Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.5

Submitted by:

Utah Department of Health, Division of Medicaid and Health Financing

Submission Date:	July 1, 2012

CMS Receipt Date *(CMS Use)*	

Provide a brief one-two sentence description of the request (e.g., renewal of waiver, request for new waiver, amendment) Include population served and broad description of the waiver program:

Brief Description:
This is a request for a new waiver to serve individuals aged two through five who have an autism spectrum disorder diagnosis and who meet ICF/ID* level of care. The waiver will provide Intensive Individual Support Services (e.g., Applied Behavioral Analysis) and other supportive services such as Respite Care and Support Coordination Services. The waiver will provide services through traditional and Self-Administered Services provider methods. Support Coordination (Case Management) will be provided by the operating agency as an administrative function. *Utah's use of the term ICF/ID has the same meaning as (or is equivalent to) ICF/MR under Federal law.

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

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the 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.

State:	
Effective Date	

1. Request Information

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

B. Waiver Title (*optional*): Medicaid Autism Waiver

C. Type of Request *(select only one)*:

⦿	**New Waiver (3 Years)**	CMS-Assigned Waiver Number (*CMS Use*):	
○	**New Waiver (3 Years) to Replace Waiver #** CMS-Assigned Waiver Number (*CMS Use*): *Attachment #1 contains the transition plan to the new waiver.*		
○	**Renewal (5 Years) of Waiver #**		
○	**Amendment to Waiver #**		

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

○	**Model Waiver**. In accordance with 42 CFR §441.305(b), the State assures that no more than 200 individuals will be served in this waiver at any one time.
⦿	**Regular Waiver**, as provided in 42 CFR §441.305(a)

E.1 Proposed Effective Date: October 1, 2012

E.2 Approved Effective Date *(CMS Use)*:

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

☐	Hospital *(select applicable level of care)*	
	○	Hospital as defined in 42 CFR §440.10. If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
	○	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
☐	Nursing Facility *(select applicable level of care)*	
	○	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 the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150). If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR facility level of care:	

	The State limits the waiver to children ages two through five years who have a confirmed autism spectrum disorder diagnosis. Diagnosis must be rendered by clinician who is authorized under the scope of their licensure.

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

☐	Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I			
☐	Waiver(s) authorized under §1915(b) of the Act. *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*			
	Specify the §1915(b) authorities under which this program operates (*check each that applies*):			
	☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
	☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of providers)
☐	A program operated under §1932(a) of the Act. *Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved.*			
☐	A program authorized under §1915(i) of the Act			
☐	A program authorized under §1915(j) of the Act			
☐	A program authorized under §1115 of the Act. *Specify the program:*			
☑	Not applicable			

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.

This is a request for a new waiver to serve individuals aged two through five who have an autism spectrum disorder (ASD) diagnosis and meet ICF/ID level of care.

The waiver will provide Intensive Individual Support Services, such as Applied Behavioral Analysis, and other supportive services such as Respite Care and Support Coordination Services. The waiver will provide services through traditional and self-administered services provider methods. Support Coordination (Case Management) will be provided by the operating agency as an administrative function.

Empirical data shows that early intervention with intensive individual supports services such as Applied Behavioral Analysis have the ability to improve outcomes for children. The goal of the program is to intervene shortly after a child has been diagnosed with an ASD. The National Research Council Report, *Educating Children with Autism (2001),* indicates that significant parental and family involvement is integral to the success of these interventions and result in better outcomes for the entire family. Through the provision of waiver services, parents and families will be empowered and expected to play an active role in the training and skill building of their children.

The waiver is offered on a statewide basis.

The Utah Department of Health, Division of Medicaid and Health Financing, will enter into an Interagency Agreement with the Department of Human Services, Division of Services for People with Disabilities to act as the operating agency for this waiver. The State Medicaid Agency retains final administrative authority for the waiver.

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)*:

⦿	The waiver provides for participant direction of services. *Appendix E is required*.
○	Not applicable. The waiver does not provide for participant direction of services. *Appendix E is not completed*.

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 overall systems improvement for this waiver.

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

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

4. Waiver(s) Requested

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

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

⦿	Yes
○	No
○	Not applicable

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

○	**Yes** *(complete remainder of item)*
⦿	**No**

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

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

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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 §431.51, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

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

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

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

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

In 2010, a legislative mandate required the Department of Health study options for ASD services. The study was completed by the Department of Health with the involvement of a variety of stakeholders. The stakeholders group included parents, providers, researchers, State agency staff, and local autism advocates. Some of the study's recommendations are reflected in aspects of this waiver application.

In 2012, the State Medicaid Agency (SMA,) in collaboration with the Utah Department of Human Services, Division of Services for People with Disabilities convened a waiver development work

group comprised of multiple stakeholders included parents, providers, researchers, State agency staff, and local autism advocates. This group participated in the development of the waiver application. The workgroup met three times in April and May 2012. In addition, the SMA had a series of statewide meetings to allow parents, providers and other stakeholders to be informed about the waiver application. The meetings were held in the following locations: Logan, Ogden, Price, Provo, Salt Lake City, and St. George. The SMA met with the Indian Health Advisory Board on May 4, 2012. In addition the draft was shared with a broad network of families, disabilities advocates, providers, Tribal Governments, DSPD stakeholders group, and the Medical Care Advisory Committee (MCAC), the Utah Developmental Disabilities Council and the Coordinating Council for People with Disabilities.

A Medicaid Autism Website was developed http://health.utah.gov/autismwaiver/. The waiver draft was available online as was the ability to submit public comment by using the *Submit Public Comments* tab on the website.

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

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

7. Contact Person(s)

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

First Name:	Tonya
Last Name	Hales
Title:	RN, Director
Agency:	Bureau of Authorization and Community Based Services, Division of Medicaid and Health Financing, Utah Department of Health.
Address 1:	PO Box 143112
Address 2:	
City	Salt Lake City
State	UT
Zip Code	84114-3112
Telephone:	801-538-9136
E-mail	thales@utah.gov
Fax Number	801-323-1564

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

First Name:	Paul	
Last Name	Smith	
Title:	Division Director	
Agency:	Division of Services for People with Disabilities, Utah Department of Human Services	
Address 1:	195 North 1950 West	
Address 2		
City	Salt Lake City	
State	Utah	
Zip Code	84116	
Telephone:	801-538-8299	
E-mail	ptsmith@utah.gov	
Fax Number	801-538-4279	

8. Authorizing Signature

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

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

Signature: _____ **Date:**

State Medicaid Director or Designee

First Name:	Michael	
Last Name	Hales	
Title:	Deputy Director	
Agency:	Utah Department of Health, Director, Division of Medicaid and Health Financing	
Address 1:	288 North 1460 West	
Address 2:	PO Box 143101	
City	Salt Lake City	
State	Utah	
Zip Code	84114-3101	
Telephone:	801-538-6965	
E-mail	mthales@utah.gov	
Fax Number	801-538-6860	

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

State:	
Effective Date	

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 *(name of unit) (do not complete Item A-2*):	
	○	Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit (name of division/unit). 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	The Utah Department of Human Services, Division of Services for People with Disabilities	
	a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (*Complete item A-2-b).*		

2. **a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities.

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

requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

An interagency agreement between the State Medicaid Agency (SMA) and the Division of Services for People with Disabilities (DSPD) sets forth the respective responsibilities for the administration and operation of this waiver.

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. All of these responsibilities are shared to some extent 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. Reporting
10. Data Security

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. Formal program reviews are conducted at regularly scheduled intervals by the Quality Assurance Team. If ongoing reviews conducted by the Quality Assurance Team reveal concerns with compliance DSPD is required to develop plans of correction within specific time frames to correct the problems. The Quality Assurance Team conducts follow up activities to ensure that corrections are sustaining.

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

○	**Yes.** Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the 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).

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 *(check each that applies)*:

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

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

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

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

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

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

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

a.i For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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: #1	Number and percentage of DSPD reports specified in the implementation plan that were submitted to the SMA on time and in the correct format.		
Data Source [e.g. – examples cited in IPG] DSPD 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*	*X 100% Review*
	X Operating Agency	*☐ Monthly*	*☐ Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other: Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			☐ Other: Describe
Data Aggregation and Analysis	***Responsible Party for data aggregation and***	***Frequency of data aggregation and***	

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

***Performance Measure:* 2**	Number and percentage of proposed rules and other documents, relating to the implementation of the waiver (including training curriculums and outreach materials) that are submitted by DSPD to the SMA for review and approval prior to implementation.		
Data Source [e.g. – examples cited in IPG] Document approval forms, DSPD documents	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	☐ *Weekly*	*X 100% Review*
	X Operating Agency	☐ *Monthly*	*Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	*Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	
		X Continuously and Ongoing	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	X State Medicaid Agency	☐ *Weekly*	
	Operating Agency	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	*X Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

***Performance Measure:* 3**	Number and percentage of maximum allowable rates (MARs) for covered waiver services approved by the SMA.		
Data Source [e.g. – examples cited in IPG] Approval documents, correspondence	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	X Operating Agency	*☐ Monthly*	*Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*Representative Sample; Confidence Interval =*
	☐ Other: Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			☐ Other: Describe
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	X State Medicaid Agency	*☐ Weekly*	
	Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and Ongoing	
		☐ Other: Specify:	

***Performance Measure:* 4**	Number and percentage of critical incidents and events for which DSPD follows the SMA Critical Incidents/Events Protocol.		
Data Source [e.g. – examples cited in IPG] DSPD records, SMA records	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	*☐ Weekly*	*100% Review*

	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*Representative Sample; Confidence Interval = 5*
	☐ Other: Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			☐ Other: Describe
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	X State Medicaid Agency	*☐ Weekly*	
	Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and Ongoing	
		☐ Other: Specify:	

***Performance Measure:* 5**	Number and percentage of timely notice of appeal rights provided to waiver applicants/participants who make one of the following claims: a) denied access to Medicaid Waiver Program, b) denied access to needed services while enrolled in the waiver, c) denied choice of provider if more than one qualified provider was available to render the service. .		
Data Source [e.g. – examples cited in IPG] Approval documents, correspondence	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	*☐ Weekly*	*100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*Representative Sample; Confidence Interval = 5*
	☐ Other: Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			☐ Other: Describe

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

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

a.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 Medicaid Autism Waiver (MAW) program through numerous activities including the issuance of policies, rules, and regulations relating to the waiver, the approval of all protocols, documents, and trainings, that affect any aspect of the MAW operations. Approvals are accomplished through a formal document approval process. The SMA also conducts quarterly meetings with DSPD (the operating agency), monitors compliance with the interagency agreement, conducts annual quality assurance reviews of the MAW program, and provides technical assistance to the operating agency and other entities within the state that affect the operation of the waiver program. An annual review is conducted for each of the three waiver years. A base line review will be conducted after completion of the first waiver year. The sample size for this review will be sufficient to provide a confidence level equal to 95%, a confidence interval equal to 5 and a response distribution equal to 50%. The response distribution percentage for future reviews will reflect the findings gathered during the base line review.

The SMA is the entity responsible for official communication with CMS for all issues related to the MAW.

b. Methods for Remediation/Fixing Individual Problems

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

The SMA has an interagency agreement with the Department of Human Services for the operation and implementation of the waiver as specified in the State Implementation Plan. The interagency agreement requires that DSPD fulfill all requirements stipulated in the implementation plan. When individual issues of non compliance occur the SMA will provide technical assistance including time frames to assure resolution the results of which will be documented in SMA Reports.

b.ii Remediation Data Aggregation

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

c. Timelines

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

○	**Yes** *(complete remainder of item)*
○	**No**

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

Appendix B: Participant Access and Eligibility

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

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

Select one Waiver Target Group	Target Group/Subgroup		Minimum Age	Maximum Age: Maximum Age Limit: Through age –	Maximum Age: No Maximum Age Limit
○	**Aged or Disabled, or Both** *(select one)*				
	○	**Aged or Disabled or Both – General** *(check each that applies)*			
		☐ Aged (age 65 and older)			☐
		☐ Disabled (Physical) (under age 65)			
		☐ Disabled (Other) (under age 65)			
	○	**Specific Recognized Subgroups** *(check each that applies)*			
		☐ Brain Injury			☐
		☐ HIV/AIDS			☐
		☐ Medically Fragile			☐
		☐ Technology Dependent			☐
⦿	**Mental Retardation or Developmental Disability, or Both** *(check each that applies)*				
	☑	Autism	2	5	☐
	☐	Developmental Disability			☐
	☐	Mental Retardation			☐
○	**Mental Illness** *(check each that applies)*				
	☐	Mental Illness (age 18 and older)			☐
	☐	Mental Illness (under age 18)			

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

The National Research Council Report, *Educating Children with Autism (2001)*, indicates that significant parental and family involvement is integral to the success of interventions for children with autism and that this involvement results in better outcomes for the entire family. Accordingly, as a condition of participation, in addition to receiving waiver funded services, parents and/or family members must provide at least 5 non-paid hours of direct intervention (ABA or similar service) with the child per week. The parents and/or family will self-attest their willingness to provide the weekly services as a condition of participation.

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*):
	At least 90 days prior to the child's sixth birthday, the support coordinator will work collaboratively with the child's parents, providers and school officials to establish a plan to meet the child's needs after the conclusion of waiver services.

Appendix B-2: Individual Cost Limit

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

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

State:	
Effective Date	

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

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

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

Appendix B-3: Number of Individuals Served

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

Table: B-3-a	
Waiver Year	Unduplicated Number of Participants
Year 1	300
Year 2	300
Year 3	300
Year 4 (renewal only)	
Year 5 (renewal only)	

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	
Year 2	
Year 3	
Year 4 (renewal only)	
Year 5 (renewal only)	

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). For each purpose, describe how the amount of reserved capacity was determined:
	The capacity that the State reserves in each waiver year is specified in the following table:

Table B-3-c

Waiver Year	Purpose:	Purpose:
	Capacity Reserved	Capacity Reserved
Year 1		
Year 2		
Year 3		
Year 4 (renewal only)		
Year 5 (renewal only)		

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:

Please see Utah Administrative Rule R414-509 Autism Waiver Open Enrollment Process which governs the selection of individuals for entrance to the waiver.

Attachment #1 to Appendix B-3

Waiver Phase-In/Phase Out Schedule

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

○	Phased-in
○	Phased-out

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

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

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

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

d. **Phase-In or Phase-Out Schedule**. *Complete the following table:*

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

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

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

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

a-2. Miller Trust State.

Indicate whether the State is a Miller Trust State.

○	Yes
⦿	No

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

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)			
☑	Low income families with children as provided in §1931 of the Act		
☑	SSI recipients		
☐	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121		
☐	Optional State supplement recipients		
☑	Optional categorically needy aged and/or disabled individuals who have income at: *(select one)*		
	⦿	100% of the Federal poverty level (FPL)	
	○	%	of FPL, which is lower than 100% of FPL
☐	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)		
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)		
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)		
☐	Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)		
☐	Medically needy in 209(b) States (42 CFR §435.330)		
☑	Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)		
☑	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:		
	§1902 (a)(10)(A)(i)(IV) and §1902(1)(1)(B); §1902(a)(10)(A)(i)(VI) and § 1902(1)(1)(C); §1902(a)(10)(A)(i)(VII) and §1902 (1)(1)(D); §1902(a)(10)(A)(ii)(I); §1902(a)(10)(A)(ii)(VIII).		
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)
			○	% of FBR, which is lower than 300% (42 CFR §435.236)
			○	$ which is lower than 300%
		☐	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)	
		☐	Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)	
		☐	Medically needy without spend down in 209(b) States (42 CFR §435.330)	
		☐	Aged and disabled individuals who have income at: *(select one)*	
			○	100% of FPL
			○	% of FPL, which is lower than 100%
		☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:	

Appendix B-5: Post-Eligibility Treatment of Income

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

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 *(select one)*:

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

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules.

b-1. Regular Post-Eligibility Treatment of Income: SSI State and §1634 State. The State uses the post-eligibility rules at 42 CFR §435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
○	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)	
		○	%	of the FBR, which is less than 300%
		○	$	which is less than 300%.
	○	%	of the Federal poverty level	
	○	Other standard included under the State Plan (specify):		

State:	
Effective Date	

○	The following dollar amount:	$	If this amount changes, this item will be revised.
○	The following formula is used to determine the needs allowance:		
○	Other (specify):		

ii. <u>Allowance for the spouse only</u> (*select one*):

○	SSI standard		
○	Optional State supplement standard		
○	Medically needy income standard		
○	The following dollar amount:	$	If this amount changes, this item will be revised.
○	The amount is determined using the following formula:		
○	Not applicable *(see instructions)*		

iii. <u>Allowance for the family</u> *(select one)*:

○	AFDC need standard		
○	Medically needy income standard		
○	The following 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:		
○	Other (specify):		
○	Not applicable *(see instructions)*		

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 checked.*
○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

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

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
○	The following standard included under the State plan *(select one)*			
	○	The following standard under 42 CFR §435.121:		
	○	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)	
		○	%	of the FBR, which is less than 300%
		○	$	which is less than 300% of the FBR
	○	%	of the Federal poverty level	
	○	Other standard included under the State Plan (specify):		
○	The following dollar amount:	$	If this amount changes, this item will be revised.	
○	The following formula is used to determine the needs allowance:			
○	Other (specify)			
ii. <u>Allowance for the spouse only</u> (*select one*):				
○	The following standard under 42 CFR §435.121			
○	Optional State supplement standard			
○	Medically needy income standard			
○	The following dollar amount:	$	If this amount changes, this item will be revised.	
○	The amount is determined using the following formula:			
○	Not applicable *(see instructions)*			
iii. <u>Allowance for the family</u> *(select one)*				

○	AFDC need standard
○	Medically needy income standard
○	The following 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:
○	Other (specify):
○	Not applicable *(see instructions)*

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

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

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

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

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

b-2. Regular Post-Eligibility Treatment of Income: SSI State and §1634 state. The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

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

- ⦿ The following standard included under the State plan *(select one)*
  - ○ SSI standard
  - ○ Optional State supplement standard
  - ○ Medically needy income standard
  - ○ The special income level for institutionalized persons *(select one):*
    - ○ 300% of the SSI Federal Benefit Rate (FBR)
    - ○ _____ % of the FBR, which is less than 300%
    - ○ $ _____ which is less than 300%.
  - ○ _____ % of the Federal poverty level
  - ○ Other standard included under the State Plan (specify):
- ○ The following dollar amount: $ _____ If this amount changes, this item will be revised.
- ⦿ The following formula is used to determine the needs allowance:

  The allowance for the personal needs of the waiver participant is 100% of the HHS Poverty Guidelines for one person plus the first $65 of earned income and 1/2 of the remainder of earned income. If other family members live with the waiver client, an additional amount in recognition of higher expenses that a waiver client may have to meet the extra costs of supporting the other family members will be considered. The additional amount is the difference between the allowance for a family member defined in Section 1924(d) (1) (C) of the Social Security Act and the allowance for a family member defined in 42 CFR435.726(c)(3).
- ○ Other (specify):

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

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

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

○	Not applicable *(see instructions)*

iii. <u>Allowance for the family</u> *(select one)*:

○	AFDC need standard
⦿	Medically needy income standard
○	The following 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:
○	Other *(specify)*:
○	Not applicable *(see instructions)*

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 checked.*
○	The State does not establish reasonable limits.
⦿	The State establishes the following reasonable limits *(specify)*:
	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.

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

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

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

	○	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)	
		○	%	of the FBR, which is less than 300%
		○	$	which is less than 300% of the FBR
	○	%	of the Federal poverty level	
	○	Other standard included under the State Plan (specify):		
○	The following dollar amount:	$	If this amount changes, this item will be revised.	
○	The following formula is used to determine the needs allowance:			
○	Other (*specify):*			

ii. <u>Allowance for the spouse only</u> (*select one*):

○	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:			
	Specify the amount of the allowance:			
	○	The following standard under 42 CFR §435.121:		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	○	The following dollar amount:	$	If this amount changes, this item will be revised.
	○	The amount is determined using the following formula:		
○	Not applicable *(see instructions)*			

iii. <u>Allowance for the family</u> *(select one)*

○	AFDC need standard
○	Medically needy income standard
○	The following 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:
○	Other (specify):
○	Not applicable *(see instructions)*

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

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

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

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

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

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

i. <u>Allowance for the personal needs of the waiver participant</u> *(select one)***:**			
○	SSI Standard		
○	Optional State Supplement standard		
○	Medically Needy Income Standard		
○	The special income level for institutionalized persons		
○	%	of the Federal Poverty Level	
○	The following dollar amount:	$	If this amount changes, this item will be revised
⦿	The following formula is used to determine the needs allowance:		
	The allowance for the personal needs of the waiver participant is: 100% of the HHS Poverty Guidelines for one person plus the first $65 of earned income and 1/2 of the remainder of earned income.		
○	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:		
	We added an additional amount to the allowance for the personal needs of a waiver participant without a community spouse to recognize the extra costs of supporting the other family members. The additional amount is the difference between the allowance for a family member defined in Section 1924(d) (1) (C) of the Social Security Act and the allowance for a family member defined in 42 CFR435.726(c)(3).		
iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified section 1902(r)(1) of the Act:			
a. Health insurance premiums, deductibles and co-insurance charges. b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*			
○	Not applicable *(see instructions) Note: If the State protects the maximum amount for the waiver participant, not applicable must be checked.*		
○	The State does not establish reasonable limits.		
⦿	The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.		

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

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

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

i.	**Minimum number of services**. The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is *(insert number):* One	
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:

Operating Agency Waiver Support Coordinator – QMRP

Qualified support coordinators shall possess at least a Bachelor degree in nursing, behavioral science, or a human services related field such as social work, sociology, special education, rehabilitation counseling, or psychology and has at least one year of experience working directly with persons with mental retardation or other developmental disabilities. Support coordinators must also demonstrate competency relating to the planning and delivery of health services to the waiver population through successful completion of a training program approved by the State Medicaid Agency.

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

State:	
Effective Date	

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

Utah Administrative Rule 414-502-8 defines the State's level of care criteria for intermediate care facilities for persons with intellectual disabilities. The rule defines that a client must:

(1) Have a diagnosis of intellectual disability (42 CFR 483.102(b)(3) or a condition closely related to intellectual disability (42 CFR 435.1010) and

(2) The Department considers a child under the age of seven to be at risk for functional limitation in three or more areas of major life activity, if the child has a diagnosis of intellectual disability or a condition closely related to intellectual disability. Autism spectrum disorder is considered to be a condition closely related to intellectual disability.

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 Medicaid Autism Waiver Level of Care form was created specifically for the purpose of evaluating LOC for this waiver. The form and process are different from the process and instruments used to determine LOC for institutional care. The tools used to determine level of care are different due to the ages of the children eligible for this waiver; children aged 2 – 5 with an ASD diagnosis. Because these children are a sub-set of those who would typically qualify for ICF/ID placement, the tool used is detailed to confirm the diagnosis of ASD. A child with an ASD diagnosis within the age range specified in this waiver qualifies for ICF/ID level of care as per R414-502-8.

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 Medicaid Autism Waiver Level of Care Form is completed when evaluating applicants' level of care under the waiver.

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*):

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. The qualifications of individuals who perform reevaluations are *(specify)*:

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

The Utah Systems for Tracking Eligibility, Planning, and Services (USTEPS), developed and maintained by DSPD, provides from an automated tickler "to do" message to be sent to the support coordinator 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.

To assure documents are retrievable, standard data back-up procedures employed with the USTEPS database include:

The DSPD_USTEPS_PROD_DB is backed up from Sybase database to a disk dump at 10:30 PM every night.

The UNIX backup occur on the following schedule (these are backups to tape)

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**

a.i.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.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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: LOC a.1	The number and percentage of level of care evaluations that are conducted for new enrollees prior to receiving waiver services.		
Data Source [e.g. – examples cited in IPG]] DSPD Records	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval = 5*
	☐ Other: Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			☐ Other: Describe
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	X State Medicaid Agency	*☐ Weekly*	
	X Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*X Annually*	
		Continuously and Ongoing	
		☐ Other: Specify:	

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

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

For each performance measure/indicator the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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: LOC b.1	The number and percentage of participant level of care evaluations conducted annually.		
Data Source [e.g. – examples cited in IPG] LOC Forms	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =5*
	☐ Other: Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			☐ Other: Describe
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	X State Medicaid Agency	*☐ Weekly*	
	X Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and Ongoing	
		☐ Other: Specify:	

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

a.i.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.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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: LOC.c.1	The number and percentage of support coordinators who perform level of care evaluations who meet the qualifications as specified in the State Implementation Plan.		
Data Source [e.g. – examples cited in IPG] DSPD support coordinator records	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	X Operating Agency	*☐ Monthly*	*☐ Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other: Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			☐ Other: Describe
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	X State Medicaid Agency	*☐ Weekly*	
	X Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*X Annually*	
		Continuously and Ongoing	
		☐ Other: Specify:	

Performance Measure: **LOCc.2**	The number and percentage of participants for whom the level of care is accurately documented on the level of care form described in the State

	Implementation Plan.		
Data Source [e.g. – examples cited in IPG] LOC form	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X☐ Representative Sample; Confidence Interval =5*
	☐ Other: Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			☐ Other: Describe
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	X State Medicaid Agency	*☐ Weekly*	
	X Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and Ongoing	
		☐ Other: Specify:	

***Performance Measure:* LOCc.3**	The number and percentage of newly enrolled participants for whom Form 927 "Home and Community-Based Waiver Referral Form" documented the effective date of the applicant's Medicaid eligibility determination and the effective date of the applicant's level of care eligibility determination.		
Data Source [e.g. – examples cited in IPG] Form 927	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X☐ Representative Sample; Confidence Interval =5*
	☐ Other: Specify:	*☐ Annually*	

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

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

a.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 and DSPD will both conduct quality assurance reviews of level of care. The findings from all reviews conducted by DSPD will be submitted to the SMA for review and approval. An annual review will be conducted for each of the three waiver years. A base line review will be conducted after completion of the first waiver year. The sample size for this review will be sufficient to provide a confidence level equal to 95%, a confidence interval equal to 5 and a response distribution equal to 50%. The response distribution percentage for future reviews will reflect the findings gathered during the base line review

b. Methods for Remediation/Fixing Individual Problems

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

Individual issues identified by the SMA and the OA, that affect the health and welfare of individual participants are addressed immediately. Issues that are less immediate are corrected within designated time frames, the results of which will be documented in the SMA final report.

b.ii Remediation Data Aggregation

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

c. Timelines

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

○	**Yes** *(complete remainder of item)*
○	**No**

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

Appendix B-7: Freedom of Choice

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

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

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

Freedom of Choice is documented on the Form 818. Freedom of choice procedures:

1. When an individual is determined eligible for waiver services, the individual and the individual's legal representative, if applicable, will be informed of the alternatives available under the waiver and offered the choice of institutional care (ICF/ID) or home and community-based care. A copy of the DSPD publication *AN INTRODUCTORY GUIDE—Division of Services for People with Disabilities* (hereafter referred to as the Guide), which describes the array of services and supports available in Utah including intermediate care facilities for persons with intellectual disabilities and the Medicaid Autism Waiver program, is given to each individual applying for waiver services. In addition, individuals will be given a 2-sided *Informational Fact Sheet* (Form IFS-10) which describes the eligibility criteria and services available through both the waiver program and through ICFs/ID.

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's service 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 and the Informational Fact Sheet, subsequent review of choice of program will only be required at the time a substantial change in the enrollee's condition results in a change in the individual's service plan. It is, however, the individual's option to choose institutional (ICF/ID) care at any time during the period they are in the waiver.

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

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.

Copies of the form will be maintained in the participant's case file maintained by the support coordinator within the Division of Services for People with Disabilities.

State:	
Effective Date	

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

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

Medicaid providers are required to provide foreign language interpreters for Medicaid clients who have limited English proficiency. Waiver clients 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 State Medicaid Agency encourages clients to use professional services rather than relying on a family member or friend though the final choice is theirs. Using an interpretive service provider ensures confidentiality as well as the quality of language translation.

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

For the full text of the "Exploring Medicaid" brochure, go to http://hlunix.ex.state.ut.us/medicaid/ and select the "Exploring Medicaid" hyperlink.

Appendix C: Participant Services

Appendix C-1: Summary of Services Covered

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

Statutory Services *(check each that applies)*		
Service	Included	Alternate Service Title (if any)
Case Management	☐	
Homemaker	☐	
Home Health Aide	☐	
Personal Care	☐	
Adult Day Health	☐	
Habilitation	☐	
Residential Habilitation	☐	
Day Habilitation	☐	
Expanded Habilitation Services as provided in 42 CFR §440.180(c):		
Prevocational Services	☐	
Supported Employment	☐	
Education	☐	
Respite	☑	
Day Treatment	☐	
Partial Hospitalization	☐	
Psychosocial Rehabilitation	☐	
Clinic Services	☐	
Live-in Caregiver (42 CFR §441.303(f)(8))	☐	

Other Services *(select one)*	
○	Not applicable
⦿	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute *(list each service by title)*:
a.	Intensive Individual Support - Consultation Services
b.	Intensive Individual Support - Direct Services

c.	
d.	
e.	
f.	
g.	
h.	
i.	

Extended State Plan Services *(select one)*

○	Not applicable
○	The following extended State plan services are provided *(list each extended State plan service by service title)*:
a.	
b.	
c.	

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

☑	The waiver provides for participant direction of services as specified in Appendix E. The waiver includes Information and Assistance in Support of Participant Direction, Financial Management Services or other supports for participant direction as waiver services.
☐	The waiver provides for participant direction of services as specified in Appendix E. Some or all of the supports for participant direction are provided as administrative activities and are described in Appendix E.
○	Not applicable

Support	Included	Alternate Service Title (if any)
Information and Assistance in Support of Participant Direction	☐	
Financial Management Services	☑	

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

a.	
b.	
c.	

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants *(check each that applies)*:

☐	As a waiver service defined in Appendix C-3 (*do not complete C-1-c)*
☐	As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option). *Complete item C-1-c.*
☐	As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c*.
☑	As an administrative activity.
☐	Not applicable – Case management is not furnished as a distinct activity to waiver participants. *Do not 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:

Support coordinators employed by the Division of Services for People with Disabilities conduct case management activities on behalf of waiver participants as an administrative function.

Appendix C-2: General Service Specifications

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

⦿	**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 Utah Administrative Code R501-14 requires all persons having direct access to children or vulnerable adults must undergo a criminal history/ background investigation except in the case where the waiver enrollee has chosen to self-employ a family member as part of their self-directed program. If the person has lived in Utah continuously for 5 years or more a regional check is conducted. For those who have not lived in Utah for 5 continuous years a national check through the FBI is conducted. The Office of Licensing, an agency within the Utah Department of Human Services has the responsibility of conducting background checks on all direct care workers who provide waiver services. The scope of the investigation includes a check of the State's child and adult abuse registries, and a Criminal History check through the Criminal Investigations and Technical Services Division of the Department of Public Safety. If a person has lived within two to five years outside the State of Utah or in foreign countries the FBI National Criminal History Records and National Criminal History will be accessed to conduct a check in those states and countries where the person resided. For providers under the Self-Administered Service Model, the state will withhold payments for services for anyone who has not completed a background check. DSPD keeps a database on all approved employees. A client has the option of having a criminal background check completed on a family member if they chose to do that, but it is not required. 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.
○	**No**. Criminal history and/or background investigations are not required.

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

⦿	**Yes**. The State maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):
	Utah Code (Annotated) 62A-2-121, 122 and R501-14 of the Utah Administrative Code require all persons having direct access to children or vulnerable adults must undergo an abuse screening except in the case where the waiver enrollee has chosen to self-employ a family member as part of their self-directed program. The Utah Division of Aging and Adult Services and The Utah Division of Child and Family Services maintain these abuse registries.

	A designated staff person within DHS, Office of Licensing, completes all screenings. DSPD maintains a database on all approved employees. DSPD will not approve continued employment or provider payments if the required screenings have not been completed.
○	**No**. The State does not conduct abuse registry screening.

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

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

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

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

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

iii. Scope of Facility Standards. By type of facility listed in Item C-2-c-i, specify whether the State's standards address the following *(check each that applies)*:

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

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

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

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

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

○	The State does not make payment to relatives/legal guardians for furnishing waiver services.
○	The State makes payment to relatives/legal guardians under ***specific circumstances*** and only when the relative/guardian is qualified to furnish services. Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-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-3. Specify any limitations on the types of relatives/legal guardians who may furnish services. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*
	As per Administrative Rule R539-5-5 parents, step-parents and legal guardians are not permitted to provide waiver services. Relatives, other than those listed above, may provide specified waiver services. The same payment controls are employed as described in Appendix E-1:1. Relatives may not provide services to multiple participants at the same time, but relatives may provide more than one service to a participant with the limitation that the services may not be provided at the same time. For example, a relative may be a provider of both Intensive Individual Supports – Direct Services and Respite Services, but they are not eligible to bill for both services concurrently. Since parents, step parents and legal guardians are not permitted to provide waiver services, the

	State avoids the problem of having those with decision making authority also providing services. For Relatives: Support coordinators conduct monthly reviews of all services provided before claims are paid. Support coordinators monitor the use of services as defined in the Care Plan. DSPD conducts random sample audits each year on the SAS programs that focus on service usage and interviews with clients and employees about service utilization. DSPD monitors service utilization each month and notifies the contract monitoring units if there is any indication of fraud or abuse of funds - for more in-depth audits to be completed.
○	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 recipients and meet licensure, certification, competency requirements and all other provider qualifications.

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

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

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: **Qualified Providers**

a.i.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.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:QP a.1.	**The number and percentage of providers that meet DSPD provider contract criteria.**		
Data Source [e.g. – examples cited in IPG] DSPD contract	***Responsible Party for data collection/generation*** *(check each that*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*

reviews ***Provider staff interviews***	*applies)*		
	☐ State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	X Operating Agency	*☐ Monthly*	*☐ Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other: Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			☐ Other: Describe
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	☐ State Medicaid Agency	*☐ Weekly*	
	X Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and Ongoing	
		☐ Other: Specify:	

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

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

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:QP b. 1.	**Number and percentage of providers of respite services under the Self-Administered Services (SAS) Model who have undergone a**

	background check prior to providing services as required by the SIP.		
Data Source [e.g. – examples cited in IPG] **DSPD records**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X Operating Agency	☐ *Monthly*	*X Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	*X Representative Sample; Confidence Interval =5*
	☐ *Other: Specify:*	☐ *Annually*	
		X Continuously and Ongoing	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	☐ *State Medicaid Agency*	☐ *Weekly*	
	X Operating Agency	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	*X Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

Performance Measure:QP b. 2.	**Number and percentage of providers of respite services under the Self-Administered Services (SAS) Model who have undergone an abuse screening through the State's abuse registry as required by the SIP.**		
Data Source [e.g. – examples cited in IPG] **DSPD records**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X Operating Agency	☐ *Monthly*	*X Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	*X Representative Sample; Confidence Interval =5*
	☐ *Other: Specify:*	☐ *Annually*	

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

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

a.i.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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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: QP c.1.	**Number and percentage of providers of respite services under the Self-Administered Services (SAS) Model who have received training by the parent of the waiver participant when warranted.**		
Data Source: • DSPD records • Parent Interviews	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*

	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =5*
	☐ Other: Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			☐ Other: Describe
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	X State Medicaid Agency	*☐ Weekly*	
	X Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and Ongoing	
		☐ Other: Specify:	

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

a.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.*

DSPD contract analysts conduct annual provider reviews which include monitoring all criteria in the provider contract of agency based providers of Medicaid Autism Waiver services. When deficiencies are identified, plans of correction are required and implemented within designated time frames. All DSPD reviews and plans of correction are submitted to the SMA for review and approval. In addition, DSPD support coordinators monitor SAS providers by monitoring payments, reviewing actual expenditures in comparison with the individual service plan budget, contacting the parent if any concerns arise and assisting in resolution of billing problems.

b. Methods for Remediation/Fixing Individual Problems

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

Individual provider issues identified during the contract reviews are corrected immediately by the provider or at a minimum within designated time frames. To assure issues have been corrected DSPD

Contract Analysts monitor the implementation of plans of correction. Findings and corrections are documented in DSPD Final Reports.

b.ii Remediation Data Aggregation

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

c. Timelines

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

○	**Yes** *(complete remainder of item)*
○	**No**

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

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Intensive Individual Support - Consultation Service
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Intensive Individual Support - Consultation Service (IIS-CS) includes the individual assessment, development, coordination, implementation, and evaluation of skill development and behavioral supports for children with autism spectrum disorders.

Based on the child's individual assessment, the consultant will be responsible for developing the Autism Training Plan (training plan) focused on skill development and if needed, the Behavior Support Plan focusing on decreasing problem behaviors. All plans will primarily be based on treatments with a rating of "established" as effective for individuals with autism spectrum disorders by the *National Autism Center's National Standards Report, 2009*. For each training focus area specific procedures will be written, training schedules developed, and data collection methods established including baselines and objectives.

The majority of the service will focus on support in the individual's home but may include additional community settings when necessary to address specific issues. IIS-CS may be provided remotely using technologies such as "Tele-a-heath" or other HIPAA compliant communication methods, particularly in areas of the State where availability of IIS-CS may be limited. The plans will include specific procedures and schedules for including the family in the training and implementation of Autism Training Plan and if needed, the Behavior Support Plan. The expectation is for the family to actively participate with the IIS-CS and the Intensive Individual Support Direct Staff Services (IIS-DS,) as well as implement supports at appropriate times when support services are not present.

The IIS-CS is directly involved in the ongoing evaluation of the effectiveness of the training plan through regular direct observation of the interactions the IIS-DS staff and family have with the child. The IIS-CS will supervise the IIS-DS a minimum of one hour for every ten hours worked by the direct services staff. The IIS-CS is responsible for meeting with the family and others implementing the training and behavioral plans. The IIS-CS will consult and coordinate with others such as school districts or providers of Medicaid State Plan Services. A monthly progress note is required that summarizes the IIS-CS and IIS-DS provided, discusses any changes in plans, reviews implementation issues, summarizes data collected, and includes the evaluation of expected progress and effectiveness of supports.

Behavior Support Plans must be based on Functional Behavior Assessments and follow the requirements in Rule R539-4.

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

1. Excludes treatments rated as "Unestablished" for individuals with autism spectrum disorders by the *National Autism Center's National Standards Report, 2009.*
2. Exclude all prohibited procedures included in Rule R539-3-10

3. The IIS-CS is expected to consult or coordinate with others such as school districts or providers of Medicaid State Plan Services but will not provide specific support plans or ongoing training.
4. Excludes ongoing support in schools or other settings with special autism treatment programs.
5. Excludes services that focus primarily on the treatment of co-occurring conditions.
6. Payment for IIS-CS through the waiver will be limited in cases where participants have access to these services through private insurance, community resources or other resources. Other payment sources must be exhausted prior to the waiver providing this service.

Provider Specifications

Provider Category(s) *(check one or both)*:	☑	Individual. List types:	☑	Agency. List the types of agencies:
	Board Certified Behavioral Analyst		An agency that employees Board Certified Behavioral Analysts, Interns or Licensed Psychologists	
	Board Certified Behavioral Analyst Intern			
	Licensed Psychologist			

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

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Board Certified Behavior Analyst		Board Certification	1. Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. 2. Provide evidence of successful completion of six months of work experience utilizing behavior analysis procedures with children with autism or evidence of equivalent experience and training. 3. Enrolled as a Medicaid Provider
Board Certified Behavior Analyst Intern			1. Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. 2. Provide evidence of successful completion of six months of work experience utilizing behavior analysis procedures with children with autism or evidence of equivalent experience and training. 3. Certified by DSPD as a Behavior Analysis Intern, actively pursuing BCBA certification. This is demonstrated by completion of a

			Master's degree in behavior analysis or a related field according to the Behavior Analysis Certification Board. This is verified by successful completion of at least one semester long graduate course in behavior analysis, and participating in weekly supervision by a BCBA and following all Behavior Analysis Certification Board standards for supervision. 4. Behavior Analysis Interns must be supervised by a BCBA at least one hour per week, and may be more as required by Behavior Analysis Certification Board. The BCBA can provide the weekly supervision by supervising the BCBA intern's work with a single child in a given week, but could also supervise by reviewing the case notes of multiple children in the BCBA intern's case load for example. The supervising BCBA must directly observe the BCBA Intern providing services to an individual in waiver services at a minimum of monthly. The supervising BCBA will be required to co-sign and approve all training plans, Behavior Support Plans, and monthly progress notes. 5. Enrolled as a Medicaid Provider
Licensed Psychologist	R414-13 UAC		1. Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. 2. Provide evidence of successful completion of six months of work experience utilizing behavior analysis procedures with people with autism or evidence of equivalent experience and training. 3. Enrolled as a Medicaid Provider

Verification of Provider Qualifications

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

BCBA Intern	Division of Services for People with Disabilities	Annually

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

Service Specification	
Service Title:	Intensive Individual Support – Direct Service
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Intensive Individual Support– Direct Service (IIS-DS)
IIS-DS includes assisting the IIS-CS with the individual assessment, development, coordination, implementation, and evaluation of skill building and behavioral supports for children with autism spectrum disorders. The focus of the service is the one-on-one implementation of the plans developed by the IIS Consultant: Autism Training Plan focused on skill development and if needed, the Behavior Support Plan.

All plans implemented will be primarily based on treatments with a rating of "established" as effective for individuals with autism spectrum disorders by the *National Autism Center's National Standards Report, 2009.* For each training focus area specific procedures will be written, training schedules developed, and data collection methods established including baselines and objectives.

IIS-DS staff document all services provided, collect data used to evaluate progress, support family members in learning and implementing supports.

The majority of the service will focus on support in the individual's home but may include additional community settings when necessary to address specific issues. IIS-DS will follow specific procedures and schedules for including the family in the training and implementation of the training plan and if needed, the Behavior Support Plan. When providing services, ISS-DS staff will work with family to encourage their active participation while the support staff is present and to support the family's implementation of ongoing supports at times when ISS-DS staff is not present.

At least one family member is expected to be present and working with the ISS-DS staff at least 40% of the time ISS-DS is being provided. ISS-DS staff will track the percentage of family/parental involvement time as a component of their data collection requirements.

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

1. Exclude treatments rated as "Unestablished" for individuals with autism spectrum disorders by the *National Autism Center's National Standards Report, 2009.*
2. Exclude all prohibited procedures included in Rule R539-3-10
3. Excludes ongoing support in schools or other settings with special autism treatment programs.
4. Excludes services that focus primarily on the treatment of co-occurring conditions.
5. Payment for IIS-DS through the waiver will be limited in cases where participants have access to these services through private insurance, community resources or other resources. Other payment sources must be exhausted prior to the waiver providing this service.

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Agencies that employ IIS-DS workers.

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

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
IIS-DS Agency			1. Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. 2. Provide evidence of successful completion of six months of work experience utilizing behavior analysis procedures with children with autism or evidence of equivalent experience and training. 3. Must have a sufficient number of BCBAs employed or on contract to meet the direct staff supervision requirements. Direct Staff Requirements: 1. At least 18 years old. 2. High School Diploma. 3. Documentation of 20 hours of pre-service training on autism spectrum disorders, autism skill training supports, Behavior Support Plans, data collection, and working with families. 4. Completion of a minimum of one semester of college level courses in a related field or demonstrated experience of more than six months in working directly with children with disabilities. * *Exceptions to item 4 may be granted by the Director of the Division of Services for People with Disabilities or Designee. Exceptions would be granted if the ISS-DS agency can provide evidence that it has made diligent efforts to recruit employees who meet the provider qualifications without success. The agency must demonstrate that the lack of direct staff who can meet the

			provider qualification is creating an access to care issue. 5. Agencies must pay the direct services employee a minimum of 67% of the final rate paid to the agency. 6. Enrolled as a Medicaid Provider

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Intensive Individual Support - Direct Services Agency	Division of Services for People with Disabilities	Annually

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

Service Title:	**Financial Management Services**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Financial Management Services is offered in support of the Self-Administered Services delivery option. Services rendered under this definition include those to facilitate the employment of respite services providers by the child's parent including:

a) Provider qualification verification;

b) Employer-related activities including federal, state, and local tax withholding/payments, unemployment compensation fees, wage settlements, fiscal accounting and expenditure reports;

c) Medicaid claims processing and reimbursement distribution, and

d) Providing monthly accounting and expense reports to the consumer.

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

Service is provided to those utilizing Self-Administered Services

Provider Specifications

Provider Category(s)	☐	Individual. List types:	X	Agency. List the types of agencies:
				Licensed Public Accounting Agency

(check one or both):		

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

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Financial Management Services	Certified Public Accountant Sec 58-26A, UCA And R 156-26A, UAC	Certified by the BACBS as an authorized provider of services and supports.	• Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA • Comply with all applicable State and Local licensing, accrediting, and certification requirements. • Understand the laws, rules and conditions that accompany the use of State and local resources and Medicaid resources. • Utilize accounting systems that operate effectively on a large scale as well as track individual budgets. • Utilize a claims processing system acceptable to the Utah State Medicaid Agency. • Establish time lines for payments that meet individual needs within DOL standards. • Generate service management, and statistical information and reports as required by the Medicaid program. • Develop systems that are flexible in meeting the changing circumstances of the Medicaid program. • Provide needed training and technical assistance to clients, their representatives, and others. • Document required Medicaid provider qualifications and enrollment requirements and maintain results in provider/employee file. • Act on behalf of the person receiving supports and services for the purpose of payroll reporting. • Develop and implement an effective payroll system that addresses all related

			tax obligations. • Make related payments as approved in the person's budget, authorized by the case management agency. • Generate payroll checks in a timely and accurate manner and in compliance with all federal and state regulations pertaining to "domestic service" workers. • 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-2's. Wage and Tax Statements and related documentation annually to all support workers who meet the statutory threshold earnings amounts during the tax year by January 31st. • File and deposit federal and state income taxes in accordance with federal IRS and state rules and regulations. • Assure that employees are paid established unit rates in accordance with

			the federal and state Department of Labor Fair Labor Standards Act (FLSA) • Process all judgments, garnishments, tax levies or any related holds on an employee's funds as may be required by local, state or federal laws. • Distribute, collect and process all employee time sheets as summarized on payroll summary sheets completed by the person or his/her representative. • Prepare employee payroll checks, at least monthly, sending them directly to the employees. • Keep abreast of all laws and regulations relevant to the responsibilities it has undertaken with regard to the required federal and state filings and the activities related to being a Fiscal/Employer Agent. • Establish a customer service mechanism in order to respond to calls from 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. • Enrolled as a Medicaid Provider

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Financial Management Services	Division of Services for People with Disabilities	Upon initial enrollment and annual sampling of waiver providers thereafter.

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

Service Specification	
Service Title:	**Respite Care**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
Respite Care is provided to give relief to, or during the absence of, the normal care giver. Respite Care may be provided in the individual's place of residence, in the private residence of the Respite Care provider or other community based setting.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Limitations: Payment for respite services are not made for room and board. Services are limited to a maximum of three hours per week.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	X	Individual. List types:	X	Agency. List the types of agencies:
	Self-directed services provider		Respite Provider	

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

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Self-directed—Respite			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
Agency based--Respite			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		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Respite Provider	Division of Services for People with Disabilities	Annually

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

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

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

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

☑	**Limit(s) on Set(s) of Services**. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver. *Furnish the information specified above*.
	To allow maximum flexibility in designing the Intensive Individual Support Services that will best meet the needs of the individual child, a maximum dollar amount for Intensive Individual Support – Consultation Services (Code T1023) and Intensive Individual Support – Direct Services (Code T2013) has been set. The maximum dollar amount is: $28,500 per year. The basis for the dollar limit is as follows: Twelve hours per year of IIS-CS to complete baseline and periodic assessments, approximately five hours per month of IIS-CS to provide supervision and direction to the IIS-DS staff and family and the IIS-DS utilization is estimated at approximately 20 hours per week. Because each child's needs related to their ASD are varied, the flexibility to identify the proper balance between the number of consultation hours and the number of direct services hours will be allowed. This determination will be made by the support coordinator with input from the participant's support team. If during the waiver period, legislative appropriation is made to increase provider rates, the maximum dollar amount will be raised in correlation with the provider rate increase. This waiver is targeted to individuals who are expected to have available services and supports from other sources such as family and other publicly funded programs. The intention of this program is to supplement existing resources, not to supplant them. As such, it is anticipated that the combination of available non-waiver supports in combination with the available waiver services are sufficient to assure individual health and welfare. If situations arise in which adjustment of the maximum dollar limit is needed, the case will be referred to the operating agencies for review and approval of a revised care plan. As stated previously, the individuals served in this waiver are expected to have an array of non-waiver supports that primarily assure the individual's health and welfare, but the ability to have individual cases reviewed by the operating agency is the State's mechanism for assuring that safeguards are in place to meet the participants' needs. Participants/families will be notified of the maximum dollar amount by the support coordinator, upon entrance into the waiver and during the care plan development process.
☐	**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.*
☐	**Not applicable.** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	

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

☐	Registered nurse, licensed to practice in the State
☐	Licensed practical or vocational nurse, acting within the scope of practice under State law
☐	Licensed physician (M.D. or D.O)
☐	Case Manager (qualifications specified in Appendix C-3)
☑	Case Manager (qualifications not specified in Appendix C-3). *Specify qualifications*:
	Qualified Mental Retardation Professional (QMRP) as specified in the job specifications contained within: Interpretive Guidelines for ICF for Persons with Mental Retardation (W159-W180); Code of Federal Regulations, Centers for Medicare and Medicaid Services, State Operations Manual – Appendix J, pages 77-87. 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 persons with intellectual impairments or other related conditions through successful completion of a training and testing program approved by the State Medicaid Agency. An individual with a "Bachelor's degree in a human services related field" means an individual who has received: **at least** a Bachelor's degree from a college or university (master and doctorate degrees are also acceptable) and has received academic credit for a minimum of 20 credit hours of coursework concentration in a human services field, as defined above. Although a variety of degrees may satisfy the requirements, majors such as geology and chemical engineering are not acceptable.
☐	Social Worker. *Specify qualifications:*
☐	Other (*specify the individuals and their qualifications):*

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

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

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 parents or legal guardians, primary paid service providers, and any others at the invitation of the child's parents are involved throughout the assessment and planning process. The DSPD Support coordinators complete the formal assessment process with the participant, parents or legal guardians, and primary paid service providers. The results of the assessment 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 the Participant-Centered Service Plan (PCSP.)

The parent or legal guardian is asked to invite anyone they wish to participate in the planning process. During the planning process, the participant's parent or guardian is given the opportunity to select their waiver services providers.

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

(a) Who develops the plan, who participates in the process, and the timing of the plan;

The DSPD support coordinator develops the Participant-Centered Service Plan (PCSP) in consultation those listed in Appendix D-1(c) above.

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

The DSPD support coordinator completes a Vineland II ©assessment with the parents and family. Completing this survey interview and Parent/Caregiver rating tool assists in the development of the PCSP. Reassessments are completed at a minimum of annually in the same calendar month in which it was completed the previous year. The PCSP will be completed within 31 days of the assessment completion date.

The IIS-CS completes the VB-MAPP©, a criterion-referenced assessment tool that serves as a curriculum guide, and skill tracking system. The assessment is based on B.F. Skinner's (1957) analysis of verbal behavior, established developmental milestones, and research from the field of behavior analysis. The assessment is used to develop the Autism Training Plan and to develop of the PCSP. Reassessments are completed at a minimum of annually in the same calendar month in which it was completed the previous year. The PCSP will be completed within 31 days of the assessment completion date.

In addition, assessments completed by physicians or other clinicians are reviewed as a component of the PCSP development process.

(c) How the participant is informed of the services that are available under the waiver.

During the initial planning meeting the participant or the participant's representative is given a list of the services provided in the waiver, a definition of each service, a list of enrolled service providers in the area, and a description of the maximum dollar limit for the two types of Intensive Individual Support Services. In addition, this information is also listed on both the DSPD and DHCF websites.

(d) How the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences.

In addition to utilizing the assessment tools identified in item (b) and informing clients about services as described in item (c), the support coordinator will educate the parents and family about services available through the Medicaid State Plan and the publicly funded programs.

(e) How waiver and other services are coordinated.

The PCSP lists all the participant's supports and services including waiver and non-waiver services. Parents and families will play a significant role in coordinating with the IIS-CS to

determine the appropriate balance of consultation and direct services. Support coordinators are continuously available to families to help coordinate Medicaid State Plan services including medical and mental health services and to support the family in coordinating with other publicly funded programs.

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

The PCSP lists the chosen provider for each service. As per the IIS-CS service definition, the IIS-CS is responsible to provide training and supervision of the implementation of the Autism Training Plan. The IIS-CS is responsible to supervise the IIS-DS a minimum of one hour for every ten hours provided by the IIS-DS.

The parents take a lead responsibility in monitoring and assuring the plan is implemented as agreed upon. Parents will contact the support coordinator with any concerns with the implementation of the plan or service providers.

(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.

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.

As stated in Appendix D-1 (d)(b), the IIS-CS will conduct an assessment of the child. One aspect of the assessment is to evaluate the presence of problem behaviors. When necessary the ISC-CS will develop a Behavior Support Plan to reduce the problematic behaviors. This is one method of mitigating risk associated with the child's specific circumstances.

This waiver is targeted to individuals who are expected to have available supports primarily from parents and family. The supports provided by parents and family are viewed as the primary method of mitigating risk and providing back-up services in the event that waiver services or providers are not available for any reason.

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.

Parents or legal guardians are informed of all available qualified, waiver services providers during the PCSP planning meeting. Parents are informed that if at any time, they wish to change service providers they should contact their support coordinator for assistance.

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

The SMA retains final authority for oversight and approval of the service planning process. The oversight function involves at a minimum a periodic review of a representative sample of waiver enrollee's service plans that will be sufficient to provide a confidence level equal to 95% and a confidence interval equal to 5. The specific sample of each review is selected based on the identified focus of the review and the number of reviews determined to be necessary to evaluate the waiver's performance. If the sample evaluation identifies system-wide service planning problems,

an expanded review is initiated by the SMA.

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

○	Every three months or more frequently when necessary
○	Every six months or more frequently when necessary
⦿	Every twelve months or more frequently when necessary
○	Other schedule (*specify*):

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-2: Service Plan Implementation and Monitoring

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

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

The support coordinator completes the PCSP which is approved by DSPD Administrative Program Managers prior to implementation.

The support coordinator monitors the implementation of the PCSP and the health and welfare of the participant by doing the following:

1. Face to face visits with the participant will be scheduled at a minimum of every 90 days. (While a visit at least once every 90 days is the standard, the support coordinator has the discretion to conduct face to face visits with the client more frequently. In all cases the frequency of visits will be based on the assessed needs of the participant.
2. Monthly review of progress reports
3. Working/meeting with providers and families to ensure that participants are receiving quality services according to the PCSP.

(b) The monitoring and follow-up method(s) that are used;

The support coordinator is responsible for monitoring and using follow up methods that:

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.

(c) The frequency with which monitoring is performed.
The PCSP is updated or revised on an annual basis and as necessary by the support coordinator, and reviewed and approved by DSPD Administrative Program Managers.

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

Quality assurance monitoring of PCSPs is conducted:

- On an ongoing basis by DSPD and annually 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 5.
- Records are reviewed for documentation that demonstrates participants have been made aware of all services available on the Autism 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,
- 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.

b. Monitoring Safeguards. *Select one:*

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

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**

a.i.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.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:SP a. 1.	**Number and percentage of PCSPs that address all participants' assessed needs including health needs, safety risks and personal goal by the provision of a sufficient amount of covered waiver services and other services including State Plan, generic and natural supports.**

Data Source [e.g. – examples cited in IPG] • **PCSP** • **DSPD records**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =5*
	☐ Other: Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			☐ Other: Describe
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	X State Medicaid Agency	*☐ Weekly*	
	X Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and Ongoing	
		☐ Other: Specify:	

Performance Measure:SP a. 2.	**Number and percentage of participants for whom there is sufficient documentation to ascertain whether participants have made progress on goals.**		
Data Source [e.g. – examples cited in IPG] • **DSPD records** • **PCSP**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence*

State:	
Effective Date	

			Interval =5
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			☐ Other: Describe
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	X State Medicaid Agency	*☐ Weekly*	
	X Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and Ongoing	
		☐ Other: Specify:	

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

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

For each performance measure/indicator the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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: SP b. 1.	**Number and Percentage of the Vineland II © Assessments administered, at a minimum, annually**		
Data Source [e.g. – examples cited in IPG] • **Assessment** • **DSPD records**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*

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	X Operating Agency	*☐ Monthly*	*☐ Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =5*
	☐ Other: Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			☐ Other: Describe
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	X State Medicaid Agency	*☐ Weekly*	
	X Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and Ongoing	
		☐ Other: Specify:	

Performance Measure: SP b. 1.	**Number and Percentage of PCSPs in which State Plan services and other resources, for which the individual is eligible, are exhausted prior to authorizing the same service offered throught the waiver..**		
Data Source [e.g. – examples cited in IPG] • **PCSP**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*☐ Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =5*
	☐ Other: Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			☐ Other: Describe
Data Aggregation and Analysis	***Responsible Party for data aggregation and***	***Frequency of data aggregation and***	

State:	
Effective Date	

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

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

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

For each performance measure/indicator the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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: SP c. 1.	**Number and percentage of PCSPs reviewed and updated at least annually.**		
Data Source [e.g. – examples cited in IPG] • **PCSP** • **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)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =5*
	☐ Other: Specify:	*☐ Annually*	

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

Performance Measure: **SP c. 2.**	**Number and percentage of PCSPs that are updated/revised when warranted by changes in the participant's needs.**		
Data Source • **DSPD records** • **PCSP** • **Claims Data**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X *State Medicaid Agency*	*☐ Weekly*	*☐ 100% Review*
	X *Operating Agency*	*☐ Monthly*	**X** *Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	**X** *Representative Sample; Confidence Interval* = 5
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Groups*
		Other: Specify:	
			☐ Other: Describe

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

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

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

For each performance measure/indicator the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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: SP d. 1.	**Number and percentage of participants who received services in accordance with their PCSP including the type, amount, frequency and duration.**		
Data Source [e.g. – examples cited in IPG] • **PCSP** • **Claims Data**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	☐ *Weekly*	☐ *100% Review*
	X Operating Agency	☐ *Monthly*	*X Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	*X Representative Sample; Confidence*

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			Interval =5
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			☐ Other: Describe
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	X State Medicaid Agency	*☐ Weekly*	
	X Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and Ongoing	
		☐ Other: Specify:	

Add another Data Source for this performance measure

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

a.i.e Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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: SP e. 1.	**Number and percentage of participants who are offered the choice of either ICF/ID care or Medicaid Autism Waiver services as per the SIP.**		
Data Source [e.g. – examples cited in IPG]	***Responsible Party for data collection/generation*** *(check each that*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*

• **Form 818**	*applies)*		
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =5*
	☐ Other: Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			☐ Other: Describe
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	X State Medicaid Agency	*☐ Weekly*	
	X Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and Ongoing	
		☐ Other: Specify:	

Add another Data Source for this performance measure

Performance Measure: **SP e. 2.**	**Number and percentage of participants who are made aware of all services available on the Medicaid Autism Waiver as per the SIP.**		
Data Source • **PCSP** • **DSPD records**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X *State Medicaid Agency*	*☐ Weekly*	*☐ 100% Review*
	X *Operating Agency*	*☐ Monthly*	**X** *Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	**X** *Representative Sample; Confidence Interval* = 5
	☐ Other: Specify:	*☐ Annually*	
		X *Continuously and Ongoing*	*☐ Stratified: Describe Groups*

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

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

Performance Measure: **SP e. 3.**	**Number and percentage of participants who are offered choice among providers as per the SIP.**		
Data Source • **PCSP** • **DSPD records**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval* = 5
	☐ *Other: Specify:*	☐ *Annually*	
		X *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and	***Responsible Party for***	***Frequency of data***	

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

a.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 and DSPD will both conduct quality assurance reviews of service plan develop and monitoring of service delivery. The findings from all reviews conducted by DSPD will be submitted to the SMA for review and approval. An annual review will be conducted for each of the three waiver years. A baseline review will be conducted after completion of the first waiver year. The sample size for this review will be sufficient to provide a confidence level equal to 95%, a confidence interval equal to 5 and a response distribution equal to 50%. The response distribution percentage for future reviews will reflect the findings gathered during the baseline review.

b. Methods for Remediation/Fixing Individual Problems

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

Individual issues identified by the SMA and the OA, that affect the health and welfare of individual participants are addressed immediately. Issues that are less immediate are corrected within designated timeframes, the results of which will be documented in the SMA final report.

b.ii Remediation Data Aggregation

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

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

c. Timelines

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

○	**Yes** *(complete remainder of item)*
○	**No**

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

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Appendix E: Participant Direction of Services

[NOTE: *Complete Appendix E only when the waiver provides for one or both of the participant direction opportunities specified below.*]

Applicability *(select one)*:

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

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction. Indicate whether Independence Plus designation is requested (select one):

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

Appendix E-1: Overview

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

Self-Administered Services are made available to all waiver enrollees who elect to participate in this method. Support coordinators provide ongoing oversight of the enrollees' ability to successfully utilize Self-Administered Services. Support coordinators will provide assistance to parents who are in need additional help and training in aspects of self-administration. 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, parents hire individual employees to perform respite services in the waiver. The parent is 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.) Parents may receive additional help and training for their support coordinator if they request or are assessed to need additional support and assistance in carrying out these responsibilities.

Appointed decision-makers cannot also be providers of Self-Administered Services.

Parents 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 parents in the following ways: (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 parent of the waiver participant 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 parent. 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 parent if any concerns arise, and assists in resolution of billing problems.

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

⦿	**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)*:

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*:

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 DSPD support coordinator provides the individual with an orientation, which involves providing written materials as well as describing that respite services are available under the Self-Administered Services model. At that time it is further explained that by using the Self-Administered Services 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.

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 a representative. 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:

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-3. *(Check the opportunity or opportunities available for each service)*:

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Respite Services	☑	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

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*.	

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

⦿	FMS are covered as the waiver service entitled	Financial Management Services
	as specified in Appendix C-3. *Provide the following information:*	
○	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 entities to furnish FMS. Any qualified, willing provider may enroll to offer this service. The procurement method is the same as with all other services.	
ii.	**Payment for FMS**. Specify how FMS entities are compensated for the administrative activities that they perform:	
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 requirements, by imposing more stringent record keeping requirements on the Financial Management Services provider. 8. Obtain IRS approval for Agent status. The Financial Management Services provider shall consolidate the federal filing requirements, obtain approval for Utah State Tax Commission consolidated filings, and obtain approval for consolidated filing for unemployment insurance through the Department of Workforce Services. For those Employers retaining domestic help less than 40 hours per week, Workers Compensation coverage is optional. If the 40-hour threshold is achieved or exceeded, the Worker's Compensation Act requires coverage. Statutory requirements and the nature of insurance entail policies on an individual basis. Consolidated filings of Workers Compensation are not an option. 9. Financial Management Services provider cannot provide waiver recipients with community-based services in addition to Financial Management Services.
	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 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. DSPD 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, and a formal documentation monitoring tool used by support coordinators to audit SAS employers.

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

☐	**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:*
☐	**Waiver Service Coverage**. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-3 entitled:
☑	**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:*
	The DSPD support coordinator will provide information and assistance in support of participant direction of respite services both during the enrollment process and as needed on an ongoing basis. During the enrollment process, the DSPD support coordinator will provide the parents with an orientation which includes information about receiving respite through the Self-Administered Services (SAS) model. This support is participant direction is provided as an aspect of administrative support coordination activities provided by DSPD staff. Families choosing to receive respite under the SAS method are required to participate in standardized mandatory DSPD training and are provided with an SAS manual. The support coordinator will monitor the implementation of the SAS model on an ongoing basis. If concerns with the parents' ability to self-administer the Respite Services arise, the DSPD support coordinator will provide additional instruction and assistance. The Operating Agency and the SMA will monitor the support coordinators' provision of assistance to families utilizing the SAS model.

k. Independent Advocacy *(select one)*.

○	**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*:
⦿	**No.** Arrangements have not been made for independent advocacy.

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service

delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

The DSPD support coordinator will provide the parent with the list of enrolled traditional respite providers from which to choose. Health and welfare and continuity of services are assured during the transition process, because the consumer continues to receive services under the Self-Administered Services method until the transfer to the agency-based provider method is made.

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

All participants in the waiver program are considered to be eligible for self-administration. Only after a parent of 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 help from the support coordinators 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 parent's incapacity to self-administer as determined by the individual's person centered planning team.

The DSPD support coordinator will provide the parent with the list of enrolled traditional respite providers from which to choose.

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 routine traditional services provider if secured.
Prior to enrolling in Self-Administered Services, parents are informed of their responsibilities and the rules that must be followed in order to participate. The individual is provided with 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. Involuntary termination of Self-Administered Services is not a grievable action per Appendix E of the CMS Version 3.5 HCBS Waiver Application Instruction Manual.

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

Table E-1-n		
	Employer Authority Only	**Budget Authority Only or Budget Authority in Combination with Employer Authority**
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	125	
Year 2	125	
Year 3	125	
Year 4 (renewal only)		
Year 5 (renewal only)		

Appendix E-2: Opportunities for Participant-Direction

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

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Check each that applies:*

☐	**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; the standards and qualifications the State requires of such entities and the safeguards in place to ensure that individuals maintain control and oversight of the employee:*
☑	**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. *Check the 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:
☑	Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-3.
☑	Determine staff duties consistent with the service specifications in Appendix C-3.
☑	Determine staff wages and benefits subject to applicable 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)*:

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

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

☐	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-3
☐	Specify how services are provided, consistent with the service specifications contained in Appendix C-3
☐	Identify service providers and refer for provider enrollment
☐	Authorize payment for waiver goods and services
☐	Review and approve provider invoices for services rendered
☐	Other *(specify):*

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

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

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

○	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:
○	Modifications to the participant-directed budget must be preceded by a change in the service plan.

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 under42 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 the waiver support coordinator 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.

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.

Appeals related to establishing eligibility for state matching funds through DSPD/Utah Department of Human Services in accordance with UCA 62A-5 will be addressed through the Department of Human Services hearing process. Decisions made through the Department of Human Services hearing process on the question of DSPD eligibility will be the final decision.

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-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*:

⦿	**Yes**. The State operates an additional dispute resolution process *(complete Item b)*
○	**No**. This Appendix does not apply (*do not complete Item b)*

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

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

When DSPD receives a Hearing Request Form (490S) a three 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 yet reached, Division staff arranges a Region Review meeting between the individual and/or their legal representative and the Region Supervisor and/or the Region Director.

3. If the Region Review process is unsuccessful, Division staff arrange a Division Review meeting between the individual and/or their legal guardian and the Division Director and Region Director.

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 three 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 support coordinator's

DSPD Administrative Program Manager (APM). The APM reviews all complaints submitted either orally or written and any relevant information submitted with the complaint. The APM 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 Region Director. The Region Director will meet with the parties and review any evidence presented. The Region Director shall determine the best solution for the dispute. The Region Director 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 Region 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.

Appendix F-3: State Grievance/Complaint System

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

⦿	**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 *(complete the remaining items)*.
○	**No.** This Appendix does not apply (*do not complete the remaining items*)

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

Utah Department of Human Services, Division of People with Disabilities and Utah Department of Health, Division of Medicaid and Health Financing

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

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

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

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

The Quality Assurance Team within the Bureau of Authorization and Community Based Services, Division of Medicaid and Health Financing investigates complaints/grievances that are reported to the SMA and pertain to the operation of the Waiver program. The SMA makes all efforts to resolve the complaint or grievance to the satisfaction of all parties within two weeks of the submission of the complaint/grievance. Some complaints/grievances may require additional time to investigate and implement a resolution. Findings and resolutions of all complaints/grievances are documented by fiscal year in the SMA complaint/grievance 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 of Utah Reporting Requirements:
In accordance with section 62A-3-305 of the Utah State Code, any person who has reason to believe that any vulnerable adult has been the subject of abuse, neglect, or exploitation shall immediately notify Child Protective Services or the nearest law enforcement agency.

State Medicaid Agency Critical Event or Incident Reporting Requirements:
1**.** Critical Incidents and events that require reporting for review and follow-up action by an appropriate authority include: unexpected or accidental deaths, suicide attempts, medication errors that lead to death or other serious outcomes, abuse or neglect that results in death, hospitalization or other serious outcomes, 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, events that compromise participants' working or living environment that put a participant(s) at risk, Medicaid Fraud investigations that involve any providers of services to waiver participants and events that are anticipated to receive media, legislative, or other public scrutiny.

2. Individuals and/or entities that are required to report such events and incidents:
A waiver participant and/or their representative, and waiver service providers are required to report to the support coordinator any critical incident/event that occurs either to or by a participant. The support coordinator is then required to notify DSPD administration of any

critical incident/event. A representative from DSPD must notify a member of the SMA Quality Assurance Team via email, telephone or in person of the occurrence of any critical incident or event.

3. The timelines for reporting critical incident/events:
Critical incidents or events require notification to the SMA by the next business day after the incident/event occurs or as per the SMA Critical Incident/Event Protocol.

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

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

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 participant's support team. The participant support team is defined as the parent of the participant, the Intensive Individual Support – Consultation Services provider, and the support coordinator. The participant support team is responsible for reviewing right issues related to supports.

<u>Training for support coordinators</u>:
Within the first week of employment a support coordinator receives the "Support Coordinator Manual." This manual educates and trains a support coordinator of Legal Advocacy Programs and Policies, Child Protective Services, Adult Protective Services, as well as Abuse and Neglect reporting.

"According to Division's Staff Directive 1.18 "Division Support Coordination Training Requirements" states that by the end of the first year of employment, the support coordinator will complete more intensive training in the following areas:…one of them being Abuse, Neglect, and Exploitation."

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

<u>Training for contracted providers</u>:
Department of Human Services (DHS)/DSPD service contracts contain a section that defines the frequency of training and education regarding protections from abuse, neglect, and exploitation. This is located in the DHS/DSPD Statement of Interest and Qualifications #DHS40335 Section Two: Scope of Services, General Staff Training Requirements, paragraph B., and sub-paragraph 5,

and paragraph C.

Paragraph B., reads as follows:

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

Paragraph C., reads as follows:

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

How training and or information are furnished to participants and/or family concerning protections from abuse, neglect or exploitation, including how to notify the appropriate authorities.

Training and/or information is provided by the support coordinator to participants and/or families concerning protections from abuse, neglect, and exploitation, initially upon enrollment and annually thereafter. The family is given the Child Protective Services phone number so they can notify appropriate authorities when the participant may have experienced abuse, neglect, or exploitation. The family is also given the support coordinator's phone number to contact for concerns related to abuse, neglect or exploitation.

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

The SMA is the agency that receives reports of critical incidents/events. Within two weeks of reporting a critical incident/event to the SMA, the Operating Agency investigates the incident/event and submits the completed Critical Incident/Event Investigation document to the SMA. Cases that are complicated and involve considerable investigation may require additional time to complete the investigation document. The SMA reviews the Investigation document to determine if the incident could have been avoided, if additional supports or interventions have been implemented to prevent the incident from recurring, if changes to the care plan and/or budget have been made, if any systemic issues were identified and a plan to address systemic issues developed. The SMA then completes the SMA portion of the investigation document which includes a summary of the incident/event, remediation activities and SMA Findings and Recommendations. 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.

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

The SMA is the agency responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants. Information about critical incidents and events is collected in the SMA critical incident/event data base. This information is analyzed and an annual report is submitted to the State Medicaid Director and DSPD director which describes the number of incidents by category, number of incidents that resulted in corrective action by the OA, support coordinator or other provider, number of corrective actions implemented, a summary analysis of systemic trends that required additional intervention or process improvement steps.

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

a. Use of Restraints or Seclusion *(select one):*

○	The State does not permit or prohibits the use of restraints or seclusion. Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:
⦿	The use of restraints or seclusion 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 or Seclusion. 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 or 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).

R539-3-10. Prohibited Procedures.

(1) The following procedures are prohibited for Division staff and Providers, including staff hired for Self-Administered Services, in all circumstances in supporting Persons receiving Division funding:

(a) Physical punishment, such as slapping, hitting, and pinching.

(b) Demeaning speech to a Person that ridicules or is abusive.

(c) Locked confinement in a room. [definition of seclusion]

(d) Denial or restriction of access to assistive technology devices, except where removal prevents injury to self, others, or property as outlined in Sections R539-3-6 and R539-4-7.

(e) Withholding or denial of meals, or other supports for biological needs, as a consequence or punishment for problems.

(f) Any Level II or Level III Intervention, as defined in R539-4-3(n) and R539-4-3(o), used as coercion, as convenience to staff, or in retaliation.

(g) Any procedure in violation of R495-876, R512-202, R510-302, 62A-3-301 thru 62A-3-321, and 62A-4a- 402 thru 62A-4a-412 prohibiting abuse.

R539-4-4. Levels of Behavior Interventions.

(2) All Behavior Support Plans shall be implemented only after the Person or Guardian gives consent and the Behavior Support Plan is approved by the Team.

(3) All Behavior Support Plans shall incorporate Positive Behavior Supports with the least intrusive, effective treatment designed to assist the Person in acquiring and maintaining skills, and preventing problems.

(4) Behavior Support Plans must:

(a) Be based on a Functional Behavior Assessment.

(b) Focus on prevention and teach replacement behaviors.

(c) Include planned responses to problems.

(d) Outline a data collection system for evaluating the effectiveness of the plan.

(5) All Provider staff involved in implementing procedures outlined in the Behavior Support Plan shall be trained and demonstrate competency prior to implementing the plan.

(a) Completion of training shall be documented by the Provider.

(b) The Behavior Support Plan shall be available to all staff involved in implementing or supervising the plan.

(8) Level II Interventions may be used in pre-approved Behavior Support Plans or

emergency situations. [Includes manual restraint].

(9) Level III Interventions may only be used in pre-approved Behavior Support Plans. [Includes mechanical restraint and seclusion (time-out room)].

(10) Behavior Support Plans that utilize Level II or Level III Interventions shall be implemented only after Positive Behavior Supports, including Level I Interventions, are fully implemented and shown to be ineffective. A rationale on the necessity for the use of intrusive procedures shall be included in the Behavior Support Plan.

(11) Time-out Rooms shall be designed to protect Persons from hazardous conditions, including sharp corners and objects, uncovered light fixtures, and unprotected electrical outlets. The rooms shall have adequate lighting and ventilation.

(a) Doors to the Time-out Room may be held shut by provider staff, but not locked at any time.

(b) Persons shall remain in Time-out Rooms no more than 2 hours per occurrence.

(c) Provider staff shall monitor Persons in a Time-out Room visually and auditorially on a continual basis. Staff shall document ongoing observation of the Person while in the Time-out Room at least every fifteen minutes.

(12) Time-out Rooms shall be used only upon the occurrence of problems previously identified in the Behavior Support Plan.

(a) Persons shall be placed in the Time-out Room immediately following a previously identified problem. Time delays are not allowed.

(b) Persons shall not be transported to another location for placement in a Time-out Room.

(c) Behavior Support Plans must outline specific release criteria that may include time and behavior components. Time asleep must count toward time-release criteria.

(13) Mechanical restraints shall ensure the Person's safety in breathing, circulation, and prevent skin irritation.

(a) Persons shall be placed in Mechanical Restraints immediately following the identified problem. Time delays are not allowed.

(b) Persons shall not be transported to another location for Mechanical Restraints.

(14) Mechanical Restraints shall be used only upon the occurrence of problems previously identified in the Behavior Support Plan.

(a) Behavior Support Plans must outline specific release criteria that may include time and behavior components. Time asleep must count toward time-release criteria. The plan shall also specify maximum time limits for single application and multiple use.

(b) Behavior Support Plans shall include specific requirements for monitoring the Person, before, during, and after application of the restraint to ensure health and safety.

(c) Provider staff shall document their observation of the Person as specified in the Behavior Support Plan.

(15) Manual restraints shall ensure the Person's safety in breathing and circulation. Manual restraint procedures are limited to the Mandt System (Mandt), the Professional Assault Response Training (PART), or Supports Options and Actions for Respect (SOAR) training programs. Procedures not outlined in the programs listed above may only be used if pre-approved by the State Behavior Review Committee.

(16) Behavior Support Plans that include Manual Restraints shall provide information on the method of restraint, release criteria, and time limitations on use.

R539-4-5. Review and Approval Process.

(1) The Behavior Peer Review Committee shall review and approve the Behavior Support Plan annually. The plan may be implemented prior to the Behavior Peer Review Committee's review; however the review and approval must be completed within 60 calendar days of implementation.

(2) The Behavior Peer Review Committee's review and approval process shall include the following:

(a) A confirmation that appropriate Positive Behavior Supports, including Level I Interventions, were fully implemented and revised as needed prior to the implementation of Level II or Level III Interventions.

(b) Ensure the technical adequacy of the Functional Behavior Assessment and Behavior Support Plan based on principles from the fields of Positive Behavior Supports and Applied Behavior Analysis.

(c) Ensure plans are in place to attempt reducing the use of intrusive interventions.

(d) Ensure that staff training and plan implementation are adequate.

(3) The Provider Human Rights Committee shall approve Behavior Support Plans with Level II and Level III Interventions annually. Review and approval shall focus on rights issues, including consent and justification for the use of intrusive interventions.

(4) The State Behavior Review Committee must consist of at least three members, including representatives from the Division, Provider, and an independent professional having a recognized expertise in Positive Behavior Supports. The Committee shall review and approve the following:

(a) Behavior Support Plans that include Time-out Rooms, Mechanical Restraints or Highly Noxious Stimuli.

(b) Behavior Support Plans that include forms of Manual Restraint or Exclusionary Time-out used for long-term behavior change and not used in response to an emergency situation.

(c) Behavior Support Plans that include manual restraint not outlined in Mandt, PART or SOAR training programs.

(5) The Committee shall determine the time-frame for follow-up review.

(6) Behavior Support Plans shall be submitted to the Division's state office for temporary approval prior to implementation pending the State Behavior Review Committee's review of the plan.

(7) Families participating in Self-Administered Services may seek State Behavior Review Committee recommendations, if desired.

R539-4-6. Emergency Behavior Interventions.

(1) Emergency Behavior Interventions may be necessary to prevent clear and imminent threat of injury or property destruction during emergency situations.

(2) Level I Interventions shall be used first in emergency situations, if possible.

(3) The least intrusive Level II Interventions shall be used in emergency situations. The length of time in which the intervention is implemented shall be limited to the minimum amount of time required to resolve the immediate emergency situation.

(4) Each use of Emergency Behavior Interventions and a complete Emergency Behavior Intervention Review shall be documented by the Provider on Division Form 1-8 and forwarded to the Division, as outlined in the Provider's Service Contract with the Division.

(a) The Emergency Behavior Intervention Review shall be conducted by the Provider supervisor or specialist and staff involved with the Emergency Behavior Intervention. The review shall include the following:

(i) The circumstances leading up to and following the problem.

(ii) If the Emergency Behavior Intervention was justified.

(iii) Recommendations for how to prevent future occurrences, if applicable.

(5) The Person's Support Coordinator shall review Form 1-8 received from Providers and document the follow-up action.

(6) If Emergency Behavior Interventions are used three times, or for a total of 25 minutes, within 30 calendar days, the Team shall meet within ten business days of the date the above criteria are met to review the interventions and determine if:

(a) A Behavior Support Plan is needed;

(b) Level II or III Interventions are required in the Behavior Support Plan;

(c) Technical assistance is needed;

(d) Arrangements should be made with other agencies to prevent or respond to future crisis situations; or

(e) Other solutions can be identified to prevent future use of Emergency Behavior

Interventions.

(7) The Provider's Human Rights Committee shall review each use of Emergency Behavior Interventions.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints or 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 restraints or seclusion during annual 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 the use of restraints or seclusion have been reported and appropriately addressed. 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 the participant's support team and provider peer review team have appropriately reviewed and approved the use of restraints or seclusion interventions.

Unauthorized use of restraints or seclusion identified by the SMA is addressed immediately, including implementing plans of correction, training or other initiatives. Information about restraints or seclusion is collected in the SMA critical incident/event data base. This information is analyzed and included in an annual report submitted to the State Medicaid Director and DSPD director which describes the number of incidents, corrective action by the OA, support coordinator or other provider, number of corrective actions implemented, and an analysis of systemic trends that required additional intervention or process improvement steps.

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 uses of restraint and time-out rooms are recorded on incident reports and are reviewed at least monthly by support coordinators. The participant's support team and a Behavior Peer Review Designee review all emergency restraint use. All programmatic use of restraint and time-out is reviewed and approved annually by the participant's support team and Behavior Peer Review.. All programmatic use of restraint and time-out rooms are also summarized in provider's Behavior Consultation Service Progress Notes and reviewed at least monthly by support coordinators. State Quality Management and State Behavior Specialist will review data at least annually.

b. Use of Restrictive Interventions

○ The State does not permit or prohibits the use of restrictive interventions. Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

⦿	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-a-ii:

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

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

R539-3-10. Prohibited Procedures.

(1) The following procedures are prohibited for Division staff and Providers, including staff hired for Self-Administered Services, in all circumstances in supporting Persons receiving Division funding:

(a) Physical punishment, such as slapping, hitting, and pinching.

(b) Demeaning speech to a Person that ridicules or is abusive.

(c) Locked confinement in a room. [definition of seclusion]

(d) Denial or restriction of access to assistive technology devices, except where removal prevents injury to self, others, or property as outlined in Sections R539-3-6 and R539-4-7.

(e) Withholding or denial of meals, or other supports for biological needs, as a consequence or punishment for problems.

(f) Any Level II or Level III Intervention, as defined in R539-4-3(n) and R539-4-3(o), used as coercion, as convenience to staff, or in retaliation.

(g) Any procedure in violation of R495-876, R512-202, R510-302, 62A-3-301 thru 62A-3-321, and 62A-4a- 402 thru 62A-4a-412 prohibiting abuse.

R539-4-4. Levels of Behavior Interventions.

(2) All Behavior Support Plans shall be implemented only after the Person or Guardian gives consent and the Behavior Support Plan is approved by the Team.

(3) All Behavior Support Plans shall incorporate Positive Behavior Supports with the least intrusive, effective treatment designed to assist the Person in acquiring and maintaining skills, and preventing problems.

(4) Behavior Support Plans must:

(a) Be based on a Functional Behavior Assessment.

(b) Focus on prevention and teach replacement behaviors.

(c) Include planned responses to problems.

(d) Outline a data collection system for evaluating the effectiveness of the plan.

(5) All Provider staff involved in implementing procedures outlined in the Behavior Support Plan shall be trained and demonstrate competency prior to implementing the plan.

(a) Completion of training shall be documented by the Provider.

(b) The Behavior Support Plan shall be available to all staff involved in implementing or supervising the plan.

(8) Level II Interventions may be used in pre-approved Behavior Support Plans or emergency situations. [Includes manual restraint].

(9) Level III Interventions may only be used in pre-approved Behavior Support Plans. [Includes mechanical restraint and seclusion (time-out room)].

(10) Behavior Support Plans that utilize Level II or Level III Interventions shall be implemented only after Positive Behavior Supports, including Level I Interventions, are fully implemented and shown to be ineffective. A rationale on the necessity for the use of intrusive procedures shall be included in the Behavior Support Plan.

(11) Time-out Rooms shall be designed to protect Persons from hazardous conditions, including sharp corners and objects, uncovered light fixtures, and unprotected electrical outlets. The rooms shall have adequate lighting and ventilation.

(a) Doors to the Time-out Room may be held shut by Provider staff, but not locked at any time.

(b) Persons shall remain in Time-out Rooms no more than 2 hours per occurrence.

(c) Provider staff shall monitor Persons in a Time-out Room visually and auditorially on a continual basis. Staff shall document ongoing observation of the Person while in the Time-out Room at least every fifteen minutes.

(12) Time-out Rooms shall be used only upon the occurrence of problems previously identified in the Behavior Support Plan.

(a) Persons shall be placed in the Time-out Room immediately following a

previously identified problem. Time delays are not allowed.

(b) Persons shall not be transported to another location for placement in a Time-out Room.

(c) Behavior Support Plans must outline specific release criteria that may include time and behavior components. Time asleep must count toward time-release criteria.

(13) Mechanical restraints shall ensure the Person's safety in breathing, circulation, and prevent skin irritation.

(a) Persons shall be placed in Mechanical Restraints immediately following the identified problem. Time delays are not allowed.

(b) Persons shall not be transported to another location for Mechanical Restraints.

(14) Mechanical Restraints shall be used only upon the occurrence of problems previously identified in the Behavior Support Plan.

(a) Behavior Support Plans must outline specific release criteria that may include time and behavior components. Time asleep must count toward time-release criteria. The plan shall also specify maximum time limits for single application and multiple use.

(b) Behavior Support Plans shall include specific requirements for monitoring the Person, before, during, and after application of the restraint to ensure health and safety.

(c) Provider staff shall document their observation of the Person as specified in the Behavior Support Plan.

(15) Manual restraints shall ensure the Person's safety in breathing and circulation. Manual restraint procedures are limited to the Mandt System (Mandt), the Professional Assault Response Training (PART), or Supports Options and Actions for Respect (SOAR) training programs. Procedures not outlined in the programs listed above may only be used if pre-approved by the State Behavior Review Committee.

(16) Behavior Support Plans that include Manual Restraints shall provide information on the method of restraint, release criteria, and time limitations on use.

R539-4-5. Review and Approval Process.

(1) The Behavior Peer Review Committee shall review and approve the Behavior Support Plan annually. The plan may be implemented prior to the Behavior Peer Review Committee's review; however the review and approval

must be completed within 60 calendar days of implementation.

(2) The Behavior Peer Review Committee's review and approval process shall include the following:

(a) A confirmation that appropriate Positive Behavior Supports, including Level I Interventions, were fully implemented and revised as needed prior to the implementation of Level II or Level III Interventions.

(b) Ensure the technical adequacy of the Functional Behavior Assessment and Behavior Support Plan based on principles from the fields of Positive Behavior Supports and applied behavior analysis.

(c) Ensure plans are in place to attempt reducing the use of intrusive interventions.

(d) Ensure that staff training and plan implementation are adequate.

(3) The Provider Human Rights Committee shall approve Behavior Support Plans with Level II and Level III Interventions annually. Review and approval shall focus on rights issues, including consent and justification for the use of intrusive interventions.

(4) The State Behavior Review Committee must consist of at least three members, including representatives from the Division, Provider, and an independent professional having a recognized expertise in Positive Behavior Supports. The Committee shall review and approve the following:

(a) Behavior Support Plans that include Time-out Rooms, Mechanical Restraints or Highly Noxious Stimuli.

(b) Behavior Support Plans that include forms of Manual Restraint or Exclusionary Time-out used for long-term behavior change and not used in response to an emergency situation.

(c) Behavior Support Plans that include manual restraint not outlined in Mandt, PART or SOAR training programs.

(5) The Committee shall determine the time-frame for follow-up review.

(6) Behavior Support Plans shall be submitted to the Division's state office for temporary approval prior to implementation pending the State Behavior Review Committee's review of the plan.

(7) Families participating in Self-Administered Services may seek State Behavior Review Committee recommendations, if desired.

R539-4-6. Emergency Behavior Interventions.

(1) Emergency Behavior Interventions may be necessary to prevent clear

and imminent threat of injury or property destruction during emergency situations.

(2) Level I Interventions shall be used first in emergency situations, if possible.

(3) The least intrusive Level II Interventions shall be used in emergency situations. The length of time in which the intervention is implemented shall be limited to the minimum amount of time required to resolve the immediate emergency situation.

(4) Each use of Emergency Behavior Interventions and a complete Emergency Behavior Intervention Review shall be documented by the Provider on Division Form 1-8 and forwarded to the Division, as outlined in the Provider's Service Contract with the Division.

(a) The Emergency Behavior Intervention Review shall be conducted by the Provider supervisor or specialist and staff involved with the Emergency Behavior Intervention. The review shall include the following:

(i) The circumstances leading up to and following the problem.

(ii) If the Emergency Behavior Intervention was justified.

(iii) Recommendations for how to prevent future occurrences, if applicable.

(5) The Person's support coordinator shall review Form 1-8 received from Providers and document the follow-up action.

(6) If Emergency Behavior Interventions are used three times, or for a total of 25 minutes, within 30 calendar days, the Team shall meet within ten business days of the date the above criteria are met to review the interventions and determine if:

(a) A Behavior Support Plan is needed;

(b) Level II or III Interventions are required in the Behavior Support Plan;

(c) Technical assistance is needed;

(d) Arrangements should be made with other agencies to prevent or respond to future crisis situations; or

(e) Other solutions can be identified to prevent future use of Emergency Behavior Interventions.

(7) The Provider's Human Rights Committee shall review each use of Emergency Behavior Interventions.

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

The SMA monitors the use of restrictive interventions during annual 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 the use of restrictive interventions have been reported and appropriately addressed. 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 the participant's support team and provider peer review team have appropriately reviewed and approved the use of restrictive interventions. Unauthorized use of restrictive interventions identified by the SMA is addressed immediately, including implementing plans of correction, training or other initiatives. Information about restrictive interventions is collected in the SMA critical incident/event data base. This information is analyzed and included in an annual report submitted to the State Medicaid Director and DSPD director which describes the number of incidents, corrective action by the OA, support coordinator or other provider, number of corrective actions implemented, and an analysis of systemic trends that required additional intervention or process improvement steps.

The Operating Agency has the day to day responsibility to assure that appropriate procedures are followed regarding the implementation of the use of restrictive interventions. All uses of restrictive interventions are recorded on incident reports and are reviewed at least monthly by support coordinators. The participant's support team and a Behavior Peer Review review all restrictive interventions use. All programmatic use of restrictive interventions is reviewed and approved annually by the participant's support teamand Behavior Peer Review.. All programmatic use of restrictive interventions are also summarized in provider's Behavior Consultation Service Progress Notes and reviewed at least monthly by support coordinators. State Quality Management and State Behavior Specialist will review data at least annually.

Appendix G-3: Medication Management and Administration

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

a. Applicability. Select one:

○	**Yes**. This Appendix applies *(complete the remaining items)*.
⦿	**No**. This Appendix is not applicable *(do not complete the remaining items)*.

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

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

c. Medication Administration by Waiver Providers

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

○	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)*
○	Not applicable (*do not complete the remaining items*)

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

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

○	Providers that are responsible for medication administration are required to *both* record and report medication errors to a State agency (or agencies). *Complete the following three items:*
	(a) Specify State agency (or agencies) to which errors are reported:
	(b) Specify the types of medication errors that providers are required to *record:*
	(c) Specify the types of medication errors that providers must *report* to the State:
○	Providers responsible for medication administration are required to *record* medication errors but make information about medication errors available only when requested by the State. Specify the types of medication errors that providers are required to record:

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

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, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

a.i *For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

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:* HW 1.**	**Number and percentage of referrals made to Child Protective Services and/or law enforcement according to State law.**		
Data Source ***DSPD records*** ***Incident Reports***	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	☐ *Annually*	
		X *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	X *State Medicaid Agency*	☐ *Weekly*	
	X *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		Other: Specify:	

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

***Performance Measure:* HW 2.**	**Number and percentage of participant representatives who have been informed of how to report abuse, neglect and exploitation.**

PCSP	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X *State Medicaid Agency*	☐ *Weekly*	*100% Review*
	X *Operating Agency*	☐ *Monthly*	**X** *less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval:* **5**
	☐ *Other: Specify:*	☐ *Annually*	
		X *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	X *State Medicaid Agency*	☐ *Weekly*	
	X *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		Other: Specify:	

Performance Measure: **HW 3.**	**Number and percentage of critical incidents and events in which the SMA was notified by DSPD per the "Protocol: Critical Incidents and Events Notification to the SMA.**		
Data Source [e.g. – examples cited in IPG] • **DSPD records** • **Provider Records**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	☐ *Weekly*	☐ *100% Review*
	X Operating Agency	☐ *Monthly*	*X Less than 100% Review*

	☐ *Sub-State Entity*	☐ *Quarterly*	*X Representative Sample; Confidence Interval =5*
	☐ *Other: Specify:*	☐ *Annually*	
		X Continuously and Ongoing	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	X State Medicaid Agency	☐ *Weekly*	
	X Operating Agency	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	*X Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

***Performance Measure:* HW 4.**	**Number and percentage of participant's behavior support plans that are developed and monitored in accordance with the criteria established in the SIP**		
Data Source ***DSPD records*** ***Behavior support plans*** ***Incident Reports***	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	☐ *Annually*	
		X *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*

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

a.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 and DSPD will both conduct quality assurance reviews of health and welfare. The findings from all reviews conducted by DSPD will be submitted to the SMA for review and approval. An annual review will be conducted for each of the three waiver years. A baseline review will be conducted after completion of the first waiver year. The sample size for this review will be sufficient to provide a confidence level equal to 95%, a confidence interval equal to 5 and a response distribution equal to 50%. The response distribution percentage for future reviews will reflect the findings gathered during the baseline review.

b. Methods for Remediation/Fixing Individual Problems

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

Individual issues identified by the SMA and the OA, that affect the health and welfare of individual participants are addressed immediately. Issues that are less immediate are corrected within designated time frames, the results of which will be documented in the SMA final report.

b.ii Remediation Data Aggregation

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

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

c. Timelines

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

○	**Yes** *(complete remainder of item)*
○	**No**

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: Systems Improvement

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

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

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

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

Quality Improvement Strategy: Minimum Components

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

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

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

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

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

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

H.1 Systems Improvement

H.1.a.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. A grid displays the percentage of how well the performance measures are met for each waiver year. The review findings from the previous years are presented side by side with the current year's results, thus allowing for tracking and trending of performance measures. After a three-year cycle of reviews (and annually thereafter), the performance measures will be analyzed to determine if, over time, a negative trend has occurred and if a systems improvement will address the problem.

System improvement initiatives may be prioritized based on several factors including the health and welfare of participants, financial considerations and the intensity of the problem.

H.1.a.ii

System Improvement Activities	***Responsible Party*** *(check each that applies*	***Frequency of monitoring and analysis*** *(check each that applies*
	X State Medicaid Agency	*☐ Weekly*
	☐ Operating Agency	*☐ Monthly*
	☐ Sub-State Entity	*☐ Quarterly*
	☐ Quality Improvement Committee	*☐ Annually*
	☐ Other: Specify:	*X Other: Specify: initially every three years and annually, thereafter*

H.1.b.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, and how the results of the changes and the assessment are communicated (and with what frequency) to stakeholders, including participants, families, providers, agencies and other interested parties. 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 and the DSPD web site.

H.1.b.ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Quality Improvement Strategy is a dynamic document that is continuously evaluated each year by the SMA's quality management team. The team evaluates the data collection process and makes changes as necessary to allow for accurate data collection and analysis. In addition the Quality Improvement Committee will 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 Autism Waiver. Improvements to the QIS will be made at this time and submitted in the following waiver renewal application.

Appendix I: Financial Accountability

APPENDIX I-1: Financial Integrity and Accountability

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

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

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

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

1. Plan, develop and manage an array of services and supports for individuals with disabilities;
2. Contract for services and supports for persons with disabilities;
3. Approve and monitor and conduct certification reviews of approved providers;
4. Act as a Fiscal Agent to receive and disburse funds*; and
5. Develop standards and rules for the administration and operation of programs operated by or under contract with the division.

*During the 2012 Legislative Session, a bill was passed that required the Department of Health (SMA) to develop an Autism Waiver. The funding for the waiver was appropriated to the Department of Health rather than to the DHS, Division of Services for People with Disabilities. However, DSPD retains the State statutory authority of overseeing services for people with disabilities.

In accordance with DSPD's lead role and designated responsibilities, to assure the proper accounting of State funds, DSPD enters into a written State contract with each provider. The State contract is the sole responsibility of, and is managed by, DSPD's parent agency, the Department of Human 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.

2. The State Medicaid Agency processes waiver service claims through the MMIS system.
3. The State Medicaid Agency approves all proposed rules, policies, and other documents related to the 1915(c) waivers prior to adoption by DSPD.

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 SMA.

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;
8. Coordination of DHS Policy Development as it Relates to Implementation of the Medicaid Program; and,

9. Data Security.

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: **Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

a.i *For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

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: **FA 1.**	**Number and percentage of payments made for services that do not exceed the amount, frequency and duration identified on the participant's PCSP.**		
Data Source [e.g. – examples cited in IPG] • ***PCSP*** • **Participant Claims Data**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =5*
	☐ Other: Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			☐ Other: Describe
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that*	***Frequency of data aggregation and analysis:*** *(check each that*	

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

Add another Data Source for this performance measure

***Performance Measure:* FA 2.**	**Number and percentage of participant claims paid only for services authorized on the participant's PCSP.**		
Data Source • **Participant Claims Data** • **PCSP**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X *State Medicaid Agency*	*☐ Weekly*	*☐ 100% Review*
	X *Operating Agency*	*☐ Monthly*	**X** *Less than 100% Review*
	☐ Sub-State Entity	*☐Quarterly*	**X** *Representative Sample; Confidence Interval* 5
	☐ Other: Specify:	*☐ Annually*	
		X *Continuously and Ongoing*	*Stratified: Describe Groups*
		☐ Other: Specify:	
			☐ Other: Describe
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	X *State Medicaid Agency*	*☐ Weekly*	
	X *Operating Agency*	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	**X** *Annually*	
		☐ Continuously and Ongoing	

		☐ *Other: Specify:*	

***Performance Measure:* FA 3.**	**Number and percentage of participant claims paid for services that use approved waiver codes and rates.**		
Data Source • **Participant Claims Data** • **PCSP**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval* 5
	☐ *Other: Specify:*	☐ *Annually*	
		X *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	X *State Medicaid Agency*	☐ *Weekly*	
	X *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

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

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

b. Methods for Remediation/Fixing Individual Problems

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

b.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 Financial Accountability that are currently non-operational.

○	**Yes** *(complete remainder of item)*

○	**No**

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 I-2: Rates, Billing and Claims

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

In 2011 and 2012, DSPD conducted rate surveys comparing rates paid in Utah with eight western states for the following services:
Respite Care
Financial Management Services
Intensive Individual Supports – Direct Service (the Intensive Individual Supports – Direct Service was patterned after Support Living - Hourly Services that exists within the Community Supports Waiver for Individual with Intellectual Disabilities.) The rate survey was conducted for the Supported Living - Hourly Services Rate.

Intensive Individual Supports – Consultation Services – This is a new service. The rate was derived by conducting a survey among Utah providers that are currently providing ABA services through contracts with private insurance companies that offer autism services coverage.

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

Waiver services providers submit claims directly to the SMA via the State Medicaid MMIS system, the SMA then pays the waiver service provider directly.

For individuals participating in the Self-Administered Services delivery method, the participant submits their staff time sheet(s) to the FMS Agent. The FMS Agent pays the claim(s) and submits a bill to the SMA. The SMA reimburses the FMS.

c. Certifying Public Expenditures *(select one)*:

○		**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 (*check each that applies*):
	☐	**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.*)
⦿	**No**. State or local government agencies do not certify expenditures for waiver services.	

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 designated individual within Utah's Department of Workforce Services determines recipient Medicaid eligibility. The information is entered into the eligibility system which automates Medicaid eligibility decisions, benefits amounts, participants' notices and administrative reports. The eligibility system also interfaces with other governmental agencies such as, Social Security, Employment Security and the Internal Revenue Service. The system is a Federally-Approved Management Information System (FAMIS). In Utah, the following programs are accessed through the eligibility system: 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 the eligibility system to ensure the participant is Medicaid eligible before payment of claims is made.

2. Post-payment reviews are conducted by the State Medicaid agency as described under each assurance to ensure: (1) all of the services required by the individual are identified in the plan of care, (2) that the individual is receiving the services identified in the plan of care, and (3) that Medicaid reimbursement is not claimed for waiver services which were not included in the plan of care.

3. The Self-Administered Services model for Respite Services requires the individual to use a Financial Management Services agent as an integral component of the waiver service to assist with managing the employer-related financial responsibilities associated with the Self-Administered Services model. The FMS agency is a person or organization that assists waiver enrollees and their representatives, in performing a number of employer-related tasks. Self-administered Respite Service providers complete a time sheet for work performed. The participant's parent confirms the accuracy of the time sheet, signs it, and forwards it to the FMS agency for processing. The FMS agency submits a claim for reimbursement on behalf of the service worker through the Medicaid MMIS system. Upon receipt of payment the FMS agent completes the employer related responsibilities and forwards payment directly to the Respite Service provider for the services documented on the time sheet.

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

APPENDIX I-3: Payment

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

⦿	Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).
○	Payments for some, but not all, waiver services are made through an approved MMIS. Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.
○	Payments for waiver services are not made through an approved MMIS. Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:
○	Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS. Describe how payments are made to the managed care entity or entities:

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

☑	The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.
☐	The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
☐	The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent. Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:
☐	Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity. Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

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.

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

○	**Yes.** State or local government providers receive payment for waiver services. Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish. *Complete item I-3-e.*
⦿	**No**. State or local government providers do not receive payment for waiver services. *Do not complete Item I-3-e.*

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:

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.

g. Additional Payment Arrangements

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

○	**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.
⦿	**No**. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

ii. Organized Health Care Delivery System. *Select one:*

○	**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:
⦿	**No**. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

○	The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.
○	This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain *waiver* and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.
⦿	The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

APPENDIX I-4: Non-Federal Matching Funds

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Check each that applies:*

☑	**Appropriation of State Tax Revenues to the State Medicaid agency**
☐	**Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.** If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:
☐	**Other State Level Source(s) of Funds.** Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2- c:

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. *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:
☑	**Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.

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-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. (*Do not complete Item I-5-b*).
○	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual. (*Complete Item I-5-b*)

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

APPENDIX I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.
Select one:

○	**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:*
⦿	**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.

APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

⦿	**No**. The State does not impose a co-payment or similar charge upon participants for waiver services. (*Do not complete the remaining items; proceed to Item I-7-b*).
○	**Yes**. The State imposes a co-payment or similar charge upon participants for one or more waiver services. (*Complete the remaining items*)

i. Co-Pay Arrangement Specify the types of co-pay arrangements that are imposed on waiver participants *(check each that applies)*:

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*	
☐	Nominal deductible
☐	Coinsurance
☐	Co-Payment
☐	Other charge *(specify)*:

ii Participants Subject to Co-pay Charges for Waiver Services. Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded

iii. Amount of Co-Pay Charges for Waiver Services. In the following table, list the waiver services for which a charge is made, the amount of the charge, and the basis for determining the charge.

Waiver Service	Amount of Charge	Basis of the Charge

iv. Cumulative Maximum Charges. Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant *(select one)*:

○	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.
○	There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. Specify the cumulative maximum and the time period to which the maximum applies:

v. Assurance. The State assures that no provider may deny waiver services to an individual who is eligible for the services on account of the individual's inability to pay a cost-sharing charge for a waiver service.

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants as provided in 42 CFR §447.50. *Select one:*

⦿	**No**. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
○	**Yes**. The State imposes a premium, enrollment fee or similar cost-sharing arrangement. Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income (c) the groups of participants subject to cost-sharing and the groups who are excluded~~;~~ and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the following table for each year of the waiver.

Level(s) of Care *(specify)*:			ICF/ID				
Col. 1	**Col. 2**	**Col. 3**	**Col. 4**	**Col. 5**	**Col. 6**	**Col. 7**	**Col. 8**
Year	**Factor D**	**Factor D′**	**Total: D+D′**	**Factor G**	**Factor G′**	**Total: G+G′**	**Difference (Column 7 less Column 4)**
1	$30,026	$6,662	$36,688	$78,408	$5,048	$83,456	$46,768
2	$30,637	$6,795	$37,432	$79,976	$5,149	$85,125	$47,693
3	$31,252	$6,931	$38,183	$81,576	$5,252	$86,828	$48,645
4							
5							

Appendix J-2 - Derivation of Estimates

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (From Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
Year 1	300		
Year 2	300		
Year 3	300		
Year 4 (renewal only)			
Year 5 (renewal only)			

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-d.

The Average Length of Stay (ALOS) estimate is based on the ALOS in the nursing home. The reason the ICF/ID ALOS was not used, is that the participants on this waiver can age out of services and that will cause the ALOS to be lower than an ICF/ID.

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Factor D is an estimate that is based off the actual preliminary Community Supports Waiver utilization numbers for State fiscal year 2011. To project the actual 2011 average cost per unit data forward to 2013 the following equation was used: (actual 2011 average cost per unit) * ((1.02)^2). A cost of living adjustment of two percent has been added to each additional year to address inflation and is within the medical consumer price index. This data was entered into the Factor D tables for calculation.

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:

Factor D' is an estimate that is based off the actual preliminary Community Supports Waiver numbers for State fiscal year 2011. To project the actual 2011 average cost per

unit data forward to 2013 the following equation was used: (actual 2011 average cost per unit) * ((1.02)^2). A cost of living adjustment of two percent has been added to each additional year to address inflation and is within the medical consumer price index. Factor D' includes the Medicaid costs for all services that are furnished in addition to waiver services while the individual is in the waiver. This calculation includes institutional costs when a person leaves the waiver for the institution and returns to the waiver in the same waiver year. If a waiver participant does not return to the waiver following institutionalization, the cost of institutional care is not included. The costs of prescribed drugs for Medicare/Medicaid dual eligible clients under the provisions of Part D are also not included in the estimate.

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:

Factor G is an estimate that is based off the actual preliminary Community Supports Waiver utilization numbers for State fiscal year 2011. Factor G is calculated utilizing the average annual institutional costs of services for a person receiving ICF/ID level of care. These are the same services that would be furnished to waiver participants in the absence of the Community Supports Waiver. The average annual costs are then divided by the ICF/ID ALOS to calculate the average cost per day. The average cost per day is then multiplied by the Community Supports Waiver ALOS to get Factor G. To project the actual 2011 average cost per unit data forward to 2013 the following equation was used: (actual 2011 average cost per unit) * ((1.02)^2). Also, a cost of living adjustment of two percent has been added to each additional year to address inflation and is within the medical consumer price index.

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:

Factor G' is an estimate that is based off the actual preliminary Community Supports Waiver utilization numbers for State fiscal year 2009. Factor G' is calculated utilizing the average annual cost of all other (non institutional) Medicaid services furnished while the individual is in the ICF/ID. The average annual costs are then divided by the ICF/ID ALOS to calculate the average cost per day. The average cost per day is multiplied by the Community Supports Waiver ALOS to get Factor G'. To project the actual 2011 average cost per unit data forward to 2013 the following equation was used: (actual 2011 average cost per unit) * ((1.02)^2). Also, a cost of living adjustment of two percent has been added to each additional year to address inflation and is within the medical consumer price index. The costs of prescribed drugs for Medicare/Medicaid dual eligible clients under the provisions of Part D are also not included in the estimate.

d. Estimate of Factor D. *Select one:* Note: Selection below is new.

⦿	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
○	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

i. Estimate of Factor D – Non-Concurrent Waiver. Complete the following table for each waiver year

Waiver Year: Year 1					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Financial Management Services	Monthly	250	12	$39.00	$117,000
Intensive Individual Support – Consultant Service	Hourly	300	72	$80.00	$1,728,000
Intensive Individual Support – Direct Service	15 Minute Unit	300	4160	$5.38	$6,714,240
Respite Services	15 Minute Unit	250	625	$2.87	$448,438
GRAND TOTAL:					$9,007,678
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					300
FACTOR D (Divide grand total by number of participants)					$30,026
AVERAGE LENGTH OF STAY ON THE WAIVER					273

Waiver Year: Year 2					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Financial Management Services	Monthly	250	12	$39.78	$119,340
Intensive Individual Support – Consultant Service	Hourly	300	72	$81.60	$1,762,560
Intensive Individual Support – Direct Service	15 Minute Unit	300	4160	$5.49	$6,851,520
Respite Services	15 Minute Unit	250	625	$2.93	$457,813
GRAND TOTAL:					$9,191,233
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					300
FACTOR D (Divide grand total by number of participants)					$30,637
AVERAGE LENGTH OF STAY ON THE WAIVER					273

State:	
Effective Date	

Waiver Year: Year 3					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Financial Management Services	Monthly	250	12	$40.58	$121,740
Intensive Individual Support – Consultant Service	Hourly	300	72	$83.23	$1,797,768
Intensive Individual Support – Direct Service	15 Minute Unit	300	4160	$5.60	$6,988,800
Respite Services	15 Minute Unit	250	625	$2.99	$467,188
GRAND TOTAL:					$9,375,496
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					300
FACTOR D (Divide grand total by number of participants)					$31,252
AVERAGE LENGTH OF STAY ON THE WAIVER					273

Waiver Year: Year 4 *(renewal only)*					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
GRAND TOTAL:					
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					
FACTOR D (Divide grand total by number of participants)					
AVERAGE LENGTH OF STAY ON THE WAIVER					

Waiver Year: Year 5 *(renewal only)*					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
GRAND TOTAL:					
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					
FACTOR D (Divide grand total by number of participants)					
AVERAGE LENGTH OF STAY ON THE WAIVER					

ii. Estimate of Factor D – Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year.

Waiver Year: Year 1						
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
Waiver Service	**Check if included in capitation**	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 2						
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
Waiver Service	**Check if included in capitation**	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 3						
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
Waiver Service	**Check if included in capitation**	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 4 (Renewal Only)						
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
Waiver Service	**Check if included in capitation**	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 5 (Renewal Only)						
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
Waiver Service	**Check if included in capitation**	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						