;**
  - ☐ **The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;**
  - ☐ **The HCBS must be identified in the individual's person-centered service plan; and**
  - ☐ **The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.**

*And specify:***(a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting;(b) How the 1915(c) HCBS will assist the individual in returning to the community; and(c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.**

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

a. ***Sub-Assurance: The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

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

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

Performance Measure:
Number and percentage of licensed and/or certified providers who meet DHS provider contract criteria. The numerator is the number of providers in the review for which, upon initial enrollment and annually thereafter, meet provider

requirements; the denominator is the total number of providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider records and Provider Staff interviews

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

Data Aggregation and Analysis:

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

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

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):
Other
If 'Other' is selected, specify:
DHS Contract Analyst Certification checklist and DHS Office of Licensing Residential Support Rules checklist

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

Specify: DHS Office of Licensing		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percentage of Self-Administered Services (SAS) providers who have a Self-Administered Services Agreement in place. The numerator is the number of family directed service providers in compliance; the denominator is the total number of family directed service providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Billing data, Employee files, PCSP and Participant records

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percentage of 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):
Other
If 'Other' is selected, specify:
Provider records and Provider staff interviews

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

		95% Confidence Level, 5% Margin of Error
☒ **Other** Specify: DHHS	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is***

conducted in accordance with state requirements and the approved waiver.

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

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

Performance Measure:
Number and percentage of provider agencies who conduct staff training in accordance with state requirements and the approved waiver. The numerator is the total number of provider agencies who conduct staff training in accordance with state requirements and the approved waiver; the denominator is the total number of providers reviewed.

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

	Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percentage of ABI Support Coordinators who completed DSPD core curriculum. The numerator is the number of ABI Support Coordinators reviewed who complete the core curriculum as contractually required; the denominator is the total number of ABI Support Coordinators reviewed.

Data Source (Select one):
Other
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**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

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

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

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

ii. Remediation Data Aggregation

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

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

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

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are

assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

1. Description of the settings in which 1915(c) HCBS are recieved. *(Specify and describe the types of settings in which waiver services are received.)*

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 in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)*

3. *By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:*

☐ **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 and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board. *(see Appendix D-1-d-ii)***

☐ **Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.**

☐ **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.**

☐ **Facilitates individual choice regarding services and supports, and who provides them.**

☐ **Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.**

Provider-owned or controlled residential settings. (*Specify whether the waiver includes provider-owned or controlled settings.*)

- ○ **No, the waiver does not include provider-owned or controlled settings.**
- ○ **Yes, the waiver includes provider-owned or controlled settings.** (By checking each box below, the state assures that each setting, *in addition to meeting the above requirements, will meet the following additional conditions*):
  - ☐ **The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.**
  - ☐ **Each individual has privacy in their sleeping or living unit:**
    - ☐ **Units have entrance doors lockable by the individual.**
    - ☐ **Only appropriate staff have keys to unit entrance doors.**
    - ☐ **Individuals sharing units have a choice of roommates in that setting.**
    - ☐ **Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.**
  - ☐ **Individuals have the freedom and support to control their own schedules and activities.**
  - ☐ **Individuals have access to food at any time.**
  - ☐ **Individuals are able to have visitors of their choosing at any time.**
  - ☐ **The setting is physically accessible to the individual.**
  - ☐ **Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan*(see Appendix D-1-d-ii of this waiver application).***

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Individual Service 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. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. *(Select each that applies):*

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

☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

b. Service Plan Development Safeguards. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

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

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.** ***Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:***

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a process in place to ensure:*

☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**

☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**

☐ **Direct oversight of the process or periodic evaluation by a state agency;**

☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**

☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

d. i. 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; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

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

The primary assessment tool conducted to support service plan development is the Comprehensive Brain Injury Assessment (CBIA). Other assessments include: review of the previous year's assessment, the Person-Centered Profile, and educational, psychological, psychiatric, medical and other therapy evaluations as needed.

a) who develops the plan, who participates in the process, and the timing of the plan;
The ABI Waiver support coordinator has ultimate responsibility to develop the PCSP; however, it is the entire team's responsibility to participate. The team must consist of at least the participant and legal representative, support coordinator, primary paid service providers and others as invited by the participant; at times and locations convenient to both the waiver participant and the other individuals whom the participant has invited. The PCSP is reviewed and updated at least once a year with changes made throughout the year as needed based on the participant's needs. Anytime during the plan year the ABI Waiver support coordinator can choose to complete a whole new plan or make modifications (addendums) to the existing plan.

(b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences, strengths, capacities, desired outcomes, risk factors, goals, and health status.
The ABI Waiver utilizes a comprehensive approach to service plan development. The CBIA is the primary assessment tool for the development of the Person Centered Support Plan (PCSP). Other important assessments include: the Person-Centered Profile, educational assessments, psychological assessments, psychiatric assessments, medical assessment, other therapy evaluations as needed and the review of the past year.

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

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

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

(e) how waiver and other services are coordinated.
The Action Plan lists all the person's supports and services including: Formal/Written Support Strategies, Medicaid State Plan Services, Natural Supports, One-Time and On-Going, Behavior Supports and Psychotropic Med Plans, Specific Medical, Skill Training, Opportunities, Relationship development, etc.

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

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

ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

☐ **The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.**

☐ **For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:**

- ☐ **A specific and individualized assessed need for the modification.**
- ☐ **Positive interventions and supports used prior to any modifications to the person-centered service plan.**
- ☐ **Less intrusive methods of meeting the need that have been tried but did not work.**
- ☐ **A clear description of the condition that is directly proportionate to the specific assessed need.**
- ☐ **Regular collection and review of data to measure the ongoing effectiveness of the modification.**
- ☐ **Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.**
- ☐ **Informed consent of the individual.**
- ☐ **An assurance that interventions and supports will cause no harm to the individual.**

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The participant and/or representative are informed of all available qualified providers of waiver services during the PCSP planning meeting.
Each participant or legal representative is given a copy of the booklet, "An Introductory Guide-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. Support Coordinators will assist in arranging participants' visits with providers if needed to obtain more detailed information. The participant's choice of providers of services is documented on the PCSP.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update, when the individual's circumstances or needs change significantly, or at the request of the individual, to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

○ **Every three months or more frequently when necessary**

○ **Every six months or more frequently when necessary**

◉ **Every twelve months or more frequently when necessary**

○ **Other schedule**

Specify the other schedule:

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

☐ **Medicaid agency**

☐ **Operating agency**

☒ **Case manager**

☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

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

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

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

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

Should problems or a change in need be identified by the Support Coordinator, the PCSP will updated or revised and support strategies modified in order to meet the needs of the individual. Technical assistance will be pursued with the Operating Agency as necessary to resolve care issues.

The Support Coordinator monitors the implementation of the PCSP by doing the following:
1. Monthly face to face visits with the person (While monthly face to face visits is the standard, the Support Coordinator has the discretion to conduct face to faces visits with the client more frequently or less frequently than once a month. 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. Recording a monthly case management note within the USTEPS system documenting activities performed in the month and summarizing results/issues/resolution.
4. Working/ meeting with Providers and families of supports to ensure that participants are receiving quality supports in the environment of their choice.
5. Evaluating established back-up plans for appropriateness and ability to meet health and safety needs.

PCSPs are reviewed at least every two years by DSPD and at least every five year by the SMA. The sample size for each review will be sufficient to provide a confidence level equal to 95% and a confidence interval equal to five. Records are reviewed for documentation that demonstrates participants have been made aware of all services available on the ABI Waiver and have been offered choice among available providers. Records are also reviewed for compliance with health and welfare standards. This includes the documentation that prevention strategies are developed and implemented (when applicable) when abuse, neglect, or exploitation is identified, verification (during face to face visits) that the safeguards and interventions are in place, notification of incidents to support coordinators has occurred, and documentation that participants have assistance, when needed, to take their medications, and verification that backup plans are effective. Records are also reviewed to determine that the PCSP addresses all of the participant's assessed needs, including health needs, safety risks, and personal goals either by the provision of Waiver services or other funding sources (State Plan services, generic services, and natural supports). Significant findings from these reviews will be addressed with DSPD. A plan of correction with specific time frames for completion will be required. The SMA will conduct follow-up reviews as necessary to ensure the plan of correction is implemented and sustained.

When individual issues arise, additional reviews can and do take place for the individual(s) involved in the issue. Depending on the nature of the issue, a broader review of care plans may be required. While reviews take place at least as frequently as listed above, critical incidents, complaints, audits, and other issues also involve a review of the person-centered support plan at the time of the action. Individual issues are identified and remediated through the State's critical incident process, constituent services calls, and complaint/appeals/grievances processes.

b. Monitoring Safeguard. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

◉ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.** *(Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation).*

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. *By checking each box, the state attests to having a process in place to ensure:*

☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**

☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**

☐ **Direct oversight of the process or periodic evaluation by a state agency;**

☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**

☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

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

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:

Number and percentage of 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):
Other
If 'Other' is selected, specify:
Participant records and PCSP

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

Data Aggregation and Analysis:

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

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):
Other
If 'Other' is selected, specify:
CBIA, 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):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence Level, 5% Margin of Error

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

Data Aggregation and Analysis:

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

b. ***Sub-assurance: Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.***

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the state to

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

Performance Measure:
Number and percentage of PCSPs created which appropriately address the assessed needs/goals of the individual and are agreed upon by the participant/legal representative before waiver services were provided. The numerator is the number of PCSPs which met criteria; the denominator is the total number of PCSPs reviewed.

Data Source (Select one):
Other
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):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence Level, 5% Margin of Error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and percentage of PCSPs which are updated/revised when warranted by changes in the participant's needs. The numerator is the number of PCSPs which were updated/revised; the denominator is the total number of PCSPs which required updates/revision due to a change in need.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Participant records and Incident reports

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

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **Other** Specify: Every two years

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):
Other
If 'Other' is selected, specify:
PCSP, Participant records and Participant interviews

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

	☒ **Other** Specify: Every two years	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and percentage of provider monthly summary reports indicating that services are being delivered in accordance with the PCSP. The numerator is the total number of PCSPs reviewed for which monthly summary reports indicate that services are being delivered in accordance with the PCSP; the denominator is the total number of PCSPs reviewed.

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

Participant records, PCSP, Provider Monthly reports and Participant interviews

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

Data Aggregation and Analysis:

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

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

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):
Other
If 'Other' is selected, specify:
PCSP, Claims Data and Participant interviews

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

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

Data Aggregation and Analysis:

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

e. ***Sub-assurance: The state monitors service plan development in accordance with its policies and procedures.***

Performance Measures

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

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

Performance Measure:
Number and percentage of participants who are made aware of all services available

on the ABI Waiver. The numerator is the total number of participants reviewed who were made aware of all services available on the ABI Waiver; the denominator is the total number of participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
PCSP, Participant records and Participant interviews

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percentage of participants who are offered choice among providers when more than one is available. The numerator is the total number of participants reviewed who are offered choice among providers when more than one is available; the denominator is the total number of participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
PCSP, Participant records and Participant interviews

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

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

Data Aggregation and Analysis:

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

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

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

The CBIA is conducted when a participant enters the waiver and a screening is conducted at a minimum every twelve months. If there have been significant changes, the assessment is re-administered. All services are identified on the service

plan regardless of funding source. Participants are offered choice of either nursing facility care or ABI Waiver services and choice is documented in USTEPS. Participants are made aware of all services available on the ABI Waiver and are offered choice among providers whenever choice exists. Choice of providers is documented in the participant's record.

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

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

ii. Remediation Data Aggregation

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

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

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

- ◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

Self-Administered Services are made available to all waiver enrollees who elect to participate in this method. Information about self-direction is provided during initial program orientation and resources are available in the member/family section of DSPD's website. ABI Waiver support coordinators provide ongoing oversight of the enrollees' ability to successfully utilize self-administered services. The Financial Management Services (FMS) agency can provide additional assistance and training to participants (employers) regarding methods of interviewing, selecting and hiring employees, legal requirements for retaining and discharging employees, methods of employee supervision, fraud controls and such other topics as required, in the opinion of the FMS agency, to assist employers to effectively self-administer their services. Enrollees who subsequently demonstrate to their support coordinator their incapacity to successfully self-administer their services are transferred to Agency Based Provider Services.

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

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

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

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

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

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

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

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

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

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

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

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

Specify the criteria

Participant direction is offered to participants.
1. Participants may only choose to direct the covered waiver services listed in E-1(g).
2. Participants must acknowledge the obligation of the State to assure basic health and safety and agree to abide by necessary safeguards negotiated during the risk assessment/service planning process.
3. In the case of an individual who cannot direct his or her own waiver services, another person may be appointed as the decision-maker in accordance with applicable State law.
4. Alternate service delivery methods are available to participants who have are not able to successfully direct their services.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

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

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Waiver Service	Employer Authority	Budget Authority
Transportation Services (non-medical)	☒	☐
Companion Services	☒	☐
Homemaker	☒	☐
Respite	☒	☐
Chore Services	☒	☐
Supported Living	☒	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

◉ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

Financial Management Services

○ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

The State uses private vendors to furnish FMS. Any qualified, willing provider may enroll to offer this service. The procurement method is the same as with all other service.

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

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:

☒ **Assist participant in verifying support worker citizenship status**

☒ **Collect and process timesheets of support workers**

☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**

☒ **Other**

Specify:

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

1. Verify that the employee completed the following forms
a. Form I-9, including supporting documentation (i.e. copies of driver's license, social security card, passport). If fines are levied against the person for failure to report INS information, the Fiscal Agent shall be responsible for all such fines.
b. Form W-4

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

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

4. Process and pay 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

Supports furnished when the participant exercises budget authority:

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

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

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

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

☐ **Other services and supports**

Specify:

Additional functions/activities:

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

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

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

☐ **Other**

Specify:

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

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 annually that high standards are maintained by way of a comprehensive system of quality assurance including: (a) formal surveys of providers for measurement of individual and organizational outcomes, (b) contract compliance reviews, (c) regular observation and evaluation by support coordinators, (d) provider quality assurance systems, (e) consumer/family/legal representative satisfaction measures, (f) performance contracts with and reviews of State agency staff, (g) audits completed by entities external to the agency, and (h) other oversight activities as appropriate.

The division improved the accountability of SAS service delivery through standardized mandatory training & manuals for SAS families and support coordinators, development of the Family to Family Network & Peer Mentors, and a formal documentation monitoring tool used by support coordinators to audit SAS employers.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant

direction opportunity under the waiver:

In order to provide information and assistance to participants about self-directing their services, the Support Coordinator is responsible to provide the participant/representative with a Self-Administered Services Support Book. The support coordinator reviews the information in the Support Book with the participant/participant family and is available to answer any questions and provide assistance as needed. The support coordinator is responsible to assess whether the information provided is sufficient to meet the needs of the individual. If the assessment of the situation shows that the participant/representative requires additional training - such as hiring, scheduling, or training of employees, the support coordinator will contact the Financial Management Services agency to provide more detailed training on how to self-direct services.

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

☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Behavior Consultation III	☐
Personal Emergency Response System	☐
Environmental Adaptations - Vehicle	☐
Transportation Services (non-medical)	☐
Specialized Medical Equipment/Supplies/Assistive Technology - Purchase	☐
Companion Services	☐
Extended Living Supports	☐
Day Supports	☐
Supported Employment	☐
Professional Medication Monitoring	☐
Behavior Consultation II	☐
Homemaker	☐
Community Transition Service	☐
Personal Budget Assistance	☐
Center-Based Prevocational Services	☐
Respite	☐
Chore Services	☐
Environmental Adaptations - Home	☐
Financial Management	☒

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Services	
Residential Habilitation	☐
Behavior Consultation I	☐
Consumer Preparation Services	☐
Supported Living	☐
Specialized Medical Equipment/Supplies/Assistive Technology- Monthly Fee	☐
ABI Waiver Support Coordination	☒
Massage Therapy	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

◉ **No. Arrangements have not been made for independent advocacy.**

○ **Yes. Independent advocacy is available to participants who direct their services.**

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

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

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

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

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

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants

Table E-1-n

	Employer Authority Only			Budget Authority Only or Budget Authority in Combination with Employer Authority		
Waiver Year	Number of Participants			Number of Participants		
Year 1		16				
Year 2		17				
Year 3		18				
Year 4		19				
Year 5		20				

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

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

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

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

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

☒ **Recruit staff**

☐ **Refer staff to agency for hiring (co-employer)**

☐ **Select staff from worker registry**

☒ **Hire staff common law employer**

☒ **Verify staff qualifications**

☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

The 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:

Background checks remain consistent with C-2-a.

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☒ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☐ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

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

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

☐ **Reallocate funds among services included in the budget**

☐ **Determine the amount paid for services within the state's established limits**

☐ **Substitute service providers**

☐ **Schedule the provision of services**

☐ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**

☐ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

☐ **Identify service providers and refer for provider enrollment**

☐ **Authorize payment for waiver goods and services**

☐ **Review and approve provider invoices for services rendered**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ○ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

RIGHTS TO A FAIR HEARING DOCUMENTATION

An individual and the individual's legal representative will receive a written Notice of Agency Action, Form 522 and a Hearing Request Form 490S from a DSPD administrative program manager, if the individual is denied a choice of institutional or waiver program, found ineligible for the waiver program, or denied access to the provider of choice for a covered waiver service or experiences a denial, reduction, suspension, or termination in waiver services in accordance with R539-2-5. If the individual is enrolled in services, the State follows regulation in accordance with 42 CFR §431.230. In instances in which an individual is found to be ineligible for entrance to the waiver, they may request an administrative fair hearing from the Depart of Human Services, which is dispositive. Services are not afforded during this period of pendency.

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

Notices and the opportunity to request a fair hearing documentation are kept in the individual's case record/file and at the Operating Agency - State Office.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates an additional dispute resolution process**

- **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 participants concerns without unnecessary formality. The dispute resolution process is not intended to limit a participants access to formal hearing procedures; the participant may file a Request for Hearing any time in the first 30 days after receiving Notice of Agency Action. Examples of the types of disputes include but are not limited to: choice of provider or service, denial/reduction/suspension/termination of a waiver service, etc.

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

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

DSPD Policy 1.11 Conflict Resolution requires the 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 reviewers report the Division Director will determine the appropriate resolution for the dispute and shall implement any necessary corrective action.

Expectations surrounding follow-up time frames are communicated to the individual with methods for direct contact provided in the event additional questions or concerns are found.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

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

- **Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

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

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

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

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

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

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

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

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

◉ **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*

○ **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

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

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

When an incident occurs, an immediate response takes place, while the OA or SMA receives notification of the incident by the next business day. 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 (either inpatient or outpatient)

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

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 DHHS/DSPD Support Coordinator and the person's Guardian by phone, email, or fax.

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

enforcement agency, and shall immediately notify the Division of Children and Family Services Child Protective Services intake or the nearest peace officer, law enforcement agency in a case involving a child.

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

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

Currently the SMA receives quarterly summaries of incidents that don't meet the severity criteria outlined in Appendix G-1b. Any incident that meets the criteria outlined for reporting to the SMA in Appendix G-1b requires reporting to the SMA from the OA within 24 hours. When incidents do not meet that severity criteria, the primary benefit for the SMA is reviewing trends that may indicate more systemic issues. In addition, the SMA reviews these periodically to assess whether the OA is appropriately assigning severity levels to incidents. The Fatality Review Committee operated by the OA convenes every other month. In cases where clinical review is required, the SMA Quality Assurance team seeks consultation from licensed staff within the Office of Long Term Services and Supports.

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 DHHS90743 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.

Findings are shared between APS/CPS/Law Enforcement and the SMA/OA. Full copies of the reports may/may not be provided.

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

Support coordinators provide on-going training and information about abuse, neglect, and exploitation; and how to report known or suspected incidents.

Support Coordinators complete initial and annual online training modules. Provider training requirements are specified in their contract ensuring knowledge of the Human Rights processes and reporting requirements.

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.

For incidents classified as ‘Level 1’, the SMA is responsible to determine when remediation is complete. Frequently this involves the need to request additional information and receive information on follow-up activities requested from the OA/provider. In addition, the SMA reviews incidents classified as ‘Level 2’ during quarterly reporting from the OA to validate overall strategies in investigation/remediation appear to be adequate.

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 DHHS 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 DHHS and legal guardians of involved clients within one business day; (A) if the critical incident involves a client or service under a DHHS contract, the critical incident report must be completed within one business day and may require a five day follow up report to the involved DHHS Division;
(B) if the critical incident involves a client or service to a youth currently in the custody of DHHS or its Divisions an immediate live-person verbal notification to the involved Division is additionally required.
(ii) Initial critical incident reports to DHHS 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 DHHS 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 DHHS 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 DHHS 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 DHHS 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 DHHS/DSPD annual Incident Report. If the SMA detects systemic problems either through this reporting mechanism or during the SMA's program review process, DHHS/DSPD will be requested to submit a plan of correction to the SMA. The plan of correction will include the interventions to be taken and the time frame for completion. All plans of correction are subject to acceptance by the SMA. The SMA will conduct follow-up activities to determine that systems corrections have been achieved and are sustaining.

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

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

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

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: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

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

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

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

R539-4-4. Levels of Behavior Interventions.
(2) All Behavior Support Plans shall be implemented only after the Person or Guardian gives consent and the Behavior Support Plan is approved by the Team.
(3) All Behavior Support Plans shall incorporate Positive Behavior Supports with the least intrusive, effective treatment designed to assist the Person in acquiring and maintaining skills, and preventing problems.
(4) Behavior Support Plans must:
(a) Be based on a Functional Behavior Assessment.
(b) Focus on prevention and teach replacement behaviors.
(c) Include planned responses to problems.
(d) Outline a data collection system for evaluating the effectiveness of the plan.
(5) All Provider staff involved in implementing procedures outlined in the Behavior Support Plan shall be trained and demonstrate competency prior to implementing the plan.
(a) Completion of training shall be documented by the Provider.
(b) The Behavior Support Plan shall be available to all staff involved in implementing or supervising the plan.
(8) Level II Interventions may be used in pre-approved Behavior Support Plans or emergency situations. [Includes manual restraint].
(9) Level III Interventions may only be used in pre-approved Behavior Support Plans. [Includes mechanical restraint and seclusion (time-out room)].
(10) Behavior Support Plans that utilize Level II or Level III Interventions shall be implemented only after Positive Behavior Supports, including Level I Interventions, are fully implemented and shown to be ineffective. A rationale on the necessity for the use of intrusive procedures shall be included in the Behavior Support Plan.
(11) Time-out Rooms shall be designed to protect Persons from hazardous conditions, including sharp corners and objects, uncovered light fixtures, and unprotected electrical outlets. The rooms shall have adequate lighting and ventilation.
(a) Doors to the Time-out Room may be held shut by Provider staff, but not locked at any time.
(b) Persons shall remain in Time-out Rooms no more than 2 hours per occurrence.
(c) Provider staff shall monitor Persons in a Time-out Room visually and auditorially on a continual basis. Staff shall document ongoing observation of the Person while in the Time-out Room at least every fifteen minutes.
(12) Time-out Rooms shall be used only upon the occurrence of problems previously identified in the Behavior Support Plan.
(a) Persons shall be placed in the Time-out Room immediately following a previously identified problem. Time delays are not allowed.
(b) Persons shall not be transported to another location for placement in a Time-out Room.
(c) Behavior Support Plans must outline specific release criteria that may include time and behavior components. Time asleep must count toward time-release criteria.

(13) Mechanical restraints shall ensure the Person's safety in breathing, circulation, and prevent skin irritation.
(a) Persons shall be placed in Mechanical Restraints immediately following the identified problem. Time delays are not allowed.
(b) Persons shall not be transported to another location for Mechanical Restraints.
(14) Mechanical Restraints shall be used only upon the occurrence of problems previously identified in the Behavior Support Plan.
(a) Behavior Support Plans must outline specific release criteria that may include time and behavior components. Time asleep must count toward time-release criteria. The plan shall also specify maximum time limits for single application and multiple use.
(b) Behavior Support Plans shall include specific requirements for monitoring the Person, before, during, and after application of the restraint to ensure health and safety.
(c) Provider staff shall document their observation of the Person as specified in the Behavior Support Plan.
(15) Manual restraints shall ensure the Person's safety in breathing and circulation. Manual restraint procedures are limited to the Mandt System (Mandt), the Professional Assault Response Training (PART), or Supports Options and Actions for Respect (SOAR) training programs. Procedures not outlined in the programs listed above may only be used if pre-approved by the State Behavior Review Committee.
(16) Behavior Support Plans that include Manual Restraints shall provide information on the method of restraint, release criteria, and time limitations on use.

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

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

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

The unauthorized use, overuse, inappropriate/ineffective use of restrictive interventions may be reported through any of the following channels: Provider self-report; Other provider reports; log notes; participant/family reporting; etc. Unauthorized use/overuse/inappropriate use would also likely fall into the criteria of a Human Rights Violation and would be a reportable incident.

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

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

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

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

Documents/policies/procedures follow the approval process in Appendix A. It is required that the SMA has a member who participates in the OA Human Rights Council and provides technical assistance in addition to reporting concerns to SMA leadership.

The unauthorized use, overuse, inappropriate/ineffective use of restraints may be reported through any of the following channels: Provider self-report; Other provider reports; log notes; participant/family reporting; etc. Unauthorized use/overuse/inappropriate use would also likely fall into the criteria of a Human Rights Violation and would be a reportable incident.

The SMA and OA are actively working to improve data collection as current systems allow primarily for the analysis of the types of incidents occurring and the ability to see when a particular individual is involved in multiple/frequent incidents. More granular information is being collected surrounding the providers involved in care to see if deficits may exist in care delivery.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The 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.

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. When an incident occurs, an immediate response takes place, while the OA or SMA receives notification of the incident by the next business day.

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.

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

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

R539-4-4. Levels of Behavior Interventions.
(2) All Behavior Support Plans shall be implemented only after the Person or Guardian gives consent and the Behavior Support Plan is approved by the Team.
(3) All Behavior Support Plans shall incorporate Positive Behavior Supports with the least intrusive, effective treatment designed to assist the Person in acquiring and maintaining skills, and preventing problems.
(4) Behavior Support Plans must:
(a) Be based on a Functional Behavior Assessment.
(b) Focus on prevention and teach replacement behaviors.
(c) Include planned responses to problems.
(d) Outline a data collection system for evaluating the effectiveness of the plan.
(5) All Provider staff involved in implementing procedures outlined in the Behavior Support Plan shall be trained and demonstrate competency prior to implementing the plan.
(a) Completion of training shall be documented by the Provider.
(b) The Behavior Support Plan shall be available to all staff involved in implementing or supervising the plan.
(8) Level II Interventions may be used in pre-approved Behavior Support Plans or emergency situations. [Includes manual restraint].
(9) Level III Interventions may only be used in pre-approved Behavior Support Plans. [Includes mechanical restraint and seclusion (time-out room)].
(10) Behavior Support Plans that utilize Level II or Level III Interventions shall be implemented only after Positive Behavior Supports, including Level I Interventions, are fully implemented and shown to be ineffective. A rationale on the necessity for the use of intrusive procedures shall be included in the Behavior Support Plan.
(11) Time-out Rooms shall be designed to protect Persons from hazardous conditions, including sharp corners and objects, uncovered light fixtures, and unprotected electrical outlets. The rooms shall have adequate lighting and ventilation.
(a) Doors to the Time-out Room may be held shut by Provider staff, but not locked at any time.
(b) Persons shall remain in Time-out Rooms no more than 2 hours per occurrence.

(c) Provider staff shall monitor Persons in a Time-out Room visually and auditorially on a continual basis. Staff shall document ongoing observation of the Person while in the Time-out Room at least every fifteen minutes.
(12) Time-out Rooms shall be used only upon the occurrence of problems previously identified in the Behavior Support Plan.
(a) Persons shall be placed in the Time-out Room immediately following a previously identified problem. Time delays are not allowed.
(b) Persons shall not be transported to another location for placement in a Time-out Room.
(c) Behavior Support Plans must outline specific release criteria that may include time and behavior components. Time asleep must count toward time-release criteria.
(13) Mechanical restraints shall ensure the Person's safety in breathing, circulation, and prevent skin irritation.
(a) Persons shall be placed in Mechanical Restraints immediately following the identified problem. Time delays are not allowed.
(b) Persons shall not be transported to another location for Mechanical Restraints.
(14) Mechanical Restraints shall be used only upon the occurrence of problems previously identified in the Behavior Support Plan.
(a) Behavior Support Plans must outline specific release criteria that may include time and behavior components. Time asleep must count toward time-release criteria. The plan shall also specify maximum time limits for single application and multiple use.
(b) Behavior Support Plans shall include specific requirements for monitoring the Person, before, during, and after application of the restraint to ensure health and safety.
(c) Provider staff shall document their observation of the Person as specified in the Behavior Support Plan.
(15) Manual restraints shall ensure the Person's safety in breathing and circulation. Manual restraint procedures are limited to the Mandt System (Mandt), the Professional Assault Response Training (PART), or Supports Options and Actions for Respect (SOAR) training programs. Procedures not outlined in the programs listed above may only be used if pre-approved by the State Behavior Review Committee.
(16) Behavior Support Plans that include Manual Restraints shall provide information on the method of restraint, release criteria, and time limitations on use.

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

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

The unauthorized use, overuse, inappropriate/ineffective use of restrictive interventions may be reported through any of the following channels: Provider self-report; Other provider reports; log notes; participant/family reporting; etc. Unauthorized use/overuse/inappropriate use would also likely fall into the criteria of a Human Rights Violation and would be a reportable incident.

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 participants team, Behavior Peer Review, and Human Rights Committee. All programmatic use of Level II interventions are summarized in providers Behavior Consultation Services Progress Notes and reviewed at least monthly by support coordinators. State Quality Management and State Behavior Specialist will review data at least annually.

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

The unauthorized use, overuse, inappropriate/ineffective use of restrictive interventions may be reported through any of the following channels: Provider self-report; Other provider reports; log notes; participant/family reporting; etc. Unauthorized use/overuse/inappropriate use would also likely fall into the criteria of a Human Rights Violation and would be a reportable incident.

The SMA and OA are actively working to improve data collection as current systems allow primarily for the analysis of the types of incidents occurring and the ability to see when a particular individual is involved in multiple/frequent incidents. More granular information is being collected surrounding the providers involved in care to see if deficits may exist in care delivery.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

○ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

◉ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

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

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

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

R539-4-4. Levels of Behavior Interventions.
(2) All Behavior Support Plans shall be implemented only after the Person or Guardian gives consent and the Behavior Support Plan is approved by the Team.
(3) All Behavior Support Plans shall incorporate Positive Behavior Supports with the least intrusive, effective treatment designed to assist the Person in acquiring and maintaining skills, and preventing problems.
(4) Behavior Support Plans must:
(a) Be based on a Functional Behavior Assessment.
(b) Focus on prevention and teach replacement behaviors.
(c) Include planned responses to problems.
(d) Outline a data collection system for evaluating the effectiveness of the plan.
(5) All Provider staff involved in implementing procedures outlined in the Behavior Support Plan shall be trained and demonstrate competency prior to implementing the plan.
(a) Completion of training shall be documented by the Provider.
(b) The Behavior Support Plan shall be available to all staff involved in implementing or supervising the plan.
(8) Level II Interventions may be used in pre-approved Behavior Support Plans or emergency situations. [Includes manual restraint].
(9) Level III Interventions may only be used in pre-approved Behavior Support Plans. [Includes mechanical restraint and seclusion (time-out room)].
(10) Behavior Support Plans that utilize Level II or Level III Interventions shall be implemented only after Positive Behavior Supports, including Level I Interventions, are fully implemented and shown to be ineffective. A rationale on the necessity for the use of intrusive procedures shall be included in the Behavior Support Plan.
(11) Time-out Rooms shall be designed to protect Persons from hazardous conditions, including sharp corners and objects, uncovered light fixtures, and unprotected electrical outlets. The rooms shall have adequate lighting and ventilation.
(a) Doors to the Time-out Room may be held shut by Provider staff, but not locked at any time.
(b) Persons shall remain in Time-out Rooms no more than 2 hours per occurrence.
(c) Provider staff shall monitor Persons in a Time-out Room visually and auditorially on a continual basis. Staff shall document ongoing observation of the Person while in the Time-out Room at least every fifteen minutes.
(12) Time-out Rooms shall be used only upon the occurrence of problems previously identified in the Behavior Support Plan.
(a) Persons shall be placed in the Time-out Room immediately following a previously identified problem. Time delays are not allowed.
(b) Persons shall not be transported to another location for placement in a Time-out Room.
(c) Behavior Support Plans must outline specific release criteria that may include time and behavior components. Time asleep must count toward time-release criteria.

(13) Mechanical restraints shall ensure the Person's safety in breathing, circulation, and prevent skin irritation.
(a) Persons shall be placed in Mechanical Restraints immediately following the identified problem. Time delays are not allowed.
(b) Persons shall not be transported to another location for Mechanical Restraints.
(14) Mechanical Restraints shall be used only upon the occurrence of problems previously identified in the Behavior Support Plan.
(a) Behavior Support Plans must outline specific release criteria that may include time and behavior components. Time asleep must count toward time-release criteria. The plan shall also specify maximum time limits for single application and multiple use.
(b) Behavior Support Plans shall include specific requirements for monitoring the Person, before, during, and after application of the restraint to ensure health and safety.
(c) Provider staff shall document their observation of the Person as specified in the Behavior Support Plan.
(15) Manual restraints shall ensure the Person's safety in breathing and circulation. Manual restraint procedures are limited to the Mandt System (Mandt), the Professional Assault Response Training (PART), or Supports Options and Actions for Respect (SOAR) training programs. Procedures not outlined in the programs listed above may only be used if pre-approved by the State Behavior Review Committee.
(16) Behavior Support Plans that include Manual Restraints shall provide information on the method of restraint, release criteria, and time limitations on use.

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

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

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

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

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

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

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

The unauthorized use, overuse, inappropriate/ineffective use of restrictive interventions may be reported through any of the following channels: Provider self-report; Other provider reports; log notes; participant/family reporting; etc. Unauthorized use/overuse/inappropriate use would also likely fall into the criteria of a Human Rights Violation and would be a reportable incident.

The SMA and OA are actively working to improve data collection as current systems allow primarily for the analysis of the types of incidents occurring and the ability to see when a particular individual is involved in multiple/frequent incidents. More granular information is being collected surrounding the providers involved in care to see if deficits may exist in care delivery.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

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

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

- **Medication Management and Follow-Up**

  i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

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

Methods for Conducting Monitoring:
1. Providers are required to train all applicable staff in medication assistance procedures. Training records are maintained to verify compliance. Providers are required to perform quality assurance activities and improvements which may include medication record reviews.
2. 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 conducts Quality Assurance Reviews at a minimum of every two years to determine compliance with medication. The SMA also responds to serious complaints or incidents that may involve medication issues on an on-going basis.

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

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

Methods used to ensure participant medications are managed appropriately (a.) the identification of potentially harmful practices: - Providers perform ongoing monitoring of self-directed self-administrated medication management by showing compliance with the contractual agreement of staff medication competencies. - DSPD places a contractual obligation on its providers who participate in the supervised self-directed self-administration of waiver enrollee medications to utilize "blister-pack" medication packaging from licensed pharmacies whenever possible. The licensed pharmacy plays a role in monitoring medications for potentially harmful practices. - Periodic monitoring of participant health and welfare is performed by the Support Coordinator. - DHHS/DSPD contract analyst reviews staff medication competencies annually. - DHHS/DSPD Quality Assurance compiles and analyzes incident report data that includes medication errors. - The SMA conducts Quality Assurance Reviews which include medication performance measures. (b.) The method for following up on potentially harmful practices - Notification of incidents (including medication errors) is required per contractual agreement to be submitted by the Provider to the DSPD Support Coordinator within 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 DHHS/DSPD regarding medication errors and these reports are reviewed by both the DHHS Office of Licensing as well as the Division Leadership Team. - The SMA receives an annual Incident Report Summary from DSPD which include an analysis of medication errors by Providers.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

○ **Not applicable.** *(do not complete the remaining items)*

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

• **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 DHHS 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;

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

◉ **Providers that are responsible for medication administration are required to both record and report**

medication errors to a state agency (or agencies).
Complete the following three items:

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

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 much 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:

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

DSPD compiles an annual incident report which includes medication errors reported by providers. DHHS/DSPD Contract Analyst reviews each provider on an annual basis, identifies problems with medication management and requires follow-up remediation actions and quality improvement activities if the problem is systemic. DHHS/DSPD performs Ad Hoc reviews that may identify medication management problems, which require follow-up by the provider and incorporation into their quality assurance program. The SMA receives the findings from the above monitoring activities on an on-going basis and as an annual report. The SMA has established an on-going Critical Incident Notification system that requires DSPD to notify the SMA of any serious incidents. DHHS staff review all client files annually, and compare incidents discovered through this method to incident reports filed in the DHHS database. Violations of failure to report are issued when noted.

Appendix G: Participant Safeguards

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.

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

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

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

Performance Measure:
 # and % of abuse, neglect, exploitation and unexpected death incidents reported to DSPD within 24 hours of discovery of occurrence. Numerator is total number of abuse, neglect, exploitation and unexpected death incidents reviewed reported to DSPD within 24 hours of the discovery of occurrence; denominator is the total number of abuse, neglect, exploitation and unexpected death incidents reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Participant records, Incident reports, Provider interviews and Provider records

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

	Ongoing	Specify:
	☒ **Other** Specify: Every two years	

Data Aggregation and Analysis:

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

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):
Other
If 'Other' is selected, specify:
Participant records and incident reports

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percentage of suspected abuse, neglect, exploitation and unexpected death incidents referred to Adult Protective Services and/or law enforcement as required by State law. The numerator is the total number of incidents reported correctly; the denominator is the total number of reported incidents reviewed involving suspected abuse, neglect, exploitation and/or unexpected death.

Data Source (Select one):
Other
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):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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):
Other
If 'Other' is selected, specify:
Incident reports

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

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

Data Aggregation and Analysis:

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

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Participant records and Annual report

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

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
Number and percentage of critical incident trends 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):
Other
If 'Other' is selected, specify:

Participant records, Participant Service plans, Participant interviews and Provider interviews

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:
 # & % 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):
Other
If 'Other' is selected, specify:
Participant records and incident reports

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

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
Number and percent of participants whose 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):
Other
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**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence interval, 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Referrals are made to Adult Protective Services and/or law enforcement according to State laws. Prevention strategies are developed and implemented, when abuse, neglect, or exploitation ore 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 SMA conducts an annual review of the ABI program for each of the five waiver years. At a minimum one comprehensive review will be conducted during this five year cycle. The other annual reviews will be focused reviews. The criteria for the focused reviews will be determined from 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 and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. 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. 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 SMA conducts an annual review of the ABI program for each of the five waiver years. At a minimum one comprehensive review will be conducted during this five year cycle. The other annual reviews will be focused reviews. The criteria for the focused reviews will be determined from DHS/DSPD and SMA review findings as well as other issues that develop during the review year.

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

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

ii. Remediation Data Aggregation

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

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **Other** Specify: Every 2 years

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of health and welfare that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

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

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

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

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

If the state's QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, 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 QIS 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 QIS. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

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

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

ii. System Improvement Activities

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

b. System Design Changes

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

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

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

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

Appendix H: Quality Improvement Strategy (3 of 3)

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

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

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

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

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

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

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

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

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

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

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

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

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

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

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

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

STATE MEDICAID AGENCY ROLE AND PROVIDER CONTRACT REQUIREMENT

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

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

During annual contract reviews, the DSPD Fiscal Review and Audit Unit reviews 100% of provider contracts. A component of the reviews includes a review of payment histories and the documentation to support those payments. This

ensures the services were received and the correct payment was made.

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

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

INTERAGENCY AGREEMENT FOR OPERATIONS AND ADMINISTRATION OF THE HCBS WAIVER

An interagency agreement between the State Medicaid Agency and DSPD sets forth the respective responsibilities for the administration and operation of this waiver. The agreement delineates the State Medicaid Agency's overall responsibility to provide management and oversight of the waiver including review and approval of all waiver related rules and policies to ensure compliance with Medicaid HCBS Waiver rules and regulations. The agreement also delineates DSPD's roles in relation to the statutory responsibilities to develop the State's program for persons with disabilities. The nature of the agreement enhances provider access to the Medicaid program and quality assurance of services as well as defines the fiscal relationship between the two agencies.

The major components of the agreement are:

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

Appendix I: Financial Accountability

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.

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

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

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Participant Claims Data; PCSP; Participant Budgets

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

Data Aggregation and Analysis:

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

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

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Participant Claims Data, PCSP, Participant Budgets, and Provider Records

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

☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☒ ***Other*** *Specify:* *Every two years.*

Performance Measure:
Number and percentage of recoupments in a representative sample identified and processed correctly through MMIS with an audit trail of the claim paid in error and overpayments are returned to the federal government within required time-frames. The numerator is the total number of recoupments in compliance; the denominator is the total number of recoupments identified in the review sample.

Data Source *(Select one):*
Other

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):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% Confidence Level, 5% Margin of Error*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other***	☒ ***Annually***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
Specify:	
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
Number and percentage of provider claims submitted and processed through the CAPS in a representative sample match the DSPD claims submitted and processed through the MMIS. The numerator is the total number of provider claims in compliance; the denominator is the total number of provider claims submitted and processed through CAPS in the review sample.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
CAPS claims payment history report; MMIS claims payment history report.

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% Confidence Level, 5% Margin of Error*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*

	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☒ ***Other*** *Specify:* *Every two years*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percentage of maximum allowable rates (MARs) for covered Waiver services which are consistent with the approved rate methodology. 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):*
Other
If 'Other' is selected, specify:
Participant Claims Data; PCSP; Participant Budgets

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

The SMA conducts an annual review of the ABI program for each of the five Waiver years. Due to available resources, at a minimum one comprehensive review will be conducted during this five year cycle. The comprehensive review will include participant and provider interviews. The other annual reviews will be focused reviews. The criteria for the focused reviews will be determined from DSPD and SMA review findings as well as other issues that develop during the review year. The sample size for each review will be sufficient to provide a confidence level equal to 95% and a confidence interval equal to 5.

Contract analysts from DSPD will monitor monthly usage of approved services to ensure that billed services are within the participants budget. Adjustments will be made to the service plan and budgets when warranted by changes in participant needs. The Utah Systems for Tracking Eligibility, Planning, and Services (USTEPS) will assist with preventing overpayments that are over an individuals budget by providing reports to support coordinators to review when claims are significantly under or over budget.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. 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):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☒ ***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.

◉ ***No***

○ ***Yes***

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

There are four principal methods used in setting the DHS Maximum Allowable Rate level. Each method is designed to determine a fair market rate. Four different methodologies are in place to accommodate the different market factors that exist for different types of services. With all new services and any inflationary increases or decreases to existing service rates, the SMA reviews and approves all proposed rates prior to the rates being loaded into the MMIS.

Adjustments to the following processes may be deemed necessary on occasion to comply with funding changes allocated through the legislative process. When funding is expressly committed to a service or sub-set of services, the SMA and OA work to establish the new rate amount based on funding allocated.

Additionally, the process may be adjusted on occasion to account for common factors such as the geographical location of service delivery, absentee factors, or division budget constraints, etc. Rates may also be adjusted at the direction of the Utah State Legislature.

1. Existing Market Survey or Cost Survey of Current Providers.

This methodology surveys existing providers to determine their actual cost to render a service. This would include direct labor, supervision, administration, non-labor costs allocated to the purchased service and the basis of cost allocations. The surveys are designed to assure all providers are reporting costs in a standardized manner and within allowable costs parameters established by DHS. Surveys are examined to determine if cost definitions, allocations and reporting are consistent among respondents and accurately include reasonable costs of business. The rate is set using a measure of central tendency such as median, mode or weighted average and adjusted if necessary to reflect prevailing market conditions. (For example, a large provider may distort data and smaller providers may have substantially different costs. Failure to adjust for market realities may result in lack of available providers if the rate is set too low, or unnecessarily paying too much if the rate is set too high.)

2. Component Cost Analysis

The estimated cost of each of the various components of a service code (rent, treatment, administration, direct labor, non-labor costs allocated to the service, etc) are determined and added together to determine a provisional rate. This method is often used for a new or substantially modified service that does not currently exist in the market place. Provisional rates are designed to determine a fair market rate until historical data becomes available. At a later date when historical cost data does become available a market survey may be undertaken to confirm or adjust the rate.

3. Comparative Analysis

This method may be used when a similar service exists. Adjustments are made to reflect any differences in the new service. Where possible and to provide consistency of payments in the provider community, rates are set to maintain common rates for common services purchased by various agencies. If a proposed service duplicates an existing service being used by another agency or program, the existing rate may be used to provide consistency of payments in the provider community, if the companion agency rate is considered to be in line with the market.

4. Community Price Survey

Where a broad based market exists for a service outside of DHS, existing service providers may be surveyed to determine the prevailing market price for the service. Again, measures of central tendency such as median, mode or weighted average are used and adjusted if necessary to reflect prevailing market.

The State solicited public comment during the drafting of the waiver renewal application. The State Medicaid Agency and the Division of Services for People with Disabilities completed the initial draft application November, 2013. The revised draft was submitted to a broad network of consumers, advocates, providers and Tribal Governments and the Medical Care Advisory Committee (MCAC). The entities were sent an electronic copy of the application and were asked to disseminate copies broadly. Entities had 30 days in which to submit comments or questions about all aspects of the ABI Waiver Application.

Payment rates are made available to participants so that they can make informed choices regarding their self-administered services in two ways. One: Support coordinators provide payment rate information to participants during their enrollment in self-administered services. Two: Annually, DSPD sends an approved payment rate letter to the FMS

providers. The FMS providers then communicate this information to all participants they serve.

The method used to establish the rate for each waiver service is provided below, along with information regarding how the service is reimbursed to the provider:

ABI Waiver Support Coordination - Comparative Analysis - Fixed/Predetermined
Day Supports - Comparative Analysis - Fixed/Predetermined
Homemaker - Comparative Analysis - Fixed/Predetermined
Residential Habilitation - Comparative Analysis - Varies by client based upon their acuity/supervision needs
Respite - Comparative Analysis - Fixed/Predetermined
Supported Employment- Comparative Analysis - Fixed/Predetermined (payment for 1:1 service and small group use the same methodology but adjust for staffing ratios; co-worker supports are paid to eligible employers and may be a pass-through to the worker directly assisting the waiver participant)
Financial Management Services - Comparative Analysis - Fixed/Predetermined
Behavior Consultation I - Comparative Analysis - Fixed/Predetermined
Behavior Consultation II - Comparative Analysis - Fixed/Predetermined
Behavior Consultation Service III - Comparative Analysis - Fixed/Predetermined
Chore Services - Comparative Analysis - Fixed/Predetermined
Companion Services - Comparative Analysis - Fixed/Predetermined
Environmental Adaptations – Home - Community Price Survey - Based on Episode
Environmental Adaptations – Vehicle - Community Price Survey - Based on Episode
Extended Living Supports - Comparative Analysis - Fixed/Predetermined
Living Start-Up Costs - Comparative Analysis - Fixed/Predetermined
Massage Therapy - Comparative Analysis - Fixed/Predetermined
Personal Budget Assistance - Comparative Analysis - Fixed/Predetermined
Personal Emergency Response System - Existing Market Survey - Fixed/Predetermined
Professional Medication Monitoring - Comparative Analysis - Fixed/Predetermined
Specialized Medical Equipment/Supplies/Assistive Technology - Purchase - Community Price Survey - Fixed/Predetermined
Specialized Medical Equipment/Supplies/Assistive Technology- Monthly Fee - Community Price Survey - Fixed/Predetermined
Supported Living - Comparative Analysis - Fixed/Predetermined
Transportation Services (non-medical) - Comparative Analysis - Fixed/Predetermined
Center-Based Prevocational Services - Equal to the reimbursement offered for Day Supports.

The difference in rate payment between agency and self-direction is primarily the anticipated amount used for administration/overhead, otherwise the methodologies remain similar.

The State has compared service requirements and reimbursement to several surrounding states including: Wyoming, Nevada, North Dakota, Oregon, Idaho, Colorado, Arizona, New Mexico, and Montana. The State has used this methodology as nearby states may have similar challenges with respect to urban/rural service delivery; similar labor markets; service descriptions/qualifications; etc. The State has used this method in order to validate whether payment rates established fall within reason after accounting for differences which may exist in provider qualifications (ex. Requirement service is delivered by a Registered Nurse); how reimbursement is made (daily, hourly, episodic); cost of living; etc.

The State reviews rates at least once each waiver cycle and has enlisted the assistance of a CPA firm to assist in administering a cost survey to providers. The second year of this project is nearing its end at which point the SMA and OA intend to review the data provided and determine if any rate rebasing may be required.

Beginning 4/1/22, services with direct care labor components were increased due to legislative appropriation (19.54%). Funding was appropriated to the Department and the effect (percentage) was evaluated against projected expenditure and enrollment, leading to the final amount.

March 2026 update to supported job development, supported employment and specialized supports-massage therapy:

DSPD contracted with Health Management Associates (HMA-Burns) to conduct a comprehensive rate study including payment rates for supported job development, supported employment and specialized supports- massage therapy. The rate study process

included reviewed data from multiple sources. Policies, rules and standards were reviewed including program regulations, manuals, state and federal requirements. Provider and stakeholder input was used throughout the process to inform the rate models. This included a stakeholder advisory group which met throughout the process to provide feedback and review project goals and materials. All providers were requested to complete a survey detailing costs and service delivery issues. Published sources including state and federal statutes regarding payroll taxes, Utah specific Bureau of Labor Statistics wage and inflation data, Utah specific health insurance data from the U.S. Department of Health and Human Services' Medical Expenditure Panel Survey (MEPS), and Internal Revenue Service mileage rates were used in the creation of the rate models. In some of the rates, including specialized supports- massage therapy rate benchmarking against non-Medicaid service providers and comparable services in other states was also used.

Independent rate models were created to reflect the costs that providers face in delivering a given service. Specific assumptions are made for these various costs, including:

- The wage of the direct care provider
- Benefits for the direct care provider
- The productivity of the direct care provider (to account for non-billable responsibilities)
- Other direct care costs, such as transportation and program supplies
- Agency overhead costs
- Programmatic factors that impact per-person costs, such as staffing ratios

Proposed rate models posted online. Providers and other stakeholders were notified of the posting via email. Online webinars reviewing both the proposed were held with providers and stakeholders. Recording of the webinar was posted online on a dedicated website.

A dedicated email address was created to accept comments and suggestions for a period of approximately one month. HMA-Burns reviewed every comment submitted and
prepared a written document summarizing its response to each, including any resulting revision to the rate models or an explanation for why no change was made.

After review of the public comments and DHHS leadership input, finalized rate models were again posted online and an additional webinar was conducted to communicate any changes to the proposed models.

HMA-Burns recommendations included differentiation between job development and job coaching that would require splitting the prior supported employment service code into job development and job coaching rates. They also recommended using standardized rates across programs, instead of the variable supported employment rate that had been previously used. Both job development and job coaching rates were recommended to be billed as quarterly units.

Massage therapy rates were based on research of commercial rates charged by licensed massage therapists in the greater Salt Lake City area. They also reviewed rates paid by the few other states that cover massage therapy services in their waiver programs. The rate model reflects a higher in-home service rate to account for travel time and lower productivity .

To fulfill the requirements listed in the DOJ settlement agreement, DSPD is implementing a strategic increase in provider rates for supported employment services. The rate increases will be coupled with value-based incentives based on performance goals.This adjustment is designed to address systemic barriers to competitive integrated employment by enhancing the financial viability of individualized, person-centered supports. By aligning the rate structure with the settlement's mandates, DSPD aims to incentivize providers in favor of tailored career development. This will support DSPD in achieving the following outcomes:

- By 1 year after the Implementation Date, Utah will deliver Supported Employment services to at least 50% of the Focus Population Members identified by Utah's Employment Pathway tool as being unemployed but interested in working in the year preceding the Implementation Effective Date.
- By 2 years after the Implementation Date, Utah will deliver Supported Employment services to at least 95% of the Focus Population Members identified by Utah's Employment Pathway tool as being unemployed but interested in working in the year preceding the Implementation Effective Date.

To determine the amounts for the Job Placement, Job Retention, and Data Entry milestone payments, DSPD established a baseline derived from the Utah Community Rehabilitation Program (CRP) Vocational Rehabilitation (VR) services. The rate models utilize the July 1, 2022 approved fee for Supported Job-Based Training (SJBT) and Supported Employment (SE). This baseline accounts for high quality indicators including hourly wages, work hours, placement within 60 days, health benefits, STEM, and rural job development and stability. To ensure the 2026 rates remain competitive and reflective of current economic conditions, DSPD applied the Consumer Price Index (CPI) inflation adjustment to the 2022 baseline. The Job Placement and Job Retention milestone payments are ongoing and the Data Entry milestone payment is one-time.

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 form 520; payments are then made to the providers. Dept of Human Services/DSPD submits billing claims to DOH for reimbursement.

For individuals self-directing their self-administered services, the participant submits their staff time sheet(s) to the FMS Agent. The FMS Agent pays the claim(s) and submits a bill to DHS/DSPD on form 520. DHS/DSPD pays the FMS Agent then submits billing claim to DOH for reimbursement.

Providers who voluntarily reassign payment to DHS/DSPD have three options for submitting a request for payment:
1. Upload a data file containing the payment data.
2. Manually enter the payment directly into the system.
3. Deliver a paper invoice to DSPD for hand entry into the system.

All three options fall into the same process where the payment data in the initial submission is automatically validated against the service code's prescribed rate/units in the Person Centered Support Plan (PCSP) budget. The process is:

Step 1: The payment is submitted for initial processing.
a. The payment passes the validation process:
i. The payment is automatically sent on to the support coordinator for review.

b. The payment fails validation and is put in "Error" status where the provider must choose from one of three options to resolve the problem:
i. Delete the payment;
ii. Resubmit the payment with corrected data; or
iii. Send the payment to the support coordinator with a note attached to it explaining what needs to be done to resolve the problem.

Step 2: Payments that pass the initial submission process are automatically delivered to the support coordinator for review where they must take one of the following actions.
a. Approve the payment
i. The validation process re-runs against the payment at the moment the support coordinator approves it. If the payment passes, it is forwarded on to Step 3. If it fails, it remains assigned to the support coordinator for further review / action

b. Deny the payment

c. If the payment is in error status even though it was legitimately delivered, then the support coordinator can review the service code's prescription in the PCSP budget. If a change in the plan is appropriate, it can be made. Then, the payment can be approved.

Step 3: Payments that pass the support coordinator's approval (i.e. Step 2) are automatically delivered to the DSPD payment technician for review where they must take one of the following actions. a. Approve the payment
i. The validation process re-runs against the payment at the moment the tech approves it. If the payment passes, it is automatically delivered to CAPS (the 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 the Operating Agency prior to submitting the claims to MMIS. The Operating Agency will review the billing prior authorization forms submitted by the provider and will authorize the provider to bill the MMIS as long as the claims submitted on the billing prior authorization form are consistent with the

service type, amount, frequency and duration as listed on the PCSP and budget.

If the services listed on the billing prior authorization form are consistent with the PCSP and budget, the Operating Agency will submit a notice of approval to the provider authorizing them to bill the MMIS.

If the services listed on the billing prior authorization form are not consistent with the PCSP or budget, billing for services will not be authorized by the Operating Agency. The Operating Agency will submit the denial notice to the provider that will include an explanation of why the prior authorization was denied.

Once the Operating Agency has approved the billing prior authorization forms, the provider will then submit claims directly thought the States' MMIS.

The Acquired Brain Injury Waiver only pays for Non-Medical transportation and only when in accordance with the written plan of care. No waiver expenditures are paid for by DWS and they are not a waiver provider.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

◉ ***No. state or local government agencies do not certify expenditures for waiver services.***

○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

1. A participant's Medicaid eligibility is determined by the Department of Workforce Services or the Bureau of Eligibility Services within the Department of Health. The information is entered into the electronic Resource and Eligibility Product (eREP). eREP is an on-line, rules-based eligibility system which automates Medicaid eligibility decisions, benefits amounts, participants' notices and administrative reports. eREP interfaces with other governmental agencies such as, Social Security, Unemployment Insurance, and the Internal Revenue Service. The system is a Federally-Approved Management Information System (FAMIS). In Utah, the following programs are accessed through eREP: Aid to Families with Dependent Children (AFDC), Medicaid, Food Stamps, and two state-administered programs - General Assistance and the Primary Care Network (PCN). The Medicaid Management Information System (MMIS) accesses eREP to ensure the participant is Medicaid eligible before payment of claims is made.

2. Post-payment reviews are conducted by the Medicaid agency; reviews of a sample of individual written support plans and Medicaid claims histories to ensure: (1) all of the services required by the individual are identified in the support plan, (2) that the individual is receiving the services identified in the support plan, and (3) that Medicaid reimbursement is not claimed for waiver services which were not included in the support plan. The sample size for each review will be sufficient to provide a confidence level equal to 95% and a confidence interval equal to 5.

3. The SMA will perform an annual post payment review of claims that are paid to providers through the CAPS. The review will verify that the rates paid to providers through the CAPS are equal to the rates paid to DSPD through the MMIS.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

○ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***

○ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

◉ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

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 a paper claim that is entered into the CAPS system. The CAPS system has edits in place that will deny payment for reasons such as exceeding the maximum allowable number of approved units or maximum allowable rates, etc. Providers are reimbursed by DHS with either a paper check or an electronic funds transfer as per the provider's preference. DHS then submits a tape of all claims paid through the CAPS to the SMA. The claims are then entered into the MMIS for payment. The SMA makes payment to DHS through an Intergovernmental Transfer of Funds (IGT). Each claim is individually identifiable at the level of the participant, provider, HCPCS and units of service paid.

(c) How an audit trail is maintained for all state and federal funds expended outside the MMIS-
The audit trail outside the MMIS is 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 CAPS by case managers and result in payment authorizations in CAPS. Payment authorizations result in the generation of provider billings. Provider claims are accompanied by eligibility codes that detail whether services qualify for FFP. Claims for services rendered under Medicaid eligibility are then ported to MMIS where recipient and provider eligibility are verified and claims that are determined to be eligible for FFP result in reimbursement to DHS/DSPD. Individual claim information is documented in MMIS.

Utah DOH/DSPD IGT Process
1. The Department of Health (DOH) estimates the state seed amount for the quarter.
2. The DOH sends the IGT request to the Department Human Services (DHS) for the estimated amount.
3. DHS processes the IGT request.
4. DHS approves the request.
5. DOH receives the funds before the start of the quarter.
6. At the end of the quarter, DOH determines the actual seed amount based on the paid claims.
7. The DOH sends the IGT request to the Department of Human Services (DHS) for the actual paid amount.
8. DHS approves the IGT request and DOH receives the funds.
9. DOH refunds the estimated amount to DHS via an IGT.

Utah DSPD/UTA IGT Process
UTA is initially paid out of CAPS. Quarterly IGT's will occur prior to the start of the quarter. UTA will not receive payment for any services in that quarter until the quarterly IGT has been made to DSPD. This guarantees that the provider will not recycle the Federal share of the payment.

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☒ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

The DHS/DSPD serves as the governmental entity that pays for Waiver claims for providers who voluntarily reassign payment to DHS and DHS will pay for all services provided by the Waiver when they are delivered by qualified providers according to the service plan. The DSPD obtains all of the claims for payment for services delivered directly from contract providers on the form 520. It reviews the claims for accuracy and all approved claims are paid directly to the providers by DSPD. The DSPD then submits billing claims to the DOH for reimbursement.

The DSPD has internal controls in place to assure providers paid through the CAPS system receive payment that is equal to the payment DSPD receives from DOH including a comparison of DOH's MMIS Reference File rates with 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 DSPD through the MMIS.

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ○ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ◉ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

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 an Intergovernmental Transfer (IGT). The IGT is made to the Medicaid Agency prior to any federal funds being drawn.

LOCAL GOVERNMENT OR OTHER SOURCE(S) OF THE NON-FEDERAL SHARE OF COMPUTABLE WAIVER COSTS

a. The Utah Transit Authority (UTA), a Utah public transit district, is the local governmental source of the non-federal share of computable waiver costs.
b. The source of the funding from UTA is local sales and use taxes. The funds are publicly approved sales tax revenues levied by the cities and counties within UTA's service district. The taxes are collected quarterly from businesses from the sale of retail goods. The sales tax revenues are given to the transit authority for the operation of a local public transportation agency.
c. The mechanism that is used to transfer funds from the UTA to the Department of Human Services is an IGT. After receiving funds from the UTA, the Department of Human Services will transfer the funds to the Medicaid Agency through an IGT. The reason the funds are transferred to the Department of Human Services rather than to the Medicaid Agency directly is that, in the event UTA chooses to discontinue providing the non-federal share of computable waiver costs, the Department of Human Services would become responsible to provide the non-federal share. The IGT is made to the Medicaid Agency prior to any federal funds being drawn.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

◉ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***

○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***

○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***

○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***

○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements***

under the provisions of 42 CFR § 447.10.

○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

○ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***

○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 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 section 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 section 1915(b)/section 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 section 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 section 1115/section 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 section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☐ ***Appropriation of State Tax Revenues to the State Medicaid Agency***

☒ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

The Division of 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 an Intergovernmental Transfer (IGT). This prepayment transfer is based on estimates for the upcoming quarter and takes place approximately 15 days before each new quarter. At the end of each quarter, the State Medicaid Agency will perform a reconciliation of the actual state match obligation and the prepaid amount.

State Tax Revenues (general funds) are appropriated directly to the Department of Human Services by the legislature. 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 an Intergovernmental Transfer (IGT). This prepayment transfer is based on estimates for the upcoming quarter and takes place approximately 15 days before each new quarter. At the end of each quarter, the State Medicaid Agency will perform a reconciliation of the actual state match obligation and the prepaid amount.

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

○ ***Not Applicable***. *There are no local government level sources of funds utilized as the non-federal share.*

◉ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☒ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

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.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***

◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Medicaid reimbursement rates paid to Residential Habilitation providers for habilitation services will be individualized based upon the assessed needs of the individual. The daily rate paid to the Residential Habilitation providers cover only the cost of the habilitation services. The daily Medicaid reimbursement excludes all room and board costs.

Individuals are responsible to pay room and board directly to their landlord and purchase food from their personal income. Individuals having insufficient personal income to cover their entire room and board costs may be assisted by a State funded program in which the Division of Services for People with Disabilities assists individuals in paying these costs.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- ◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	73148.60	3656.85	76805.45	89592.97	7950.81	97543.78	20738.33
2	73242.20	3729.99	76972.19	91384.83	8109.83	99494.66	22522.47
3	73242.20	3804.59	77046.79	93212.53	8272.03	101484.56	24437.77
4	73242.20	3880.68	77122.88	95076.78	8437.47	103514.25	26391.37
5	73242.20	3958.29	77200.49	96978.32	8606.22	105584.54	28384.05

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	164	164
Year 2	164	164
Year 3	164	164
Year 4	164	164
Year 5	164	164

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

Average Length of Stay (LOS) = 349 days
- Used the average annual LOS for FY21 and FY22

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

- All calculations are based off the actual amounts for FY2021 and FY2022
- Unduplicated client counts were increased and the number of users for each service was raised proportional to the change in enrollment.
- Rates were updated to reflect current provider reimbursement
- Units Per User is the average units per user for FY2016-2018 rounded to the next whole number
- Estimates may have had slight adjustments if trending data indicated that they may not be reflective of anticipated utilization
- Estimates for intermittently used services were approximated, or cost/utilization data may have been taken from other waiver programs.
- Beginning 5/1/25, inline with legislative appropriation and intent, increase the payment for Massage Therapy services by 19.54%.

- The state did not include an inflationary factor for Factor D as legislative appropriation is received intermittently and does not affect service rates in a consistent fashion

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

- All calculations are based off the actual amounts for FY2021 and FY2022. Based on previous expenditures observed and trending of data, the State has estimated D' expenditure less than G'. This waiver has a relatively low number of participants and the State may experience variance in utilization/projections as a result.
- Average cost per enrollee was increased by 2% for each subsequent year consistent with the mandatory inflation in the State's contracts with the ACOs and the consumer price index for medical services.
- The state utilizes the MMIS Categories of Service and Provider Type functionality to account for and exclude the costs of prescribed drugs from D'

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

- All calculations are based off the actual amounts for FY2021 and FY2022 with 2 years of inflationary increases (2%) for the years between 2022 and 2024
- Per diem amounts calculated and multiplied by waiver LOS for comparison
- 2% increase added for each subsequent year consistent with the mandatory inflation in the State's contracts with the ACOs and the consumer price index for medical services.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

- All calculations are based off the actual amounts for FY2021 and FY2022 with 2 years of inflationary increases (2%) for the years between 2022 and 2024
- Per diem amounts calculated and multiplied by waiver LOS for comparison
- 2% increase added for each subsequent year consistent with the mandatory inflation in the State's contracts with the ACOs and the consumer price index for medical services.
- The state utilizes the MMIS Categories of Service and Provider Type functionality to account for and exclude the costs of prescribed drugs from G'

The State believes that due to the needs of this waiver population being more habilitative in nature, the supports offered through the waiver comprise the majority of the individual's need. While the immediate care which may have surrounded the qualifying condition may have been costly, this population does not have extensive ongoing medical need. The care provided through the waiver offers stability for participants, preventing the need for more acute care needs typically paid through the State Plan.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed*

separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.

Waiver Services	
ABI Waiver Support Coordination	
Center-Based Prevocational Services	
Day Supports	
Homemaker	
Residential Habilitation	
Respite	
Supported Employment	
Consumer Preparation Services	
Financial Management Services	
Behavior Consultation I	
Behavior Consultation II	
Behavior Consultation III	
Chore Services	
Community Transition Service	
Companion Services	
Environmental Adaptations - Home	
Environmental Adaptations - Vehicle	
Extended Living Supports	
Massage Therapy	
Personal Budget Assistance	
Personal Emergency Response System	
Professional Medication Monitoring	
Specialized Medical Equipment/Supplies/Assistive Technology - Purchase	
Specialized Medical Equipment/Supplies/Assistive Technology- Monthly Fee	
Supported Living	
Transportation Services (non-medical)	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
ABI Waiver Support Coordination Total:						***452778.48***
ABI Waiver Support					***452778.48***	

GRAND TOTAL: 11996369.91

Total Estimated Unduplicated Participants: 164

Factor D (Divide total by number of participants): 73148.60

Average Length of Stay on the Waiver: 349

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Coordination	Monthly	154	12.00	245.01		
Center-Based Prevocational Services Total:						22667.52
Center-Based Prevocational Services	Daily	1	192.00	118.06	22667.52	
Day Supports Total:						2188874.54
Day Supports (Site/Non-site) - 15 Minutes	15 Minute	23	3646.00	13.53	1134598.74	
Day Supports - daily	Daily	47	190.00	118.06	1054275.80	
Homemaker Total:						133.00
Homemaker	15 Minute	1	20.00	6.65	133.00	
Residential Habilitation Total:						5811536.16
Residential Habilitation - Facility Based	Daily	54	309.00	276.66	4616348.76	
Residential Habilitation - Host Home/Professional Parent	Daily	19	270.00	232.98	1195187.40	
Respite Total:						39128.80
Respite Care - Unskilled 15 Minute	15 Minute	8	940.00	4.58	34441.60	
Respite Care - Daily	Daily	1	20.00	110.42	2208.40	
Respite Care - Room and Board Included - Daily	Daily	1	20.00	123.94	2478.80	
Supported Employment Total:						272627.90
Supported Employment - Daily	Daily	5	122.00	55.67	33958.70	
Supported Employment - 15 minute	15 Minute	21	840.00	13.53	238669.20	
Consumer Preparation Services Total:						123.20
Consumer Preparation Services	15 Minute	1	20.00	6.16	123.20	
Financial Management Services Total:						32000.00
Financial Management Services	Monthly	32	10.00	100.00	32000.00	
Behavior Consultation I Total:						6025.65
Behavior Consultation I	15 Minute	5	139.00	8.67	6025.65	
Behavior Consultation II Total:						100636.38

GRAND TOTAL: 11996369.91

Total Estimated Unduplicated Participants: 164

Factor D (Divide total by number of participants): 73148.60

Average Length of Stay on the Waiver: 349

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Behavior Consultation II	15 Minute	39	174.00	14.83	100636.38	
Behavior Consultation III Total:						92856.96
Behavior Consultation III	15 Minute	21	196.00	22.56	92856.96	
Chore Services Total:						6822.90
Chore Services	15 Minute	2	513.00	6.65	6822.90	
Community Transition Service Total:						362.41
Community Transition Service	Per Episode	1	1.00	362.41	362.41	
Companion Services Total:						27042.70
Companion Services - Daily (6 hrs +)	Daily	1	20.00	151.04	3020.80	
Companion Services - 15 minute	15 Minute	3	1271.00	6.30	24021.90	
Environmental Adaptations - Home Total:						3396.08
Environmental Adaptations - Home	Per Episode	2	1.00	1698.04	3396.08	
Environmental Adaptations - Vehicle Total:						4245.00
Environmental Adaptations - Vehicle	Per Episode	1	1.00	4245.00	4245.00	
Extended Living Supports Total:						62150.00
Extended Living Supports	15 Minute	8	1243.00	6.25	62150.00	
Massage Therapy Total:						78498.86
Massage Therapy	15 Minute	34	151.00	15.29	78498.86	
Personal Budget Assistance Total:						33389.00
Personal Budget Assistance - 15 minute	15 Minute	14	70.00	9.16	8976.80	
Personal Budget Assistance - Session	Daily	58	23.00	18.30	24412.20	
Personal Emergency Response System Total:						2702.42
Personal Emergency Response System - Service Fee Monthly	Monthly	9	10.00	28.90	2601.00	
Personal Emergency Response System - Purchase	Per Episode	2	1.00	36.48	72.96	
Personal Emergency					28.46	

GRAND TOTAL: 11996369.91

Total Estimated Unduplicated Participants: 164

Factor D (Divide total by number of participants): 73148.60

Average Length of Stay on the Waiver: 349

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Response System - Installation	Per Episode	1	1.00	28.46		
Professional Medication Monitoring Total:						**31763.67**
Professional Medication Monitoring - RN	15 Minute	31	75.00	12.03	**27969.75**	
Professional Medication Monitoring - LPN	15 Minute	6	76.00	8.32	**3793.92**	
Specialized Medical Equipment/Supplies/Assistive Technology - Purchase Total:						**121.60**
Specialized Medical Equipment/Supplies/Assistive Technology - Purchase	Per Episode	1	5.00	24.32	**121.60**	
Specialized Medical Equipment/Supplies/Assistive Technology- Monthly Fee Total:						**4115.04**
Specialized Medical Equipment/Supplies/Assistive Technology- Monthly Fee	Monthly	3	8.00	171.46	**4115.04**	
Supported Living Total:						**2495211.48**
Supported Living	15 Minute	81	3363.00	9.16	**2495211.48**	
Transportation Services (non-medical) Total:						**227160.16**
Non-Medical Transportation - Per Trip (UTA)	Per Episode	7	114.00	6.93	**5530.14**	
Non-Medical Transportation - Mileage	Per mile	1	500.00	0.42	**210.00**	
Non-Medical Transportation - Daily (Flat rate for all trips needed)	Daily	50	182.00	20.80	**189280.00**	
Non-Medical Transportation - UTA Bus Pass Purchase	Per Episode	22	11.00	132.81	**32140.02**	

GRAND TOTAL: 11996369.91

Total Estimated Unduplicated Participants: 164

Factor D (Divide total by number of participants): 73148.60

Average Length of Stay on the Waiver: 349

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
ABI Waiver Support Coordination Total:						**452778.48**
ABI Waiver Support Coordination	Monthly	154	12.00	245.01	**452778.48**	
Center-Based Prevocational Services Total:						**22667.52**
Center-Based Prevocational Services	Daily	1	192.00	118.06	**22667.52**	
Day Supports Total:						**2188874.54**
Day Supports (Site/Non-site) - 15 Minutes	15 Minute	23	3646.00	13.53	**1134598.74**	
Day Supports - daily	Daily	47	190.00	118.06	**1054275.80**	
Homemaker Total:						**133.00**
Homemaker	15 Minute	1	20.00	6.65	**133.00**	
Residential Habilitation Total:						**5811536.16**
Residential Habilitation - Facility Based	Daily	54	309.00	276.66	**4616348.76**	
Residential Habilitation - Host Home/Professional Parent	Daily	19	270.00	232.98	**1195187.40**	
Respite Total:						**39128.80**
Respite Care - Unskilled 15 Minute	15 Minute	8	940.00	4.58	**34441.60**	
Respite Care - Daily	Daily	1	20.00	110.42	**2208.40**	
Respite Care - Room and Board Included - Daily	Daily	1	20.00	123.94	**2478.80**	
Supported Employment Total:						**272627.90**
Supported Employment - Daily	Daily	5	122.00	55.67	**33958.70**	
Supported Employment - 15 minute	15 Minute	21	840.00	13.53	**238669.20**	
Consumer Preparation Services Total:						**123.20**
Consumer Preparation Services	15 Minute	1	20.00	6.16	**123.20**	
Financial Management Services Total:						**32000.00**
Financial Management Services	Monthly	32	10.00	100.00	**32000.00**	
Behavior Consultation I Total:						**6025.65**
Behavior Consultation I					**6025.65**	

GRAND TOTAL: 12011720.57

Total Estimated Unduplicated Participants: 164

Factor D (Divide total by number of participants): 73242.20

Average Length of Stay on the Waiver: 349

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	15 Minute	5	139.00	8.67		
Behavior Consultation II Total:						**100636.38**
Behavior Consultation II	15 Minute	39	174.00	14.83	**100636.38**	
Behavior Consultation III Total:						**92856.96**
Behavior Consultation III	15 Minute	21	196.00	22.56	**92856.96**	
Chore Services Total:						**6822.90**
Chore Services	15 Minute	2	513.00	6.65	**6822.90**	
Community Transition Service Total:						**362.41**
Community Transition Service	Per Episode	1	1.00	362.41	**362.41**	
Companion Services Total:						**27042.70**
Companion Services - Daily (6 hrs +)	Daily	1	20.00	151.04	**3020.80**	
Companion Services - 15 minute	15 Minute	3	1271.00	6.30	**24021.90**	
Environmental Adaptations - Home Total:						**3396.08**
Environmental Adaptations - Home	Per Episode	2	1.00	1698.04	**3396.08**	
Environmental Adaptations - Vehicle Total:						**4245.00**
Environmental Adaptations - Vehicle	Per Episode	1	1.00	4245.00	**4245.00**	
Extended Living Supports Total:						**62150.00**
Extended Living Supports	15 Minute	8	1243.00	6.25	**62150.00**	
Massage Therapy Total:						**93849.52**
Massage Therapy	15 Minute	34	151.00	18.28	**93849.52**	
Personal Budget Assistance Total:						**33389.00**
Personal Budget Assistance - 15 minute	15 Minute	14	70.00	9.16	**8976.80**	
Personal Budget Assistance - Session	Daily	58	23.00	18.30	**24412.20**	
Personal Emergency Response System Total:						**2702.42**
Personal Emergency Response System - Service Fee Monthly	Monthly	9	10.00	28.90	**2601.00**	

GRAND TOTAL: 12011720.57

Total Estimated Unduplicated Participants: 164

Factor D (Divide total by number of participants): 73242.20

Average Length of Stay on the Waiver: 349

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response System - Purchase	Per Episode	2	1.00	36.48	72.96	
Personal Emergency Response System - Installation	Per Episode	1	1.00	28.46	28.46	
Professional Medication Monitoring Total:						31763.67
Professional Medication Monitoring - RN	15 Minute	31	75.00	12.03	27969.75	
Professional Medication Monitoring - LPN	15 Minute	6	76.00	8.32	3793.92	
Specialized Medical Equipment/Supplies/Assistive Technology - Purchase Total:						121.60
Specialized Medical Equipment/Supplies/Assistive Technology - Purchase	Per Episode	1	5.00	24.32	121.60	
Specialized Medical Equipment/Supplies/Assistive Technology- Monthly Fee Total:						4115.04
Specialized Medical Equipment/Supplies/Assistive Technology- Monthly Fee	Monthly	3	8.00	171.46	4115.04	
Supported Living Total:						2495211.48
Supported Living	15 Minute	81	3363.00	9.16	2495211.48	
Transportation Services (non-medical) Total:						227160.16
Non-Medical Transportation - Per Trip (UTA)	Per Episode	7	114.00	6.93	5530.14	
Non-Medical Transportation - Mileage	Per mile	1	500.00	0.42	210.00	
Non-Medical Transportation - Daily (Flat rate for all trips needed)	Daily	50	182.00	20.80	189280.00	
Non-Medical Transportation - UTA Bus Pass Purchase	Per Episode	22	11.00	132.81	32140.02	

GRAND TOTAL: 12011720.57

Total Estimated Unduplicated Participants: 164

Factor D (Divide total by number of participants): 73242.20

Average Length of Stay on the Waiver: 349

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
ABI Waiver Support Coordination Total:						**452778.48**
ABI Waiver Support Coordination	Monthly	154	12.00	245.01	**452778.48**	
Center-Based Prevocational Services Total:						**22667.52**
Center-Based Prevocational Services	Daily	1	192.00	118.06	**22667.52**	
Day Supports Total:						**2188874.54**
Day Supports (Site/Non-site) - 15 Minutes	15 Minute	23	3646.00	13.53	**1134598.74**	
Day Supports - daily	Daily	47	190.00	118.06	**1054275.80**	
Homemaker Total:						**133.00**
Homemaker	15 Minute	1	20.00	6.65	**133.00**	
Residential Habilitation Total:						**5811536.16**
Residential Habilitation - Facility Based	Daily	54	309.00	276.66	**4616348.76**	
Residential Habilitation - Host Home/Professional Parent	Daily	19	270.00	232.98	**1195187.40**	
Respite Total:						**39128.80**
Respite Care - Unskilled 15 Minute	15 Minute	8	940.00	4.58	**34441.60**	
Respite Care - Daily	Daily	1	20.00	110.42	**2208.40**	
Respite Care - Room and Board Included - Daily	Daily	1	20.00	123.94	**2478.80**	
Supported Employment Total:						**272627.90**
Supported Employment - Daily	Daily	5	122.00	55.67	**33958.70**	
Supported Employment - 15 minute	15 Minute	21	840.00	13.53	**238669.20**	
Consumer Preparation Services Total:						**123.20**
Consumer Preparation Services	15 Minute	1	20.00	6.16	**123.20**	
Financial Management Services Total:						**32000.00**
Financial Management Services	Monthly	32	10.00	100.00	**32000.00**	
Behavior Consultation I Total:						**6025.65**
Behavior Consultation I					**6025.65**	

GRAND TOTAL: 12011720.57

Total Estimated Unduplicated Participants: 164

Factor D (Divide total by number of participants): 73242.20

Average Length of Stay on the Waiver: 349

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	15 Minute	5	139.00	8.67		
Behavior Consultation II Total:						**100636.38**
Behavior Consultation II	15 Minute	39	174.00	14.83	**100636.38**	
Behavior Consultation III Total:						**92856.96**
Behavior Consultation III	15 Minute	21	196.00	22.56	**92856.96**	
Chore Services Total:						**6822.90**
Chore Services	15 Minute	2	513.00	6.65	**6822.90**	
Community Transition Service Total:						**362.41**
Community Transition Service	Per Episode	1	1.00	362.41	**362.41**	
Companion Services Total:						**27042.70**
Companion Services - Daily (6 hrs +)	Daily	1	20.00	151.04	**3020.80**	
Companion Services - 15 minute	15 Minute	3	1271.00	6.30	**24021.90**	
Environmental Adaptations - Home Total:						**3396.08**
Environmental Adaptations - Home	Per Episode	2	1.00	1698.04	**3396.08**	
Environmental Adaptations - Vehicle Total:						**4245.00**
Environmental Adaptations - Vehicle	Per Episode	1	1.00	4245.00	**4245.00**	
Extended Living Supports Total:						**62150.00**
Extended Living Supports	15 Minute	8	1243.00	6.25	**62150.00**	
Massage Therapy Total:						**93849.52**
Massage Therapy	15 Minute	34	151.00	18.28	**93849.52**	
Personal Budget Assistance Total:						**33389.00**
Personal Budget Assistance - 15 minute	15 Minute	14	70.00	9.16	**8976.80**	
Personal Budget Assistance - Session	Daily	58	23.00	18.30	**24412.20**	
Personal Emergency Response System Total:						**2702.42**
Personal Emergency Response System - Service Fee Monthly	Monthly	9	10.00	28.90	**2601.00**	

GRAND TOTAL: 12011720.57

Total Estimated Unduplicated Participants: 164

Factor D (Divide total by number of participants): 73242.20

Average Length of Stay on the Waiver: 349

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response System - Purchase	Per Episode	2	1.00	36.48	72.96	
Personal Emergency Response System - Installation	Per Episode	1	1.00	28.46	28.46	
Professional Medication Monitoring Total:						31763.67
Professional Medication Monitoring - RN	15 Minute	31	75.00	12.03	27969.75	
Professional Medication Monitoring - LPN	15 Minute	6	76.00	8.32	3793.92	
Specialized Medical Equipment/Supplies/Assistive Technology - Purchase Total:						121.60
Specialized Medical Equipment/Supplies/Assistive Technology - Purchase	Per Episode	1	5.00	24.32	121.60	
Specialized Medical Equipment/Supplies/Assistive Technology- Monthly Fee Total:						4115.04
Specialized Medical Equipment/Supplies/Assistive Technology- Monthly Fee	Monthly	3	8.00	171.46	4115.04	
Supported Living Total:						2495211.48
Supported Living	15 Minute	81	3363.00	9.16	2495211.48	
Transportation Services (non-medical) Total:						227160.16
Non-Medical Transportation - Per Trip (UTA)	Per Episode	7	114.00	6.93	5530.14	
Non-Medical Transportation - Mileage	Per mile	1	500.00	0.42	210.00	
Non-Medical Transportation - Daily (Flat rate for all trips needed)	Daily	50	182.00	20.80	189280.00	
Non-Medical Transportation - UTA Bus Pass Purchase	Per Episode	22	11.00	132.81	32140.02	

GRAND TOTAL: 12011720.57

Total Estimated Unduplicated Participants: 164

Factor D (Divide total by number of participants): 73242.20

Average Length of Stay on the Waiver: 349

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
ABI Waiver Support Coordination Total:						**452778.48**
ABI Waiver Support Coordination	Monthly	154	12.00	245.01	**452778.48**	
Center-Based Prevocational Services Total:						**22667.52**
Center-Based Prevocational Services	Daily	1	192.00	118.06	**22667.52**	
Day Supports Total:						**2188874.54**
Day Supports (Site/Non-site) - 15 Minutes	15 Minute	23	3646.00	13.53	**1134598.74**	
Day Supports - daily	Daily	47	190.00	118.06	**1054275.80**	
Homemaker Total:						**133.00**
Homemaker	15 Minute	1	20.00	6.65	**133.00**	
Residential Habilitation Total:						**5811536.16**
Residential Habilitation - Facility Based	Daily	54	309.00	276.66	**4616348.76**	
Residential Habilitation - Host Home/Professional Parent	Daily	19	270.00	232.98	**1195187.40**	
Respite Total:						**39128.80**
Respite Care - Unskilled 15 Minute	15 Minute	8	940.00	4.58	**34441.60**	
Respite Care - Daily	Daily	1	20.00	110.42	**2208.40**	
Respite Care - Room and Board Included - Daily	Daily	1	20.00	123.94	**2478.80**	
Supported Employment Total:						**272627.90**
Supported Employment - Daily	Daily	5	122.00	55.67	**33958.70**	
Supported Employment - 15 minute	15 Minute	21	840.00	13.53	**238669.20**	
Consumer Preparation Services Total:						**123.20**
Consumer Preparation Services	15 Minute	1	20.00	6.16	**123.20**	
Financial Management Services Total:						**32000.00**
Financial Management Services	Monthly	32	10.00	100.00	**32000.00**	
Behavior Consultation I Total:						**6025.65**
Behavior Consultation I					**6025.65**	

GRAND TOTAL: 12011720.57

Total Estimated Unduplicated Participants: 164

Factor D (Divide total by number of participants): 73242.20

Average Length of Stay on the Waiver: 349

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	15 Minute	5	139.00	8.67		
Behavior Consultation II Total:						**100636.38**
Behavior Consultation II	15 Minute	39	174.00	14.83	**100636.38**	
Behavior Consultation III Total:						**92856.96**
Behavior Consultation III	15 Minute	21	196.00	22.56	**92856.96**	
Chore Services Total:						**6822.90**
Chore Services	15 Minute	2	513.00	6.65	**6822.90**	
Community Transition Service Total:						**362.41**
Community Transition Service	Per Episode	1	1.00	362.41	**362.41**	
Companion Services Total:						**27042.70**
Companion Services - Daily (6 hrs +)	Daily	1	20.00	151.04	**3020.80**	
Companion Services - 15 minute	15 Minute	3	1271.00	6.30	**24021.90**	
Environmental Adaptations - Home Total:						**3396.08**
Environmental Adaptations - Home	Per Episode	2	1.00	1698.04	**3396.08**	
Environmental Adaptations - Vehicle Total:						**4245.00**
Environmental Adaptations - Vehicle	Per Episode	1	1.00	4245.00	**4245.00**	
Extended Living Supports Total:						**62150.00**
Extended Living Supports	15 Minute	8	1243.00	6.25	**62150.00**	
Massage Therapy Total:						**93849.52**
Massage Therapy	15 Minute	34	151.00	18.28	**93849.52**	
Personal Budget Assistance Total:						**33389.00**
Personal Budget Assistance - 15 minute	15 Minute	14	70.00	9.16	**8976.80**	
Personal Budget Assistance - Session	Daily	58	23.00	18.30	**24412.20**	
Personal Emergency Response System Total:						**2702.42**
Personal Emergency Response System - Service Fee Monthly	Monthly	9	10.00	28.90	**2601.00**	

GRAND TOTAL: 12011720.57

Total Estimated Unduplicated Participants: 164

Factor D (Divide total by number of participants): 73242.20

Average Length of Stay on the Waiver: 349

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response System - Purchase	Per Episode	2	1.00	36.48	72.96	
Personal Emergency Response System - Installation	Per Episode	1	1.00	28.46	28.46	
Professional Medication Monitoring Total:						31763.67
Professional Medication Monitoring - RN	15 Minute	31	75.00	12.03	27969.75	
Professional Medication Monitoring - LPN	15 Minute	6	76.00	8.32	3793.92	
Specialized Medical Equipment/Supplies/Assistive Technology - Purchase Total:						121.60
Specialized Medical Equipment/Supplies/Assistive Technology - Purchase	Per Episode	1	5.00	24.32	121.60	
Specialized Medical Equipment/Supplies/Assistive Technology- Monthly Fee Total:						4115.04
Specialized Medical Equipment/Supplies/Assistive Technology- Monthly Fee	Monthly	3	8.00	171.46	4115.04	
Supported Living Total:						2495211.48
Supported Living	15 Minute	81	3363.00	9.16	2495211.48	
Transportation Services (non-medical) Total:						227160.16
Non-Medical Transportation - Per Trip (UTA)	Per Episode	7	114.00	6.93	5530.14	
Non-Medical Transportation - Mileage	Per mile	1	500.00	0.42	210.00	
Non-Medical Transportation - Daily (Flat rate for all trips needed)	Daily	50	182.00	20.80	189280.00	
Non-Medical Transportation - UTA Bus Pass Purchase	Per Episode	22	11.00	132.81	32140.02	

GRAND TOTAL: 12011720.57

Total Estimated Unduplicated Participants: 164

Factor D (Divide total by number of participants): 73242.20

Average Length of Stay on the Waiver: 349

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
ABI Waiver Support Coordination Total:						**452778.48**
ABI Waiver Support Coordination	Monthly	154	12.00	245.01	**452778.48**	
Center-Based Prevocational Services Total:						**22667.52**
Center-Based Prevocational Services	Daily	1	192.00	118.06	**22667.52**	
Day Supports Total:						**2188874.54**
Day Supports (Site/Non-site) - 15 Minutes	15 Minute	23	3646.00	13.53	**1134598.74**	
Day Supports - daily	Daily	47	190.00	118.06	**1054275.80**	
Homemaker Total:						**133.00**
Homemaker	15 Minute	1	20.00	6.65	**133.00**	
Residential Habilitation Total:						**5811536.16**
Residential Habilitation - Facility Based	Daily	54	309.00	276.66	**4616348.76**	
Residential Habilitation - Host Home/Professional Parent	Daily	19	270.00	232.98	**1195187.40**	
Respite Total:						**39128.80**
Respite Care - Unskilled 15 Minute	15 Minute	8	940.00	4.58	**34441.60**	
Respite Care - Daily	Daily	1	20.00	110.42	**2208.40**	
Respite Care - Room and Board Included - Daily	Daily	1	20.00	123.94	**2478.80**	
Supported Employment Total:						**272627.90**
Supported Employment - Daily	Daily	5	122.00	55.67	**33958.70**	
Supported Employment - 15 minute	15 Minute	21	840.00	13.53	**238669.20**	
Consumer Preparation Services Total:						**123.20**
Consumer Preparation Services	15 Minute	1	20.00	6.16	**123.20**	
Financial Management Services Total:						**32000.00**
Financial Management Services	Monthly	32	10.00	100.00	**32000.00**	
Behavior Consultation I Total:						**6025.65**
Behavior Consultation I					**6025.65**	

GRAND TOTAL: 12011720.57

Total Estimated Unduplicated Participants: 164

Factor D (Divide total by number of participants): 73242.20

Average Length of Stay on the Waiver: 349

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	15 Minute	5	139.00	8.67		
Behavior Consultation II Total:						**100636.38**
Behavior Consultation II	15 Minute	39	174.00	14.83	**100636.38**	
Behavior Consultation III Total:						**92856.96**
Behavior Consultation III	15 Minute	21	196.00	22.56	**92856.96**	
Chore Services Total:						**6822.90**
Chore Services	15 Minute	2	513.00	6.65	**6822.90**	
Community Transition Service Total:						**362.41**
Community Transition Service	Per Episode	1	1.00	362.41	**362.41**	
Companion Services Total:						**27042.70**
Companion Services - Daily (6 hrs +)	Daily	1	20.00	151.04	**3020.80**	
Companion Services - 15 minute	15 Minute	3	1271.00	6.30	**24021.90**	
Environmental Adaptations - Home Total:						**3396.08**
Environmental Adaptations - Home	Per Episode	2	1.00	1698.04	**3396.08**	
Environmental Adaptations - Vehicle Total:						**4245.00**
Environmental Adaptations - Vehicle	Per Episode	1	1.00	4245.00	**4245.00**	
Extended Living Supports Total:						**62150.00**
Extended Living Supports	15 Minute	8	1243.00	6.25	**62150.00**	
Massage Therapy Total:						**93849.52**
Massage Therapy	15 Minute	34	151.00	18.28	**93849.52**	
Personal Budget Assistance Total:						**33389.00**
Personal Budget Assistance - 15 minute	15 Minute	14	70.00	9.16	**8976.80**	
Personal Budget Assistance - Session	Daily	58	23.00	18.30	**24412.20**	
Personal Emergency Response System Total:						**2702.42**
Personal Emergency Response System - Service Fee Monthly	Monthly	9	10.00	28.90	**2601.00**	

GRAND TOTAL: 12011720.57

Total Estimated Unduplicated Participants: 164

Factor D (Divide total by number of participants): 73242.20

Average Length of Stay on the Waiver: 349

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response System - Purchase	Per Episode	2	1.00	36.48	72.96	
Personal Emergency Response System - Installation	Per Episode	1	1.00	28.46	28.46	
Professional Medication Monitoring Total:						31763.67
Professional Medication Monitoring - RN	15 Minute	31	75.00	12.03	27969.75	
Professional Medication Monitoring - LPN	15 Minute	6	76.00	8.32	3793.92	
Specialized Medical Equipment/Supplies/Assistive Technology - Purchase Total:						121.60
Specialized Medical Equipment/Supplies/Assistive Technology - Purchase	Per Episode	1	5.00	24.32	121.60	
Specialized Medical Equipment/Supplies/Assistive Technology- Monthly Fee Total:						4115.04
Specialized Medical Equipment/Supplies/Assistive Technology- Monthly Fee	Monthly	3	8.00	171.46	4115.04	
Supported Living Total:						2495211.48
Supported Living	15 Minute	81	3363.00	9.16	2495211.48	
Transportation Services (non-medical) Total:						227160.16
Non-Medical Transportation - Per Trip (UTA)	Per Episode	7	114.00	6.93	5530.14	
Non-Medical Transportation - Mileage	Per mile	1	500.00	0.42	210.00	
Non-Medical Transportation - Daily (Flat rate for all trips needed)	Daily	50	182.00	20.80	189280.00	
Non-Medical Transportation - UTA Bus Pass Purchase	Per Episode	22	11.00	132.81	32140.02	

GRAND TOTAL: 12011720.57

Total Estimated Unduplicated Participants: 164

Factor D (Divide total by number of participants): 73242.20

Average Length of Stay on the Waiver: 349