Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.5

Includes Changes Implemented through November 2014

Submitted by:

Utah Department of Health, Division of Medicaid and Health Financing

Submission Date:	June 30, 2015

CMS Receipt Date *(CMS Use)*	

State:	
Effective Date	

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

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors.

1. Request Information

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

B. **Program Title** (*optional – this title will be used to locate this waiver in the finder*): Medically Complex Children's Waiver

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

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

⦿	**3 years**
○	**5 years**

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

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

○	**Model Waiver**
⦿	**Regular Waiver**

E. **Proposed Effective Date:** October 1, 2015

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)*	
	⦿	**Nursing Facility as defined in 42 CFR §440.40 and 42 CFR §440.155** If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
	○	**Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**
☐	**Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)** If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID facility level of care:	

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

Select one:

⦿	**Not applicable**
○	**Applicable**

Check the applicable authority or authorities:

☐	**Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**
☐	**Waiver(s) authorized under §1915(b) of the Act.** *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*

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

☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of providers)

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

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

The purpose of the Medically Complex Children's Waiver (MCCW) is to offer supportive services statewide to individuals who meet waiver eligibility criteria and to assist these individuals to live as independently and productively as possible.

The Department of Health, Division of Medicaid and Health Financing will be responsible for the administration and daily operations of the waiver.

The MCCW will offer both agency-based and self-administered services.

3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

○	**Not Applicable**
○	**No**
⦿	**Yes**

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

⦿	**No**
○	**Yes**

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

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

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

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

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

and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified throughout the application and in **Appendix H**.

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

The State Medicaid Agency convened a workgroup comprised of advocates, family members of children with complex medical conditions and staff from the Department of Health, Division of Medicaid and Health Financing, Bureau of Authorization and Community Based Services, and the Division of Family Health and Preparedness, Bureau of Children with Special Health Care Needs. The workgroup met on four occasions during April and May 2015.

To introduce the new waiver proposal, the State met with the Utah Indian Health Advisory Board (UIHAB) on May 8, 2015. The State held a public meeting at the Department of Health on May 18, 2015. Online participation was available for those who could not attend in person. The meeting was announced through the Utah Public Notice Website at: http://www.utah.gov/pmn/index.html

The State provided information about the waiver to the Medical Care Advisory Committee (MCAC) on May 18, 2015.

Electronic and hard copies of the full draft application were available for public review from May 22 through June 22, 2015. An electronic copy of the full draft application was sent to a wide network of providers, consumers, governmental entities and other interested stakeholders including the UIHAB, MCAC, Utah Legislative Coalition for People with Disabilities, Utah Statewide Independent Living Council, Utah Developmental Disabilities Council and the Utah Disability Law Center for review. The proposed application was also posted on the State Medicaid Agency's website at http://www.health.utah.gov/ltc/.
Hard copies of the full draft application were available by calling the Utah Department of Health and requesting a hard copy by mail. Hard copies were also available by visiting the local offices of the Division of Services for people with Disabilities throughout the State.

Non-electronic notification was achieved by posting a notice regarding how to access full copies (either electronic or hard copies) of the draft application in the Salt Lake Tribune and Deseret New. The newspaper notice also provided information on how to submit public comment.

The State summarized the public comments received, including a description of whether the comments resulted in revisions to the waiver.

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

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

7. Contact Person(s)

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

Last Name:	Hales				
First Name:	Tonya				
Title:	Director, Bureau of Authorization and Community Based Services				
Agency:	Department of Health, Division of Medicaid and Health Financing				
Address :	288 N. 1460 W.				
Address 2:	PO Box 143112				
City:	Salt Lake City				
State:	Utah				
Zip:	84114-3112				
Phone:	801-538-9136	**Ext:**		☐	**TTY**
Fax:	801-323-1588				
E-mail:	thales@utah.gov				

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

Last Name:					
First Name:					
Title:					
Agency:					
Address:					
Address 2:					
City:					
State:					
Zip :					
Phone:		**Ext:**		☐	**TTY**
Fax:					
E-mail:					

8. Authorizing Signature

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

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

Signature:

_____

State Medicaid Director or Designee

Submission Date:	

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

Last Name:	Hales				
First Name:	Michael				
Title:	Deputy Director				
Agency:	Utah Department of Health Division Director, Division of Medicaid and Health Financing				
Address:	288 N. 1460 W.				
Address 2:	PO Box 143101				
City:	Salt Lake City				
State:	Utah				
Zip:	84114-3101				
Phone:	801-538-6965	**Ext:**		☐	**TTY**
Fax:	801-538-6478				
E-mail:	mthales@utah.gov				

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

There is no transition plan for this waiver. This is a new waiver that is in compliance with HCBS setting requirements.

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

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

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

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

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

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

This is a new waiver that is in compliance with HCBS setting requirements.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

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

2. **Oversight of Performance.**

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

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

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

○	**Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).** Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*
⦿	**No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

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

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

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

n/a

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:

n/a

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

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

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

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:

- ***Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver***
- ***Equitable distribution of waiver openings in all geographic areas covered by the waiver***
- ***Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014).***

Where possible, include numerator/denominator.

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

Performance Measure:	***The SMA MCCW Unit and the SMA QA Unit collaborate in the development of waiver applications/amendments, rules and other official documents relating to the administration and operation of the waiver. (Numerator = # of documents in compliance; Denominator = total # of documents)***		
Data Source *(Select one) (Several options are listed in the on-line application):Other*			
If 'Other' is selected, specify:Waiver Documents			
	Responsible Party for data collection/generation *(check each that*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*

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

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

Performance Measure:	***The SMA approves maximum allowable rates (MARs) for covered waiver services. (Numerator = # of MARs approved; Denominator = total # of MARs)***		
Data Source *(Select one) (Several options are listed in the on-line application):Other*			
If 'Other' is selected, specify:Waiver 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*
	☐ Operating Agency	*☐ Monthly*	*☐ Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

Performance Measure:	***The SMA MCCW Unit submits proposed rules and other documents, relating to the implementation of the waiver (including training curriculums and outreach materials), to the SMA QA Unit for review and approval prior to implementation. (Numerator = # of documents in compliance; Denominator = total # of documents)***		
Data Source *(Select one) (Several options are listed in the on-line application):Other*			
If 'Other' is selected, specify:Waiver 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)*

State:	
Effective Date	

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

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

Performance Measure:	***Notice of appeal rights are provided to waiver applicants who are denied access to the Medically Complex Children's Waiver program. (Numerator = # of notices sent; Denominator = total # of notices required.)***		
Data Source *(Select one) (Several options are listed in the on-line application):Other*			
If 'Other' is selected, specify:Participant Files			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*

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

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

Performance Measure:	***Number and percentage of participants who have a) had a reduction/denial of a waiver service; b) denied choice of provider if more than one was available; or c) when determined ineligible when previously receiving services; who were provided timely notice of appeal rights. (Numerator = the number of compliant cases; Denominator = the total # of cases with or without the notification.)***

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

If 'Other' is selected, specify:Participant Files

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

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

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

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 Medically Complex Children's Waiver Program through numerous activities including the issuance of policies, rules and regulations relating to the waiver and the approval of all protocols, documents and trainings that affect any aspect of the Medically Complex Children's Waiver operations. Approvals are accomplished through a formal document approval process. The SMA Quality Assurance Unit conducts an annual review of the Medically Complex Children's Waiver Program for each of the three waiver years. At a minimum, one comprehensive review will be conducted during this three year cycle. The other annual reviews will be focused reviews. The criteria for the focused reviews will be determined from the Medically Complex Children's Waiver Unit review findings as well as other issues that develop during the review year. The sample size for the first year review will be sufficient to provide a confidence level equal to 95%, a response distribution of 50%, and a confidence interval equal to 5. For

future years, the State will request a lower response distribution based on the statistical evidence of previous reviews.

b. Methods for Remediation/Fixing Individual Problems

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

Individual issues identified that affect the health and welfare of individual participants are addressed immediately. Issues requiring immediate attention are addressed in a variety of ways. Depending on the circumstances of the individual case the interventions could include: contacting the SMA Medically Complex Children's Waiver Unit, case management and/or direct care provider agencies requiring an immediate review and remediation of the issue, reporting the issue to CPS and/or local law enforcement or the state's Medicaid Fraud Control Unit, the licensing authority or the survey/certification authority. To assure the issue has been addressed, entities assigned the responsibility of review and remediation are required to report back to the SMA on the results of their interventions within designated time frames. A description of issues requiring immediate attention and outcomes are documented through the SMA Quality Assurance Unit's final report. Issues that are less immediate are corrected within designated time frames and are documented through the SMA Quality Assurance Unit's final review report.

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

ii Remediation Data Aggregation

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

c. Timelines

State:	
Effective Date	

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

X	**No**
○	**Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Select one Waiver Target Group	Target Group/Subgroup		Minimum Age	Maximum Age	
				Maximum Age Limit: Through age –	No Maximum Age Limit
☐	**Aged or Disabled, or Both - General**				
	☐	Aged (age 65 and older)			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
⊙	**Aged or Disabled, or Both - Specific Recognized Subgroups**				
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	⊙	Medically Fragile		19	☐
	☐	Technology Dependent			☐
☐	**Intellectual Disability or Developmental Disability, or Both**				
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Mental Retardation			☐
☐	**Mental Illness** *(check each that applies)*				
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

1) Have complex chronic medical conditions and medical fragility associated with disabilities, technology dependencies, ongoing involvement of multiple subspecialty services and providers and/or frequent or prolonged hospitalizations or skilled nursing facility stays.
   a) To determine if a child has the medical complexity and intensity of services required for program eligibility, the child must have had within the last 24 months from the date of program application, or since the birth of the child if the child is less than 24 months old:
      i) ≥ 3 organ systems affected; AND
      ii) Must have 3 out of 4 of items 1 through 4:
         (1) ≥ 3 physicians involved in the child's care;
         (2) Prolonged dependence (> 3 months) on device-based support to compensate for inadequate organ or system function[1].

(3) High utilization of medical therapies, treatments, or subspecialty services[2], defined as prolonged dependence (> 3 months) on any of the following:
  (a) Intravenous administration of nutritional substances or medications; or
  (b) Any other medical devices to compensate for vital bodily function; or
  (c) Child is not dependent on technology, but has any chronic medical condition that requires as great a level of care as the those listed in (a) through (c) such as:
    (i) As a consequence of the child's medical condition, needs substantial physical assistance with activities of daily living (ADLs), such as mobility, feeding, toileting, dressing and bathing, at an age when the child would otherwise not be dependent; or
    (ii) Requires consistent medical or nursing supervision for monitoring results from the complexity of their condition.

(4) Frequent need for medical intervention or consultation, such as
  (a) ≥ 10 days spent in an inpatient hospital or skilled nursing facility during the period; or
  (b) ≥ 8 emergency department visits related to the complex medical conditions during the period; or
  (c) ≥ 20 physician office visits or phone calls to the physician regarding the complex medical conditions during the period.

[1] Ventilator dependent Individuals are excluded from participation in this waiver. These individuals are eligible for the Technology Dependent Waiver

[2] Applicants whose needs are primarily related to developmental or intellectual disabilities, learning disabilities or mental health conditions are excluded from participation in this waiver.

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*:
	To begin transition planning, the waiver case manager will meet with the individual approximately one year prior to the individual's reaching the maximum age limit. The case manager will present the individual with information about other home and community based waiver options for which the individual may be eligible, including application process information. The case manager will also facilitate a discussion between the individual and the Department of Workforce Services, Medicaid financial eligibility staff, to review the case to determine if the individual will continue to meet financial Medicaid eligibility requirements when determined via regular community Medicaid rules, rather than HCBS waiver financial eligibility rules.

Appendix B-2: Individual Cost Limit

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

⦿	**No Cost Limit**. The State does not apply an individual cost limit. *Do not complete Item B-2-b or Item B-2-c*.		
○	**Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c*. The limit specified by the State is *(select one)*:		
	○	**%**	A level higher than 100% of the institutional average Specify the percentage:
	○	Other *(specify)*:	
○	**Institutional Cost Limit**. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c*.		
○	**Cost Limit Lower Than Institutional Costs**. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver. *Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c*.		
	The cost limit specified by the State is *(select one)*:		
	○	**The following dollar amount**: Specify dollar amount:	
		The dollar amount *(select one)*:	
		○	**Is adjusted each year that the waiver is in effect by applying the following formula:** Specify the formula:
		○	**May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**

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

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

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

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

Appendix B-3: Number of Individuals Served

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

Table: B-3-a	
Waiver Year	**Unduplicated Number of Participants**
Year 1	175
Year 2	175
Year 3	175
Year 4 (only appears if applicable based on Item 1-C)	
Year 5 (only appears if applicable based on Item 1-C)	

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	**165**
Year 2	**165**
Year 3	**165**
Year 4 (only appears if applicable based on Item 1-C)	
Year 5 (only appears if applicable based on Item 1-C)	

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

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

Table B-3-c

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

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

⦿	**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:

Entrance to the waiver will be managed by open application periods.

During the open enrollment period(s), the State will accept applications from interested applicants. (All references to applicants, participants or individuals within this document include the role of the individual's representative).

If the number of eligible applications received during the open application period is equal to or less than the "point in time" capacity declared in the approved waiver, all applicants will be enrolled onto the waiver and applications will continue to be accepted until capacity is reached. If the number of eligible applicants exceeds the declared point in time capacity, applications will be ranked based on a Medical Acuity and Critical Needs Grid Score. Individuals with the highest Grid Score will be enrolled until the declared point in time capacity is reached.

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

Waiver Phase-In/Phase Out Schedule

Based on Waiver Proposed Effective Date:

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

○	Phased-in
○	Phased-out

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

Beginning (base) number of Participants:

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

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

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

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

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

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

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

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

2. Miller Trust State.

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

X	No
○	Yes

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

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)			
☐	Low income families with children as provided in §1931 of the Act		
X	SSI recipients		
☐	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121		
X	Optional State supplement recipients		
X	Optional categorically needy aged and/or disabled individuals who have income at: *(select one)*		
	X	100% of the Federal poverty level (FPL)	
	○	%	of FPL, which is lower than 100% of FPL Specify percentage:
☐	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)		
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)		
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)		
☐	Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)		
☐	Medically needy in 209(b) States (42 CFR §435.330)		
X	Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)		
☐	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*:		

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*	
○	**No**. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.
X	**Yes**. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. *Select one and complete Appendix B-5*.
○	All individuals in the special home and community-based waiver group under 42 CFR §435.217
X	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 *(check each that applies)*:
X	A special income level equal to (select one):
X	300% of the SSI Federal Benefit Rate (FBR)
○	% A percentage of FBR, which is lower than 300% (42 CFR §435.236) Specify percentage:
○	$ A dollar amount which is lower than 300% Specify percentage:
☐	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
☐	Medically needy without spend down in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
☐	Medically needy without spend down in 209(b) States (42 CFR §435.330)
☐	Aged and disabled individuals who have income at: *(select one)*
○	100% of FPL
○	% of FPL, which is lower than 100%
☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:

Appendix B-5: Post-Eligibility Treatment of Income

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

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

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

X	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act. *Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.*

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

○	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. However, for the five-year period beginning on January 1, 2014, post-eligibility treatment-of-income rules may not be determined in accordance with B-5-b-1 and B-5-c-1, because use of spousal eligibility and post-eligibility rules are mandatory during this time period.

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

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

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
○	The following standard included under the State plan *(Select one):*			
	○	**SSI standard**		
	○	**Optional State supplement standard**		
	○	**Medically needy income standard**		
	○	**The special income level for institutionalized persons** *(select one):*		
		○	**300% of the SSI Federal Benefit Rate (FBR)**	
		○	%	**A percentage of the FBR, which is less than 300%** Specify the percentage:
		○	$	**A dollar amount which is less than 300%.** Specify dollar amount:
	○	%	A percentage of the Federal poverty level Specify percentage:	
	○	**Other standard included under the State Plan** Specify:		
○	**The following dollar amount** Specify dollar amount:	$	If this amount changes, this item will be revised.	
○	**The following formula is used to determine the needs allowance:** Specify:			
○	Other Specify:			
ii. <u>Allowance for the spouse only</u> (*select one*):				
○	**Not Applicable**			
Specify the amount of the allowance (*select one*):				
○	**SSI standard**			
○	**Optional State supplement standard**			
○	**Medically needy income standard**			
○	**The following dollar amount:** Specify dollar amount:	$	If this amount changes, this item will be revised.	
○	**The amount is determined using the following formula:**			

State:	
Effective Date	

	Specify:

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

○	**Not Applicable *(see instructions)***
○	**AFDC need standard**
○	**Medically needy income standard**
○	**The following dollar amount:** $ Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*
○	**Other** *Specify:*

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

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

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

Select one:

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

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

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

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

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

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

○	Not applicable *(see instructions)*
○	AFDC need standard
○	Medically needy income standard
○	The following dollar amount: $ Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula: *Specify:*
○	Other (specify):

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

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

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

Select one:

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

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

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

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

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

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

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

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

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

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

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

○	**Not Applicable *(see instructions)***
○	**AFDC need standard**
○	**Medically needy income standard**
○	**The following dollar amount:** Specify dollar amount: $ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*
○	**Other** *Specify:*

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

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

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

Select one:

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

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

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

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
○	The following standard included under the State plan *(Select one):*			
○	**The following standard under 42 CFR §435.121:** *Specify:*			
○	**Optional State supplement standard**			
○	**Medically needy income standard**			
○	**The special income level for institutionalized persons** *(select one):*			
○	**300% of the SSI Federal Benefit Rate (FBR)**			
○	%	**A percentage of the FBR, which is less than 300%** Specify the percentage:		
○	$	**A dollar amount which is less than 300%.** Specify dollar amount:		
○	%	**A percentage of the Federal poverty level** Specify percentage:		
○	**Other standard included under the State Plan** Specify:			
○	**The following dollar amount** Specify dollar amount:	$	If this amount changes, this item will be revised.	
○	**The following formula is used to determine the needs allowance:** Specify:			
○	**Other** *Specify:*			
ii. <u>Allowance for the spouse only</u> (*select one*):				
○	**Not Applicable**			
○	**The State provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**			

	Specify:

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

○	**The following standard under 42 CFR §435.121:** *Specify:*		
○	**Optional State supplement standard**		
○	**Medically needy income standard**		
○	**The following dollar amount:** Specify dollar amount:	$	If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*		

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

○	**Not Applicable *(see instructions)***
○	**AFDC need standard**
○	**Medically needy income standard**
○	**The following dollar amount:** Specify dollar amount: $ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*
○	**Other** *Specify:*

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

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

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

Select one:

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

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

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

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

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

i. Allowance for the personal needs of the waiver participant *(select one)*:			
○	**SSI Standard**		
○	**Optional State supplement standard**		
○	**Medically needy income standard**		
○	**The special income level for institutionalized persons**		
○	%	Specify percentage:	
○	**The following dollar amount:**	$	If this amount changes, this item will be revised
○	**The following formula is used to determine the needs allowance:** *Specify formula:*		
○	**Other** *Specify*:		
ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community. Select one:			
○	**Allowance is the same**		
○	**Allowance is different.** *Explanation of difference:*		
iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:			
a. Health insurance premiums, deductibles and co-insurance charges b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*			
○	**Not applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*		
○	**The State does not establish reasonable limits.**		

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

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

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

e. Regular Post-Eligibility Treatment of Income: SSI State and §1634 state – 2014 through 2018. The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
○	The following standard included under the State plan *(Select one):*			
	○	**SSI standard**		
	○	**Optional State supplement standard**		
	○	**Medically needy income standard**		
	○	**The special income level for institutionalized persons** *(select one):*		
		○	**300% of the SSI Federal Benefit Rate (FBR)**	
		○ %	**A percentage of the FBR, which is less than 300%** Specify the percentage:	
		○ $	**A dollar amount which is less than 300%.** Specify dollar amount:	
	○	%	**A percentage of the Federal poverty level** Specify percentage:	
	○	**Other standard included under the State Plan** Specify:		
○	**The following dollar amount** Specify dollar amount:	$	If this amount changes, this item will be revised.	
X	**The following formula is used to determine the needs allowance:** Specify:			
	The allowance for the personal needs of the waiver participant is: a deduction equal to 100% of the HHS Poverty Guidelines for one person, an earned income deduction equal to the Substantial Gainful Activity level for a disabled person, a deduction for a dependent child equal to 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 CFR 435.726(c)(3).			
○	**Other** Specify:			
ii. <u>Allowance for the spouse only</u> (*select one*):				
X	**Not Applicable**			
○	**The State provides an allowance for a spouse who does not meet the definition of a community**			

	spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided: *Specify:*

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

iii. <u>Allowance for the family</u> (*select one*):			
○	**Not Applicable *(see instructions)***		
○	**AFDC need standard**		
X	**Medically needy income standard**		
○	**The following dollar amount:** Specify dollar amount:	$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*		
○	**Other** *Specify:*		

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

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

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

Select one:

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

X	**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.

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

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

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

- ○ The following standard included under the State plan *(Select one):*
  - ○ **The following standard under 42 CFR §435.121:** *Specify:*
  - ○ **Optional State supplement standard**
  - ○ **Medically needy income standard**
  - ○ **The special income level for institutionalized persons** *(select one):*
    - ○ **300% of the SSI Federal Benefit Rate (FBR)**
    - ○ ____ % **A percentage of the FBR, which is less than 300%** Specify the percentage:
    - ○ $ ____ **A dollar amount which is less than 300%.** Specify dollar amount:
  - ○ ____ % **A percentage of the Federal poverty level** Specify percentage:
  - ○ **Other standard included under the State Plan** Specify:
- ○ **The following dollar amount** Specify dollar amount: $ ____ If this amount changes, this item will be revised.
- ○ **The following formula is used to determine the needs allowance:** Specify:
- ○ **Other** *Specify:*

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

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

Specify the amount of the allowance (*select one*):	
○	**The following standard under 42 CFR §435.121:** *Specify:*
○	**Optional State supplement standard**
○	**Medically needy income standard**
○	**The following dollar amount:** Specify dollar amount: $ ____ If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*
iii. Allowance for the family (*select one*):	
○	**Not Applicable *(see instructions)***
○	**AFDC need standard**
○	**Medically needy income standard**
○	**The following dollar amount:** Specify dollar amount: $ ____ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*
○	**Other** *Specify:*
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:	
a. Health insurance premiums, deductibles and co-insurance charges b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. Select one:	
○	**Not applicable *(see instructions)*** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
○	**The State does not establish reasonable limits.**

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

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

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules – 2014 through 2018

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

i. <u>Allowance for the personal needs of the waiver participant</u> *(select one)***:**			
○	**SSI Standard**		
○	**Optional State supplement standard**		
○	**Medically needy income standard**		
○	**The special income level for institutionalized persons**		
○	%	Specify percentage:	
○	**The following dollar amount:**	$	If this amount changes, this item will be revised
X	**The following formula is used to determine the needs allowance:** *Specify formula:*		
	The allowance for the personal needs of the waiver participant is: a deduction equal to 100% of the HHS Poverty Guidelines for one person, an earned income deduction equal to the Substantial Gainful Activity level for a disabled person.		
○	**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**		
X	**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 in 42 CFR §435.726:			

a. Health insurance premiums, deductibles and co-insurance charges b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*	
○	**Not applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
○	**The State does not establish reasonable limits.**
X	**The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

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

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

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

i.	**Minimum number of services**. The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is*:* 1	
ii.	**Frequency of services**. The State requires (select one):	
	○	**The provision of waiver services at least monthly**
	⦿	**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:

Waiver case managers will perform initial level of care evaluations. The waiver case managers must:
be licensed in the State of Utah as a Registered Nurse in accordance with Title 58, Occupational and Professional Licensing, Utah Code Annotated, 1953 as amended; and

Have at least one year paid professional experience in the field of pediatric nursing and at least one year experience in utilization management, discharge planning or case management.

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.

The applicant must meet the nursing facility level of care criteria to Utah Administrative Code (UAC) 414-502-3 - Approval of level of care. 1) The Department shall document that at least two of the following factors exist when it determines whether an applicant has mental or physical conditions that require the level of care provided in a nursing facility or equivalent care provided through a Medicaid Home and Community Based Waiver program: (a) Due to diagnosed medical conditions, the applicant requires substantial physical assistance with daily living activities above the level of verbal prompting, supervising, or setting up; (b) The attending physician has determined that the applicant's level of dysfunction in orientation to person, place, or time requires nursing facility care; or equivalent care provided through a Medicaid Home and Community Based Waiver program; or (c) The medical condition and intensity of services indicate that the care needs of the applicant cannot be safely met in a less structured setting, or without the services and supports of a Medicaid Home and Community Based Waiver program. Eligible applicants will be required to submit medical documentation to demonstrate the level of care criteria described in UAC 414-502-3 and additional targeting criteria, as stated in Appendix B-1(b) are met. The RN case manager will review the documentation and will document that all requirements are met using the Medical Acuity and Critical Needs Grid.

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 MDS 3.0 Assessment (MDS) is the tool used to determine level of care for nursing facility based care under the State Plan. The MDS assesses client status and service needs as it relates to residing in a nursing facility. For the MCCW, the Medical Acuity and Critical Needs Grid is the instrument used to determine nursing facility level of care and eligibility based on the criteria set forth for admission to this waiver program. The tool documents the applicant's prior history, risk factors, functional status, behavioral status, nutritional status, medical information and treatments, growth and development, in addition to assessing the applicant's level of complex chronic medical conditions

	and medical fragility. Both the MDS and the Medical Acuity and Critical Needs Grid include data fields necessary to measure the individual's level of care as defined in UAC 414-502-3.

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:

For the initial evaluation, eligible applicants will be required to submit medical documentation to demonstrate the level of care criteria described in UAC 414-502-3 and additional targeting criteria, as stated in Appendix B-1(b) are met. The RN case manager will review the documentation and will confirm that all requirements are met using the Medical Acuity and Critical Needs Grid. For reevaluations, the RN case manager will conduct a face-to face assessment to confirm the participant continues to meet the requirements of UAC 414-502-3. The results of the assessment will be documented in the MCCW Level of Care Reevaluation Tool.

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

○	**Every three months**
○	**Every six months**
○	**Every twelve months**
⦿	**Other schedule** *Specify* the other schedule:
	Level of care reevaluations will be completed at least annually and within the same calendar month as the previous assessment.

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

⦿	**The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
○	**The qualifications are different.** *Specify the qualifications:*

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

A schedule for re-evaluations is printed monthly from an Access database providing a report of re-evaluations due in the up-coming month. The re-evaluation due date is also noted on the participant's care plan.

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:

Evaluation/re-evaluation records are maintained by the RN case manager within the Medicaid agency.

Quality Improvement: Level of Care

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

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

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-assurances:

a. Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.

i. Performance Measures

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

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

Performance Measure:	*Number and percentage of new enrollees who meet level of care requirements prior to receiving services on the waiver. (Numerator = # of new recipients meeting level of care requirements; Denominator = total # of new enrollees).*		
Data Source *(Select one) (Several options are listed in the on-line application):Other*			
If 'Other' is selected, specify: Participant Files			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	☐ Operating Agency	*☐ Monthly*	*☐ Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other Specify:	*X Annually*	

State:	
Effective Date	

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

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

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

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

i. Performance Measures

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

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

Performance Measure:	*Number and percentage of waiver recipients who received an annual level of care reevaluation within 12 months of the most current level of care evaluation and completed during the calendar month in which it is due. (Numerator = # of annual LOCs completed timely; Denominator = total # of annual LOCs required)*
Data Source *(Select one) (Several options are listed in the on-line application):Other*	

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

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

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

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

i. Performance Measures

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

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

Performance Measure:	*Number and Percentage of waiver recipients whose level of care screenings and evaluations were documented using the MDS/Medical Acuity and Critical Needs Grid. (Numerator = # of LOC determinations in compliance; Denominator = total # of LOC determinations made.)*		
Data Source *(Select one) (Several options are listed in the on-line application):Other*			
If 'Other' is selected, specify:Participant Files			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	☐ Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =*
	☐ Other Specify:	*X Annually*	*95% Confidence Level, 5% Margin of Error*
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and	***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:	*Number and Percentage of Level of Care evaluations (initial or annual) which were completed accurately based on Level of Care criteria. (Numerator=# of LOC evaluations completed accurately; Denominator=Total # of LOC evaluations completed)*
Data Source *(Select one) (Several options are listed in the on-line application):Other*	
If 'Other' is selected, specify:Participant Files	

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

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for	***Frequency of data***

State:	
Effective Date	

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

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

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

The RN case manager is responsible for confirming individuals meet level of care requirements for the program. Reviews of assessments and level of care determinations will be completed by the SMA QA Unit. 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

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

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

ii Remediation Data Aggregation

State:	
Effective Date	

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

Remediation-related Data Aggregation and Analysis (including trend identification)	***Responsible Party*** *(check each that applies)*	***Frequency of data aggregation and analysis:*** *(check each that applies)*
	X State Medicaid Agency	*☐ Weekly*
	☐ 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.

X	**No**
○	**Yes**

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

Appendix B-7: Freedom of Choice

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

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

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

Applicants and participants are informed of the choice between waiver services and nursing facility based care during their initial evaluation and each annual reevaluation thereafter. In addition, the individual is informed of feasible alternatives and offered the choice among waiver services and providers.

The Initial and Annual Freedom of Choice Certification form is used to document the individual's choices.

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.

Initial and Annual Freedom of Choice Certification forms are maintained by the RN case manager in each participant's case file.

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

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

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

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

For the full text of the Medicaid Member Guide, go to:
http://health.utah.gov/umb/forms/pdf/mg_w_cover.pdf

Appendix C: Participant Services

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

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

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

Other Services *(select one)*	
X	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.	
b.	

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

Extended State Plan Services *(select one)*

X	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.	

C-1/C-3: Service Specification

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

Service Specification	
Respite Services	
Category 1:	Sub-Category 1:
Skilled Nursing Respite	
Category 2:	Sub-Category 2:
Routine Respite	
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope)**:**

Skilled Nursing Respite is an intermittent service provided by a registered nurses on behalf of a participant to relieve the primary caregiver from the stress of providing continuous skilled care, thereby avoiding premature or unnecessary nursing facility admission. Skilled Nursing Respite services may be provided by a Medicaid enrolled Home Health Agency or through the Self-Administered Services (SAS) Method.
Skilled Nursing Respite is provided in a private residence or other setting(s) in the community, outside of the participant's home, but only when the participant, the RN cases manager and the respite care provider (individual or agency) have agreed and stipulated in the care plan that the alternative setting(s) is safe and can accommodate the necessary medical equipment and personnel needed to safely care for the participant.

Routine Respite is an intermittent service provided by a non-licensed, qualified provider on behalf of a participant to relieve the primary caregiver from the stress of providing continuous care, thereby avoiding premature or unnecessary nursing facility admission. Routine Respite services may be provided by a Medicaid enrolled Home Health Agency or through the Self-Administered Services (SAS) Method.
Routine Respite is provided in a private residence or other setting(s) in the community, outside of the participant's home, but only when the participant, the RN cases manager and the respite care provider (individual or agency) have agreed and stipulated in the care plan that the alternative setting(s) is safe and can accommodate the necessary medical equipment and personnel needed to safely care for the participant.

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

This service is not available for ongoing daycare or childcare purposes and is not intended to be used for extended periods at one time. Although limited variation in use of estimated weekly respite hours, listed on the approved care plan, is permissible, the participant cannot "bank" authorized weekly respite services to be used at a single time or for an extended period. Typical utilization of respite services is estimated to be an average of three hours per week. Six hours is the maximum number of respite hours that can be used at one time. Specific limits on the amount, frequency and duration of services are specified in the individual's care plan and are based on assessed need.

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

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

Provider Specifications

Provider Category(s) *(check one or both)*:	☑	Individual. List types:	☑	Agency. List the types of agencies:
	Skilled Nursing Respite: Registered nurses licensed in the State of Utah		Home Health Agencies	
	Routine Respite: Self-Administered Respite Service Provider		Respite Provider Agency	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Skilled Nursing Respite - Agency Based	Licensed Home Health Agencies in accordance with UAC 432-700	Medicare Certified	Agency must be enrolled as a Medicaid HCBS waiver provider. Registered nurses employed by the home health agency must be licensed in the State of Utah as a registered nurse in accordance with Title 58, Chapter 31b, Part 3, Occupational and Professional Licensing, Utah Code Annotated.
Skill Nursing Respite - Self-Administered Services (SAS) Method	Licensed in the State of Utah as a registered nurse in accordance with Title 58, Chapter 31b, Part 3, Occupational and Professional Licensing, Utah Code Annotated		Current RN licensure Completed Background and Criminal Investigation (BCI) check Nursing Malpractice Insurance/Individual Professional Liability Insurance Basic CPR certification Enrolled with a Financial Management Services (FMS) Agency Demonstrated ability to perform the necessary skilled nursing functions to safely care for the participant Completed SAS Provider Agreement
Routine Respite (Provided by non-licensed individuals) - Agency Based	Licensed Home Health Agencies in accordance with UAC 432-700		Agency must be enrolled as a Medicaid HCBS waiver provider.
Routine Respite (Provided by non-licensed individuals) – Self-Administered Services Method			Completed Background and Criminal Investigation (BCI) check Basic CPR certification Enrolled with a Financial Management Services (FMS) Agency Demonstrated ability to perform the necessary functions to safely care for the participant Completed SAS Provider Agreement

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Skilled Nursing Respite - Agency Based	State Medicaid Agency	Annual review to confirm the agency's licensure.
Skill Nursing Respite - SAS Method	State Medicaid Agency	Annual review to confirm the individual's licensure.
Routine Respite - Agency Based	State Medicaid Agency	Annual review to confirm the agency's licensure.
Routine Respite – SAS Method	State Medicaid Agency	Annually

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

Service Definition (Scope)**:**

Financial Management Service is offered in support of the self-administered services delivery option. Services rendered under this definition include those to facilitate the employment of skilled nursing and routine respite service providers:

a) Provider qualification verification;

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

c) Medicaid claims processing and reimbursement distribution; and

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

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

Financial Management Services are intended to provide basic payroll services to Home and Community-Based Services waiver participants who elect the Self-Administered Services (SAS) delivery option. This service does not provide persons with assistance in managing their personal funds or budgets and does not provide representative payee services. The participant is the sole employer. The FMS provider is in no way an employer of the individuals providing respite services to the participant.

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

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

applies):		Person				

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

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Financial Management Services	Certified Public Accountant UCA Sec 58-26A And UAC 156-26A		• Enroll as a Medicaid Provider • 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 and do allow for payments that exceed amounts authorized on the care plan. • Utilize a claims processing system acceptable to the Utah State Medicaid Agency. • Establish time lines for payments that meet individual needs within DOL regulations. • 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 participants, 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 services (the employer) 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 an accounting information system to invoice and receive Medicaid reimbursement funds. • Utilize an accounting and information system to track and report the distribution of Medicaid reimbursement funds. • Generate a detailed Medicaid reimbursement funds distribution report to the individual Medicaid recipient or representative semi-annually. • Withhold, file and deposit FICA, FUTA and SUTA taxes in accordance with federal IRS and DOL, and state regulations. • 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 participant. • Prepare employee payroll checks, at least monthly, sending them directly to the employees. • Keep abreast of all laws and regulations relevant to the responsibilities it has undertaken with regard to the required federal and state filings and the activities related to being a Fiscal/Employer Agent. • Establish a customer service mechanism in order to respond to calls from participants (employers) and their employees regarding issues such as withholding and net payments, lost or late checks, reports and other documentation. • Customer service representatives are able to communicate effectively in English and Spanish by voice and TTY with people who have a variety of disabilities. • Have a Disaster Recovery Plan for restoring software and master files and hardware backup if management information systems are disabled so that payroll and invoice payment systems remain intact. • Regularly file and perform accounting auditing to ensure system accuracy and compliance with general accounting practice.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

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

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

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

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

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):
	Criminal background investigations will be required for SAS providers. Verification of mandatory investigations will be the responsibility of the Financial Management Agency prior to the delivery of family directed services. Utah Law 53-10-108 allows qualifying entities to request Utah criminal history information. The scope of investigation includes Utah Criminal History, Utah Statewide Warrant and Protective Orders and Federal Want and Warrant files.
○	**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):
⦿	**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. For this facility type, please specify whether the State's standards address the following *(check each that applies)*:

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

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

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

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

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

○	**The State does not make payment to relatives/legal guardians for furnishing waiver services.**
○	**The State makes payment to relatives/legal guardians under *specific circumstances* and only when the relative/guardian is qualified to furnish services**. Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*
⦿	**Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.** Specify the controls that are employed to ensure that payments are made only for services rendered.
	The State does not make payments to legally responsible individuals or legal guardians. The State does allow payments to relatives other than legally responsible individuals or legal guardians but only when the relative is qualified to provide services as specified in Appendix C-3. The State will not pay non-legally responsible caregivers to provide waiver services when they are already being paid by another source to care for the recipient (i.e., foster parents). On an ongoing basis, the RN case manager will verify that services provided are appropriate and furnished in the best interest of the recipient at the time a formal review

	of the care plan is completed, at least every six months or more frequently as necessary to ensure services continue to meet the needs of the waiver participant. Additionally, on an annual basis, Medicaid will complete a sample review of claims for waiver services rendered to verify the service was authorized and did not exceed the amounts authorized in the care plan.
○	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 State Medicaid Agency (SMA) will enter into a provider agreement with all willing providers who meet licensure, certification and/or other qualifications. The SMA will recruit providers in areas throughout the State. Interested providers are required to complete a Medicaid provider application and all required documentation verifying provider qualifications. Details about waiver provider qualifications and procedures for enrollment are available through the Utah Medicaid website at:

http://medicaid.utah.gov

All waiver providers, regardless of whether they are enrolled to provide Medicaid State plan services, must have a separate, signed Medicaid Application/Agreement on file with the SMA in order to provide and bill for MCCW services. Each new Medicaid Provider Application/Agreement must include all applicable licenses and certifications and must be reviewed and approved by BACBS. BACBS will submit the provider agreement/application to the Bureau of Medicaid Operations for processing and enrollment.

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.

i. Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed

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

Performance Measure:	*Number and percentage of agencies/individuals who meet required licensing standards.* ***(Numerator = # of provider agencies/individuals who meet requirements; Denominator = total # of providers reviewed)***
Data Source *(Select one) (Several options are listed in the on-line application):Other*	
If 'Other' is selected, specify:Provider Records	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	☐ Operating Agency	*☐ Monthly*	*☐ Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	X Other Specify:RN Case Managers and HFLCA	*☐ Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		X Other Specify: Upon enrollment; at least every 3 years;	
			☐ Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

State:	
Effective Date	

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

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

i. Performance Measures

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

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

Performance Measure:	*Number and percentage of 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.(Numerator = # of SAS workers in compliance; Denominator = total # of SAS workers reviewed).*		
Data Source *(Select one) (Several options are listed in the on-line application):Other*			
If 'Other' is selected, specify:Provider Files			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	☐ Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =*
	☐ Other Specify:	*X Annually*	*95% Confidence Interval; 5% Margin of Error*
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other	

		Specify:		
				☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

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

c Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

i. Performance Measures

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

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

Performance Measure:	*Number and percentage of providers of respite services under the Self-Administered Services (SAS) Model who have received training by the parent of the waiver participant when warranted. (Numerator = # of SAS providers with documented training; Denominator = # of SAS providers who required training).*
Data Source *(Select one) (Several options are listed in the on-line application):Other*	

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

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

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

ii Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	***Responsible Party*** *(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 Qualified Providers that are currently non-operational.

X	**No**

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

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

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

⦿	**Not applicable – The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.**
○	**Applicable – The State imposes additional limits on the amount of waiver services.**

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

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

Appendix C-5: Home and Community-Based Settings

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

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

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

The MCCW is fully compliant with HCBS setting requirements. MCCW Respite services are only provided in home settings. The FMS service is provided in support of Self-Administered Services.

Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

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

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

☑	**Registered nurse, licensed to practice in the State**
☐	**Licensed practical or vocational nurse, acting within the scope of practice under State law**
☐	**Licensed physician (M.D. or D.O)**
☐	**Case Manager** (qualifications specified in Appendix C-1/C-3)
☐	**Case Manager** (qualifications not specified in Appendix C-1/C-3). *Specify qualifications*:
☐	**Social Worker** *Specify qualifications:*
☐	**Other** *Specify the individuals and their qualifications:*

b. Service Plan Development Safeguards.

Select one:

⦿	**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 Person-Centered Care Plan (PCCP) is developed in conjunction with the participant, parents, family members, or their legal representatives and other individuals of the participant's choosing. RN case managers describe the waiver services and offer the choice between/among waiver services and providers. The waiver participant and those in their chosen circle of support are given a waiver information sheet for future reference. If the participant has chosen self-administered services, information to assist in the planning process will also be provided. The RN case manager reviews waiver services with the participant and their chosen circle of support each time the PCCP is updated.

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) The PCCP is developed by the RN case manager in conjunction with the participant and their chosen circle of supports. The RN case manager will discuss the service needs identified during the assessment and available waiver services to meet those needs. The RN case manager will review a list of available service providers and will discuss the self-administered services option. If the participant elects the self-administered services option, the RN case manager will provide training regarding the role and responsibilities involved with being an employer and the requirement for FMS to be a service that is included in the PCCP. Relative to the needs of the individual, the RN case manager will review both the skilled nursing and routine respite options and will discuss the types of tasks that must be performed by an RN versus those that can be performed by non-licensed personnel. With the information presented, the participant will make known their preferences about desired services and chosen service delivery method(s). The responsibilities of the RN case manager will be discussed including the requirement to assist with the implementation and monitoring of the PCCP.

(b) The RN case manager conducts a comprehensive assessment which includes a review of medical/clinical documentation and completion of comprehensive assessment forms which include sections for documenting information related to:

- Comprehensive health history;
- Physicians/clinicians and others involved in the participant's care;
- Medical technology/device-based support;
- d) Medical therapies, treatments and subspecialty services (includes hospitalizations and outpatient procedures;
- Functional limitations;
- Type and frequency of medical intervention and consultation;
- Current home care services and providers;
- Types of durable medical equipment;
- Nutrition status and mode of nutritional intake;

- Financial, SSI and private insurance information;
- Recipient needs, risks, preferences, and goals; and
- Any identified health and safety risks.

(c) The RN case manager will review a list of available service providers and will discuss the self-administered services option. If the participant elects the self-administered services option, the RN case manager will provide training regarding the role and responsibilities involved with being an employer and the requirement for FMS to be a service that is included in the PCCP. Relative to the needs of the individual, the RN case manager will review both the skilled nursing and routine respite options and will discuss the types of tasks that must be performed by an RN versus those that can be performed.

(d) PCCP development incorporates input from the participant and their circle of supports and includes offering the participant the choice of waiver providers when more than one provider is available to deliver the services. The participant and their circle of supports are an integral part of the waiver assessment and planning process. The RN case manager continually assess changes in the participant's health status and family circumstances in order to identify if additional services may be needed.

(e) RN case managers are responsible to oversee the coordination of waiver services. Participants may be referred and assisted with coordinating non-waiver services included in the PCCP; but the RN case manager is not responsible for ensuring their delivery. When non-waiver services are needed to meet the needs of the participant, the RN case manager assists, coordinates and monitors the implementation of the needed non-waiver services.

(f) The RN case manager will discuss their responsibilities related to implementation and monitoring the PCCP. The participant will be instructed to contact the RN cases manager with any questions or concerns about services, coordination with other benefits or health and safety concerns. The participant will be instructed to report hospitalizations or other incidents involving the participant. The participant will be informed of the RN case manager's authority to approve and coordinate waiver services. The RN case manager will support the participant to obtain non-waiver services but has no authority other than to link, refer and coordinate with other entities for such services.

(g) The PCCP must be reviewed and updated by the RN case manager as frequently as necessary to ensure it continues to meet the needs of the waiver participant and family. The PCCP must be reviewed at least annually, but will be reviewed more frequently as needed based on a significant change in the participant's condition. The review must be completed by the RN case manager 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.

RN case managers will assess for risks during the initial and reassessment home visits.

Potential risks will be identified and preventative interventions and strategies will be discussed with the participant. Waiver enrolled home health agencies are responsible to send a replacement provider as a back-up if the scheduled provider is not available. The RN case managers will regularly assess the amount and frequency of services as another method of mitigating identified risks. The RN case manager will assess for and help the participant to identify informal supports available in addition to waiver and State Plan services including exploring the self-administered services option under the waiver.

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.

Participants are informed of all available waiver providers and freely select the provider of choice during each assessment and reassessment, whenever there is a change in their documented service needs, or when they have indicated they are dissatisfied with their current provider. RN case managers provide any additional information needed to support the participant to make an informed choice. Freedom of choice of available providers is documented by the participant's signature on the PCCP.

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 waiver is directly managed by the Medicaid Agency.

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

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

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.

The RN case managers are responsible for PCCP monitoring the implementation through periodic home visits and phone calls. In all cases, frequency of home visits will be at six month intervals at a minimum but may be conducted more frequently based on the complexity of the participant's needs. In addition, the participant was instructed at the time of PCCP development, to contact the RN cases manager with any questions or concerns about services, coordination with other benefits or health and safety concerns. The participant will also be instructed to report hospitalizations or other incidents involving the participant. During home visits and phone calls, the RN case manager will confirm the participant is receiving services in accordance with the approved PCCP, quality services are being provided and the services are sufficient to meet the health and safety needs of the participant. These interactions provide opportunities for the RN case manager to become aware of concerns and issues.

In addition, the RN case manager, home health agencies and other providers collaborate to assure services are meeting the needs of the participant. If participants want to change providers at any time, RN case managers provide information about available providers and update the PCCP to reflect the changes. Participants who receive less than one waiver service per month will be contacted by the RN case manager on a monthly basis to assess needs and risks. RN case managers assist the participant and family in solving issues and problems through phone calls, scheduling case conferences and coordinating with providers. Participants are encouraged to call the RN case manager with concerns and problems as they arise. Back-up plans using informal supports and coordinating services among several providers are used to ensure access to services thereby promoting the health and safety of the individual.

RN case managers will make note of any issues or problems in the participant's case file along with steps that will be followed to remediate or address the problems.

Separate from the ongoing monitoring completed by the RN cases manager, an annual quality assurance review of a representative sample of PCCPs will be conducting by the quality assurance team within the Bureau of Authorization and Community based Services. These reviews will evaluate utilization of waiver services to assure that the PCCPs specify services by type, amount, duration, scope and frequency. A concurrent post-payment review of selected recipients' claims is also conducted by BACBS to verify the extent in which providers delivered authorized services.

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.**

State:	
Effective Date	

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

Quality Improvement: Service Plan

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

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

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-assurances:

a. Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

i. Performance Measures

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

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

Performance Measure:	*Number and percentage of Plans of Care that address the assessed needs of recipients including health and safety risk factors, either by waiver services or through other means (Numerator=# of Plans of care that address all assessed needs; Denominator=Total # of Plans reviewed)*		
Data Source *(Select one) (Several options are listed in the on-line application):Other*			
If 'Other' is selected, specify:Participant Files			
	Responsible Party for data collection/generation	***Frequency of data collection/generation:*** *(check each that*	***Sampling Approach*** *(check each that applies)*

State:	
Effective Date	

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

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

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

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

i. Performance Measures

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

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

Performance Measure:	*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 through the waiver. (Numerator = # of care plans in compliance; Denominator = # of total care plans reviewed).*
Data Source *(Select one) (Several options are listed in the on-line application):Other*	
If 'Other' is selected, specify:Participant Files	

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

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

State:	
Effective Date	

	Ongoing
	☐ Other Specify:

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

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

i. Performance Measures

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

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

Performance Measure:	*Number and percentage of PCSPs reviewed and updated at least annually. (Numerator = # of care plans in compliance; Denominator = # of total care plans reviewed).*		
Data Source *(Select one) (Several options are listed in the on-line application):Other*			
If 'Other' is selected, specify:Participant Files			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X *State Medicaid Agency*	*☐ Weekly*	*☐ 100% Review*
	☐ Operating Agency	*☐ Monthly*	***X*** *Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	***X*** *Representative Sample; Confidence Interval =*
	☐ Other Specify:	***X*** *Annually*	*95% Confidence Level, 5% Margin of Error*
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

State:	
Effective Date	

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

Performance Measure:	*Number and percentage of changes to PCSPs that were completed when warranted by changes in the participant's needs. (Numerator = # care plan changes completed; Denominator = # of total care plans changes required).*
Data Source *(Select one) (Several options are listed in the on-line application):Other*	
If 'Other' is selected, specify:Participant Files	

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

State:	
Effective Date	

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

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

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

i. Performance Measures

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

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

Performance Measure:	*Number and percentage of recipients who received services in accordance with their Plan of Care including the type, amount, frequency and duration. (Numerator = # of plans of care where amount/frequency/duration for all waiver services was provided; Denominator = # of care plans reviewed)*		
Data Source *(Select one) (Several options are listed in the on-line application):Other*			
If 'Other' is selected, specify:Participant Files			
	Responsible Party for data	***Frequency of data collection/generation:***	***Sampling Approach*** *(check each that*

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

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

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

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

i. Performance Measures

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

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

Performance Measure:	*Number and percentage of recipients who are offered the choice between nursing facility care and waiver services.(Numerator = # of recipients where choice of service delivery was documented; Denominator = total # of recipients reviewed)*
Data Source *(Select one) (Several options are listed in the on-line application):Other*	
If 'Other' is selected, specify:Participant Files	

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

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

State:	
Effective Date	

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

Performance Measure:	*Number and percentage of recipients who are offered choice of services and providers (when more than one is available) and is documented on a signed freedom of choice form. (Numerator = # of recipients who were offered choice of service and providers when available; Denominator = # of recipients enrolled in the waiver)*		
Data Source *(Select one) (Several options are listed in the on-line application):Other*			
If 'Other' is selected, specify:Participant Files			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	***X*** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	***X*** *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	***X*** *Annually*	*95% Confidence Level, 5% Margin of Error*
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

State:	
Effective Date	

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

ii. Remediation Data Aggregation

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

State:	
Effective Date	

	☐ **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.

X	**No**
○	**Yes**

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

State:	
Effective Date	

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

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

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

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

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

Appendix E-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 (SAS) are those provided through a non-agency based provider. Under this method, participants hire individual employees to perform respite services. During the needs assessment and PCCP development process, the RN case manager will discuss the ability to receive services under the SAS method. If the participant elects to receive SAS services the RN case manager will provide information to the participant regarding SAS requirements and the participant's responsibilities to manage their employees.

The participant is responsible to manage the employee(s) including recruiting, hiring, providing supervision, including assuring that the employee does not perform functions outside the scope of their training or licensure, training, scheduling and assuring time sheet accuracy and submitting time sheets to the FMS provider.

The SAS delivery method requires the use of Financial Management Services (FMS) to assist with managing associated employer-related financial responsibilities.

During the needs assessment and PCCP development process, the RN case manager will discuss the ability to receive services under the SAS method. If the participant elects to receive SAS services the RN case manager will provide information to the participant regarding the associated responsibilities and requirements.

At a minimum of monthly the FMS provider will send the employer and the RN case manager information at least monthly detailing the units of services used and the number of authorized units remaining.

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

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

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

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

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 initial assessment process, RN case managers will review a list of available service providers and will discuss the self-administered services option. If the participant elects the self-administered services option, the RN case manager will provide training regarding the role and responsibilities involved with being an employer and the requirement for FMS to be a service that is included in the PCCP. Relative to the needs of the individual, the RN case manager will review both the skilled nursing and routine respite options and will discuss the types of tasks that must be performed by an RN versus those that can be performed.

The RN case manager will provide the participant with written information detailing the respite services available through the SAS method and a list of enrolled FMS providers. The RN case manager will explain the option to have all or a part of their authorized services delivered through the SAS model and/or all or part of their services through a Medicaid enrolled licensed home health agency. The information provided during the initial assessment will enable the participant to make an informed choice about their options. This information also outlines the benefits, potential liabilities and participant responsibilities if the SAS option is chosen.

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

○	**The State does not provide for the direction of waiver services by a representative.**	
⦿	**The State provides for the direction of waiver services by representatives.** Specify the representatives who may direct waiver services: *(check each that applies)*:	
	☑	**Waiver services may be directed by a legal representative of the participant.**
	☐	**Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

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

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Skilled Nursing Respite	☑	☐
Routine Respite	☑	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

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 specified in Appendix C-1/C-3 **The waiver service entitled:**	Financial Management Services
○	**FMS are provided as an administrative activity.**	

	Provide the following information	
i.	**Types of Entities**: Specify the types of entities that furnish FMS and the method of procuring these services:	
	FMS agencies enrolled as Medicaid providers complying with state and local licensing, accreditation and certification requirements per UCA 58-26a. The State enrolls all willing and qualified providers.	
ii.	**Payment for FMS**. Specify how FMS entities are compensated for the administrative activities that they perform:	
	FMS agencies do not perform administrative activities. FMS will be paid through the Medicaid fee-for-service system.	
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:	
	☑	**Assists participant in verifying support worker citizenship status**
	☑	**Collects and processes timesheets of support workers**
	☑	**Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
	☑	**Other** *Specify:*
		The FMS provider will assist the employer in obtaining documentation of BCI check, CPR certification, and professional malpractice insurance and current license/certification and maintain copies of these documents for a period not less than 3 years. At a minimum of monthly the FMS provider will send the employer and the RN case manager information at least monthly detailing the units of services used and the number of authorized units remaining.
	Supports furnished when the participant exercises budget authority:	
	☐	**Maintains a separate account for each participant's participant-directed budget**
	☐	**Tracks and reports participant funds, disbursements and the balance—of participant funds**
	☐	**Processes and pays invoices for goods and services approved in the service plan**
	☐	**Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
	☐	**Other services and supports** *Specify*:
	Additional functions/activities:	
	☑	**Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
	☑	**Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
	☐	**Provides other entities specified by the State with periodic reports of expenditures**

		and the status of the participant-directed budget
	☐	**Other** *Specify:*
iv.	**Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.	
	For each participant receiving SAS, the RN case manager will review the monthly FMS report that details units of services used and the number of authorized units remaining. With each reassessment or PCCP update, RN Waiver Coordinators from CSHCN will review monthly billing statements from the FMS provider and compare them with the service authorization. If these documents reveal over utilization or significant underutilization, the RN case manager will adjust service authorization based on assessed need and input from the participant. Additionally, billing statements from the FMS and utilization data/expenditure data will be reviewed by the quality assurance team within the Bureau of Authorization and Community Based Services as part of its post-payment record review process.	

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

☑	**Case Management Activity**. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. *Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*
	During the initial assessment process, RN case managers will review a list of available service providers and will discuss the self-administered services option. If the participant elects the self-administered services option, the RN case manager will provide training regarding the role and responsibilities involved with being an employer and the requirement for FMS to be a service that is included in the PCCP. Relative to the needs of the individual, the RN case manager will review both the skilled nursing and routine respite options and will discuss the types of tasks that must be performed by an RN versus those that can be performed. The RN case manager will provide the participant with written information detailing the respite services available through the SAS method and a list of enrolled FMS providers. The RN case manager will explain the option to have all or a part of their authorized services delivered through the SAS model and/or all or part of their services through a Medicaid enrolled licensed home health agency. The information provided during the initial assessment will enable the participant to make an informed choice about their options. This information also outlines the benefits, potential liabilities and participant responsibilities if the SAS option is chosen.
☐	**Waiver Service Coverage**. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-1/C-3 (check each that applies):

	Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
	(list of services from Appendix C-1/C-3)	☐

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

k. Independent Advocacy *(select one)*.

⦿	**No. Arrangements have not been made for independent advocacy.**
○	**Yes**. Independent advocacy is available to participants who direct their services. *Describe the nature of this independent advocacy and how participants may access this advocacy*:

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

If the participant voluntarily terminates self-administered services, the RN case manager will re-evaluate the participant's service needs and assist the participant to select an agency based service provider. The transition to a new provider will include all aspects of the PCCP development including timeliness and the choice of willing and available providers. Health and safety and continuity of services will be assured during the transition.

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.

Only after a participant has repeatedly demonstrated an incapacity for self-administration or problems with fraud or malfeasance have been identified would involuntary termination of self-administered services occur. Prior to that occurrence however, the RN case manager will offer participants who are struggling with self-administered services repeated assistance and consultation to assist the participant to acquire the skills necessary to be successful. Only after the failure of all these efforts will the State involuntarily terminate self-administered services for a participant.

The transition to agency-based care will include all aspects of PCCP development including input from the participant on service needs, the assurance of health and welfare during the transition and the choice among willing and available providers. During the transition to agency-based care, self-administered services may continue (as long as the participant's health and welfare is assured) until a home health agency has been identified and waiver services initiated.

If a case of fraud or misuse of funds, is suspected, immediate termination of self-directed services is allowed. In this case, the RN case manager would be responsible for obtaining an emergency provider of waiver services.

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	100	
Year 2	165	
Year 3	165	
Year 4 (only appears if applicable based on Item 1-C**)**		
Year 5 (only appears if applicable based on Item 1-C**)**		

Appendix E-2: Opportunities for Participant-Direction

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

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both:*

☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. Specify the types of agencies (a.k.a., "agencies with choice") that serve as co-employers of participant-selected staff:
☑	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

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

☑	**Recruit staff**
☐	**Refer staff to agency for hiring (co-employer)**
☐	**Select staff from worker registry**
☑	**Hire staff (common law employer)**
☑	**Verify staff qualifications**
☑	**Obtain criminal history and/or background investigation of staff** Specify how the costs of such investigations are compensated:
	The employee will be responsible to pay for the costs associated with the background investigation.
☑	**Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
☑	**Determine staff duties consistent with the service specifications in Appendix C-1/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. *Select one or more*:

☐	**Reallocate funds among services included in the budget**
☐	**Determine the amount paid for services within the State's established limits**
☐	**Substitute service providers**
☐	**Schedule the provision of services**
☐	**Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
☐	**Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
☐	**Identify service providers and refer for provider enrollment**
☐	**Authorize payment for waiver goods and services**
☐	**Review and approve provider invoices for services rendered**
☐	Other Specify:

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

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

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

○	**Modifications to the participant directed budget must be preceded by a change in the service plan.**
○	**The participant has the authority to modify the services included in the participantdirected budget without prior approval.** Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

An applicant/participant will not be offered waiver services if the assessment indicates he/she cannot adequately/safely be served in the community and will be given written notice of rights to a fair hearing.

The participant will be offered the choice of waiver services only if the individual's needs can be met appropriately in the community with waiver and other available State Plan services and the preliminary PCCP has been agreed to by all parties.

If waiver services are chosen, the participant will also be given the opportunity to choose an available provider of waiver service(s) if more than one qualified provider is available to render the service(s).

Upon entrance to the waiver program, the participant will be informed verbally and in writing by the RN case manager during the initial home visit of:

a) the feasible alternatives available under the waiver;
b) their right to choose institutional care or home and community based care; and
c) the Medicaid complaint, grievance and fair hearing process.

A form signed by the participant will be maintained in the recipient's case record to document their awareness of rights to a fair hearing upon entrance to the waiver.

Documentation will also be maintained in the recipient file concerning the choices given and the response to those choices.

It is the policy of BACBS to resolve disputes at the lowest level. The following is not meant to foreclose the State's preference for informal resolutions through open discussion and negotiation between the State, applicants, recipients, providers and all other interested parties.

In addition to any and all hearing rights detailed in UAC 410-14, eligible waiver applicants/participants will be given an opportunity for a hearing, upon written request, if the participant:

1. Is not offered the choice of nursing facility care or community-based (waiver) services;
2. The scope, frequency and/or duration of waiver services are reduced/suspended or terminated;
3. Is denied the waiver services of their choice; or

4. Is denied the waiver provider(s) of their choice if more than one provider is available to render the service(s).

Notices of adverse actions are given to individuals verbally and followed-up with a formal written notice of agency action. Included in the formal written notice are specified timeframes for filing an appeal and informing participants that services may continue during the appeal process. However, if as a result of the hearing, the action taken by the State Medicaid Agency is found to be correct, the participant will be responsible to pay the costs of the services provided during the appeal period. Content of the notices conforms to 42 CFR 431. Documentation of these notices is maintained in the participant's case file.

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one*:

⦿	**No. This Appendix does not apply**
○	**Yes. The State operates an additional dispute resolution process**

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

Appendix F-3: State Grievance/Complaint System

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

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

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

The State Medicaid Agency is responsible for the operation of the grievance/complaint system.

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

The State Medicaid Agency operates an internal complaint/grievance system. The Medicaid constituent services' representative receives complaints from participants, providers, family or other community or stakeholder groups. The individual lodging the complaint is informed by the constituent services representative that filing a grievance or making a complaint is not a prerequisite or substitute for a formal hearing.

a) Types of complaints received may include but are not limited to, the availability of services, provider staff complaints, quality of care, eligibility problems, claims payment problems, policy clarification requests, requests for additional coverage or information about what is covered by the MCCW and other Medicaid program issues.

b) The complaints are documented in the Medicaid Managed Care System (MMCS) and assigned a tracking number. Data entered includes the client name and type of complaint they are filing. Details about the situation are documented in the system in a narrative format and steps to resolution are then entered on the case. Medicaid agency managers are notified via monthly reports generated electronically through the MMCS system regarding any resolution efforts that have been or need to be taken by the constituent services' representative and documented in the electronic case record. Time frames for addressing complaints are determined by the source, i.e. Governor's office or Director's office, or by urgency of call. Most calls are resolved with 10 days.

c) If the complaint/grievance is not resolved at the constituent service level the waiver participant will be advised by the constituent services representative of the need to file a request for a fair hearing within the allowed time limits. The informal dispute resolution process will continue during the interim period until the fair hearing is scheduled and conducted. Federal and state laws set forth for the Medicaid program are followed for resolution of claims payment, coverage and eligibility issues. Medicaid policy, found in provider manuals and the Medicaid eligibility manual, is referenced for policy and eligibility problems and service issues. If the complaint involved civil rights or discrimination

situations, the participant would be referred to the Regional Civil Rights Office to be reported in writing.

The Medicaid Member Guide informs the participant of their right to contact the Medicaid constituent services line to discuss issues or concerns. Additionally, the RN case managers provide written materials to the participant with grievances or complaints contact information. Contacts include the names and numbers of the specific RN case manager and the State Medicaid Agency's constituent services representative.

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).

In accordance with UCA 62-A-4a-403 Part 4 and 62-A-3-305, professionals and the public are required to report instances of abuse, neglect and exploitation. RN case managers and providers, shall immediately refer incidences of suspected abuse, neglect and exploitation to the nearest law enforcement agency, Child Protective Services (CPS) within the Division of Child and Family Services (DCFS) or Adult Protective Services (APS) within the Division of Aging and Adult Services (DAAS) for investigation.

Additionally, Bureau of Authorization and Community Based Services requires the participant to notify the RN case manager by phone, email or fax within 24 hours of the occurrence of all critical incidents. Depending on the nature/severity of the critical incident, the RN case manager may investigate and remediate the incident internally or forward to the Bureau of Authorization and Community Based Services for investigation/remediation. In addition, the RN case manager must document the details of the incident on a Critical Incident Investigation form. For incidents meeting the criteria of a level one incident, the Critical Incident Investigation form must also be submitted to the Bureau of Authorization and Community Based Services within ten business days of the report of the incident. Bureau of Authorization and Community Based Services provides final oversight of the investigations of all critical incidents.

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.

Upon enrollment and annually thereafter, RN case managers will provide information to participants related to laws and protections from abuse, neglect and exploitation. Under UCA 62-A-4a-403 Part 4 Child Abuse or Neglect Reporting Requirements and 62-A-3-305, Adult Reporting Requirements, professionals and the public are required to report instances of abuse, neglect and exploitation.

In addition, the RN case manager will offer information and instruct participants tatives on the following topics:

a) how to avoid theft/security issues;
b) maintaining personal safety when recruiting/interviewing potential employees;
c) assertiveness/boundaries/rules with employees;
d) maintaining personal safety when firing an employee;
e) when and how to report instances of abuse, neglect or exploitation; and
f) resources in their community to assist victims of abuse, neglect or exploitation.

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

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

The Bureau of Authorization and Community Based Services then reviews the Critical Incident Investigation document to determine if the incident could have been avoided, if additional supports or interventions have been implemented to prevent the incident from recurring, if changes to the PCCP have been made, if any systemic issues were identified and a plan to address systemic issues developed. The Bureau of Authorization and Community Based Services then completes its portion of the Critical Incident Investigation document which includes a summary of the incident, remediation activities and findings and recommendations. At the conclusion of the investigation, participants are informed in writing of the investigation results within two weeks of the closure of the case by the Bureau of Authorization and Community Based Services when appropriate to the nature of the incident.

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

The Bureau of Authorization and Community Based Services is the entity responsible for

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

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

a. Use of Restraints ***(select one):(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)***

⦿	**The State does not permit or prohibits the use of restraints** Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:
	The Divisions of Child and Family Services and Adult and Aging Services receive referrals from professionals and the public when use of restraints is suspected. The BACBS quality assurance team monitors for the use of any restraints during annual formal reviews. BACBS reviews participant records and conducts interviews with participants to identify the use of restraints or seclusion. The RN case manager is also responsible for ongoing monitoring of the participants' health and welfare including ensuring that restraints are not utilized. This is accomplished through home visits and telephone contacts with the participant and providers. Face to face visits with recipients occur at a minimum of every six months.
○	**The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii:

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

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 Divisions of Child and Family Services and Adult and Aging Services receive referrals from professionals and the public when use of restrictive interventions is suspected. The BACBS quality assurance team monitors for the use of any restrictive interventions

	during annual formal reviews. BACBS reviews participant records and conducts interviews with participants to identify the use of restrictive interventions. The RN case manager is responsible for ongoing monitoring of the participants' health and welfare including ensuring that restrictive interventions are not utilized. This is accomplished through home visits and telephone contacts with the participant and providers. Face to face visits with participants occur at a minimum of every six months.
○	**The use of restrictive interventions is permitted during the course of the delivery of waiver services.** Complete Items G-2-b-i and G-2-b-ii.

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

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

c. Use of Seclusion. *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

⦿	**The State does not permit or prohibits the use of seclusion** Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:
	The Divisions of Child and Family Services and Adult and Aging Services receive referrals from professionals and the public when use of seclusion is suspected. The BACBS quality assurance team monitors for the use of seclusion during annual formal reviews. BACBS reviews participant records and conducts interviews with participants to identify the use of seclusion. The RN case manager is responsible for ongoing monitoring of the participants' health and welfare including ensuring that seclusion is not utilized. This is accomplished through home visits and telephone contacts with the participant and providers. Face to face visits with participants occur at a minimum of every six months.
○	**The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

Appendix G-3: Medication Management and Administration

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

a. Applicability. Select one:

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

b. Medication Management and Follow-Up

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

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*:

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

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

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 demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-assurances:

a. Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

i. **Performance Measures**

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

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

Performance Measure:	***Number and percentage of suspected abuse, neglect or exploitation incidents referred to Child Protective Services and/or law enforcement as required by State law. (Numerator = # of referrals made; Denominator = total # of referrals required)***		
Data Source *(Select one) (Several options are listed in the on-line application):Other*			
If 'Other' is selected, specify:			
Progress notes, On-site Record reviews, Provider records and reports, Critical Incident Database			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	☐ Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =*
	☐ Other Specify:	*☐ Annually*	*95% Confidence Level, 5% Margin of Error*
		X *Continuously and Ongoing*	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for	***Frequency of data***

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

Performance Measure:	***Number and percentage of participant deaths which are reviewed to determine if they unexplained and require further investigation. (Numerator = # of participant deaths reviewed; Denominator = # of total participant deaths during the review period).***		
Data Source *(Select one) (Several options are listed in the on-line application):Other*			
If 'Other' is selected, specify:			
On-site Record reviews, Annual Critical Incident reports			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	☐ *Weekly*	*X 100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	
		X *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

State:	
Effective Date	

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

b. Sub-assurance: The State demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.

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

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

Performance Measure:	***Number and percentage of incidents/events that met the SMA critical incident criteria which were reported to the SMA QA Unit. (Numerator = # of incidents in compliance; Denomintor = total # of reportable incidents)***		
Data Source *(Select one) (Several options are listed in the on-line application):Other*			
If 'Other' is selected, specify:			
On-site Record reviews, Annual Critical Incident reports			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	*X Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	*X Representative Sample; Confidence Interval =*
	☐ *Other*	***X*** *Annually*	*95% Confidence*

State:	
Effective Date	

	Specify:			*Level, 5% Margin of Error*
		☐ *Continuously and Ongoing*		☐ *Stratified: Describe Group:*
		☐ *Other Specify:*		
				☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

Performance Measure:	***Number and percentage of incidents for which prevention strategies were developed and implemented when warranted. (Numerator = # of incidents with prevention developed and implemented; Denomintor = total # of reportable incidents)***		
Data Source *(Select one) (Several options are listed in the on-line application):Other*			
If 'Other' is selected, specify:			
On-site Record reviews, Annual Critical Incident reports			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	*X Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	*X Representative Sample; Confidence Interval =*
	☐ *Other*	***X*** *Annually*	*95% Confidence*

State:	
Effective Date	

	Specify:			*Level, 5% Margin of Error*
		☐ *Continuously and Ongoing*		☐ *Stratified: Describe Group:*
		☐ *Other Specify:*		
				☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

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

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

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

Performance Measure:	***Number and Percentage of incidents involving restrictive interventions (including restraints & seclusion) that are reported and investigated. (Numerator = # of incidents investigated; Denominator = # of incidents identified requiring review)***
Data Source *(Select one) (Several options are listed in the on-line application):Other*	
If 'Other' is selected, specify:	
On-site Record reviews, Annual Critical Incident reports	

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

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

d. Sub-assurance: The State establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.

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

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

Performance Measure:	***Number and percentage of recipients whose records documented they and their legal representatives/families received information related to laws and protections from abuse, neglect and exploitation upon enrollment and annually thereafter. (Numerator = # of recipients in compliance; Denominator = # of recipients reviewed)***		
Data Source *(Select one) (Several options are listed in the on-line application):Other*			
If 'Other' is selected, specify:			
On-site Record reviews			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	☐ Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =*
	☐ Other Specify:	***X*** *Annually*	*95% Confidence Level, 5% Margin of Error*
		X *Continuously and Ongoing*	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

State:	
Effective Date	

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

Performance Measure:	***Number and percentage of recipients' legal representatives/families that were provided with their RN Case Manager's phone number and the phone numbers for CPS. (Numerator = # of recipients provided with all contact information; Denominator = total # of recipients reviewed)***

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

If 'Other' is selected, specify:

On-site Record reviews

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

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

ii. **Remediation Data Aggregation**

	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 Health and Welfare that are currently non-operational.

X	**No**
○	**Yes**

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

Appendix H: Quality Improvement Strategy

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

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

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

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

Quality Improvement Strategy: Minimum Components

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

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

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

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

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

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

H.1 Systems Improvement

a. **System Improvements**

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

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

ii. System Improvement Activities

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

b. **System Design Changes**

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

The SMA will establish a Quality Improvement Committee consisting of the SMA QA Unit, the SMA MCCW Unit, and others. The team will meet to assess the results of the systems design changes. The success of the systems changes will be based on criteria that must be met to determine that the change has been accomplished and also criteria that will determine that the systems change has been sustained or will be sustained. The Quality Improvement Committee will determine the sustainability criteria. Results of system design changes will be communicated to participants and families, providers,

agencies and others through the Medicaid Information Bulletin and the MCCW website.

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

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

BACBS, operating within the State Medicaid Agency, assures financial accountability for funds expended for home and community-based services, and will maintain and make available financial records documenting the cost of services provided under the waiver. Financial oversight of the waiver program begins with system edits in the Medicaid Management Information System (MMIS) to prevent payment:

1) to non-waiver enrolled providers;
2) to non-waiver eligible recipients;
3) with inappropriate coding;
4) for claims billed in excess of maximum fee schedule rates; and
5) for overlapping/duplicative dates of service.

BACBS also conducts post-payment reviews and focused reviews of claims as part of its waiver compliance review to verify whether paid claims were:

1) rendered to a waiver recipient;
2) included in the recipient's Plan of Care;
3) properly billed by a qualified waiver provider; and
4) claimed in accordance with Plan of Care limitations.

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

Quality Improvement: Financial Accountability

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

a. **Methods for Discovery: Financial Accountability Assurance**
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-assurances:

a Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

a.i. Performance Measures

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

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

Performance Measure:	***Number and percentage of paid claims which verify that services were rendered to a waiver recipient using approved waiver codes and rates. (Numerator = # of claims in compliance; Denominator = total # of paid claims)***		
Data Source *(Select one) (Several options are listed in the on-line application):Other*			
If 'Other' is selected, specify:			
Financial 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*
	☐ *Operating Agency*	☐ *Monthly*	***X*** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	***X*** *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	***X*** *Annually*	*95% Confidence Level, 5% Margin of Error*
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

Performance Measure:	***Number and percentage of paid claims that were authorized and did not exceed the amounts documented in the recipient's Plan of Care. (Numerator = # of claims in compliance; Denominator = total # of claims paid)***
Data Source *(Select one) (Several options are listed in the on-line application):Other*	
If 'Other' is selected, specify:	
On-site Record reviews and financial 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*
	☐ *Operating Agency*	☐ *Monthly*	***X*** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	***X*** *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	***X*** *Annually*	*95% Confidence Level, 5% Margin of Error*
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

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

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

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

Performance Measure:	***Number and percentage of participant claims in a representative sample paid for services that use approved waiver rates. (The numerator is the total number of participant claims in the review sample which paid for waiver services using approved waiver rates; the denominator is the total number of participant claims in the review sample.)***
Data Source *(Select one) (Several options are listed in the on-line application):Other*	
If 'Other' is selected, specify:Claims Data	

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

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

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.

BACBS conducts an annual review of the Medically Complex Children's Waiver program for each of the three waiver years.

b. Methods for Remediation/Fixing Individual Problems

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

Recovery of Funds:
• When payments are made for a service not identified on the Plan of Care, a recovery of unauthorized paid claims based upon the Federal Medical Assistance Percentage (FMAP) will be required.
• When the amount of payments exceeds the amount, frequency and/or duration identified on the Plan of Care, a recovery of unauthorized paid claims based upon the Federal Medicaid Percentage (FMAP) will be required.
• When payments are made for services based on a coding error, the coding error will be corrected by withdrawing the submission of the claim and submitting the correct code for payment.

When BACBS discovers that unauthorized claims have been paid, BACBS works with Medicaid Operations and Medicaid Operations will reprocess the MMIS claims to reflect the recovery.

When BACBS discovers that unauthorized claims have been paid, the recovery of funds will proceed as follows:
1. BACBS will complete a Recovery of Funds form that indicates the amount of the recovery and send it to Medicaid Operations
2. Medicaid Operations will reprocess the MMIS claims to reflect the recovery.
3. Overpayments are returned to the federal government within required time frames.

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)*
	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 Financial Accountability that are currently non-operational.

X	**No**
○	**Yes**

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

APPENDIX I-2: Rates, Billing and Claims

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

The State Medicaid Agency is responsible for rate determination. BACBS proposes any new rates or rate changes based on rates from Utah Medicaid's Fee schedule including rates used in existing State Plan services and Utah State 1915(c) waivers for equivalent services and providers. The proposed rates are reviewed by rate-setting staff within Medicaid's Bureau of Coverage and Reimbursement Policy.

Skilled Nursing Respite Care (Agency) - Based on State plan private duty nursing reimbursement rates for equivalent providers.

Skilled Nursing Respite Care (Individual) – Equivalent to 61% of the agency based rate, Because these services are offered under a family directed services model the SMA also covers the cost of employer payroll burden, including FICA, Federal and State Unemployment taxes, Workers Compensation, etc.

Routine respite rates are based on the rates paid for individual personal care providers in State Plan programs. These rates are paid to individual personal care providers in the Employment Related Personal Assistance program authorized under the State Plan. Because these services are offered under a family directed services model the SMA also covers the cost of employer payroll burden, including FICA, Federal and State Unemployment taxes, Workers Compensation, etc.

Financial Management Services – Based on the rate paid for equivalent services in some of Utah's other 1915(c) waivers: the Physical Disabilities and ABI Waivers

The state actively solicits public input on revised applications for waiver amendments or renewals from a broad network including Tribal Governments, the Medical Care Advisory Committee (MCAC), Utah Family Voices (for distribution targeted towards families and potential recipients) and the Utah Association of Home Care Pediatrics Committee which includes waiver providers and family representatives. These entities then have 30 days in which to submit comments or questions, including those involving proposed rates, for consideration prior to the submission of the final application of the Medically Complex Children's Waiver.

Providers and consumers are also invited to Medicaid public hearings to offer comments and recommendations regarding all aspects of the HCBS waiver and State plan Medicaid programs. Rates are made available to recipients and other interested parties upon request or through the State Medicaid Agency website (Utah Department of Health).

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 service providers submit claims directly to the State Medicaid agency. The State Medicaid agency then pays the service provider directly.

For individuals participating in the Family Directed Services model, the recipient/legal representative submits their staff time sheets to the Financial Management Service agency. The Financial Management Agency then pays the claim and submits a bill to the State Medicaid agency. The State Medicaid agency then reimburses the Financial Management agency.

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

X	**No. State or local government agencies do not certify expenditures for waiver services.**	
○	**Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.** *Select at least one:*	
	☐	**Certified Public Expenditures (CPE) of State Public Agencies**. Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-a.*)
	☐	**Certified Public Expenditures (CPE) of Local Government Agencies**. Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

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, recipients' 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.

Post-payment reviews are conducted by BACBS 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.

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)*:

X	**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*):

X	**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:*

X	**No. The State does not make supplemental or enhanced payments for waiver services.**
○	**Yes. The State makes supplemental or enhanced payments for waiver services.** Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

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

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

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

g. Additional Payment Arrangements

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

X	**No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
○	**Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).** Specify the governmental agency (or agencies) to which reassignment may be made.

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

X	**No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
○	**Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.** Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

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

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

APPENDIX I-4: Non-Federal Matching Funds

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

X	**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. *Select one:*

X		**Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
○		**Applicable** *Check each that applies:*
	☐	**Appropriation of Local Government Revenues.** Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:
	☐	**Other Local Government Level Source(s) of Funds.** Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds . *Select one:*

X	**None of the specified sources of funds contribute to the non-federal share of computable waiver costs.**	
○	**The following source(s) are used.** *Check each that applies.*	
	☐	**Health care-related taxes or fees**
	☐	**Provider-related donations**
	☐	**Federal funds**
	For each source of funds indicated above, describe the source of the funds in detail:	

APPENDIX I-5: Exclusion of Medicaid Payment for Room and Board

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

X	**No services under this waiver are furnished in residential settings other than the private residence of the individual.**
○	**As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

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

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

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

X	**No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
○	**Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.** The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

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

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

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

i. Co-Pay Arrangement

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

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

ii Participants Subject to Co-pay Charges for Waiver Services.

Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded

iii. Amount of Co-Pay Charges for Waiver Services. The following table lists the waiver services defined in C-1/C-3 for which a charge is made, the amount of the charge, and the basis for determining the charge.

Waiver Service	Charge	
	Amount	Basis

iv. Cumulative Maximum Charges.

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

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

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

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

Appendix J: Cost Neutrality Demonstration

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

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care *(specify)*:			Nursing Home				
Col. 1	**Col. 2**	**Col. 3**	**Col. 4**	**Col. 5**	**Col. 6**	**Col. 7**	**Col. 8**
Year	**Factor D**	**Factor D′**	**Total: D+D′**	**Factor G**	**Factor G′**	**Total: G+G′**	**Difference (Column 7 less Column 4)**
1	$4,269.02	$13,214.25	$17,483.27	$47,234.10	$4,951.08	$52,185.18	$34,701.91
2	$5,692.03	$17,619.00	$23,311.03	$62,632.42	$6,565.13	$69,197.55	$45,886.52
3	$5,692.03	$17,619.00	$23,311.03	$63,885.06	$6,696.43	$70,581.50	$47,270.47
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:
		Nursing Home	
Year 1	165	165	
Year 2	165	165	
Year 3	165	165	
Year 4 (only appears if applicable based on Item 1-C)			
Year 5 (only appears if applicable based on Item 1-C)			

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in Item J-2-a.

Average Length of Stay (LOS) = 270 days for waiver year 1 and 360 days for waiver years 2 and 3.

Waiver year 1 LOS assumes a 90 day period of time for participants to be determined to meet the eligibility requirements and begin services.

Waiver years two and three assume virtually no attrition as the broad age range of potential participants will likely not result any attrition due to age, we also assume few, if any, voluntary disenrollments.

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 was derived based on the following assumptions:

1) Average per user utilization of skilled nursing respite: 2 hours per week
2) Average per user utilization of routine respite: 1 hour per week
3) 10% of Skilled Nursing Respite users will employ a family directed services model
4) All participants will employ a family directed services model for routine respite requiring

all participants to utilize 1 unit of Financial Management Services per month

The SMA will monitor these assumptions following implementation of the waiver and adjust estimates as necessary.

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' was derived based on Idaho Medicaid's estimates for average cost per year for participants in their Katie Beckett program.

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 was derived based on the following assumptions:

1) Used actual average nursing home cost per day for fiscal years 2012-2014 and multiplied by the estimated waiver LOS to get fiscal year 2015 base estimate and the increased by 2% to get Waiver year one
2) Each subsequent year was increased 2%

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' was derived based on the following assumptions:

1) Used actual average nursing home cost per day for fiscal years 2012-2014 and multiplied by the estimated waiver LOS to get fiscal year 2015 base estimate and the increased by 2% to get Waiver year one
2) Each subsequent year was increased 2%

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
	manage components
	manage components
	manage components
	manage components
	manage components
	manage components

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

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

i. Estimate of Factor D – Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1					
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
Waiver Service / Component	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Skilled Respite					
Agency	15 minute	150	312	$11.09	$519,012.00
Self-Administered	15 minute	15	312	$6.77	$31,683.60
Routine Respite	15 minute	165	156	$2.99	$76,962.60
Financial Management Services	Monthly	165	9	$51.67	$76,729.95
GRAND TOTAL:					$704,388.15
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					165
FACTOR D (Divide grand total by number of participants)					5,692
AVERAGE LENGTH OF STAY ON THE WAIVER					270

Waiver Year: Year 2					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Skilled Respite					
Agency	15 minute	150	416	$11.09	$692,016.00
Self-Administered	15 minute	15	416	$6.77	$42,244.80
Routine Respite	15 minute	165	208	$2.99	$102,616.80
Financial Management Services	Monthly	165	12	$51.67	$102,306.60
GRAND TOTAL:					$939,184.20
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					165
FACTOR D (Divide grand total by number of participants)					5,692
AVERAGE LENGTH OF STAY ON THE WAIVER					360

State:	
Effective Date	

Waiver Year: Year 3					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Skilled Respite					
Agency	15 minute	150	416	$11.09	$692,016.00
Self-Administered	15 minute	15	416	$6.77	$42,244.80
Routine Respite	15 minute	165	208	$2.99	$102,616.80
Financial Management Services	Monthly	165	12	$51.67	$102,306.60
GRAND TOTAL:					$939,184.20
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					165
FACTOR D (Divide grand total by number of participants)					5,692
AVERAGE LENGTH OF STAY ON THE WAIVER					360

State:	
Effective Date	

Waiver Year: Year 4 *(only appears if applicable based on Item 1-C)*					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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 *(only appears if applicable based on Item 1-C)*					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

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

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

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

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