

# Application for a §1915 (c) HCBS Waiver

## HCBS Waiver Application Version 3.5

Includes Changes Implemented through November 2014

**Submitted by:**

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<b>Submission Date:</b>	<u>June 30, 2015</u>
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<b>CMS Receipt Date (CMS Use)</b>	
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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.

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# 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*): Waiver for Technology Dependent, Medically Fragile Individuals

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.*)

<input type="radio"/>	3 years
<input checked="" type="radio"/>	5 years

<input type="checkbox"/>	<b>New to replace waiver</b> Replacing Waiver Number: <span style="border: 1px solid black; padding: 2px 20px; display: inline-block; width: 150px; height: 20px; vertical-align: middle;"></span>	
<input type="checkbox"/>	<b>Migration Waiver</b> – this is an existing approved waiver Provide the information about the original waiver being migrated	
	<b>Base Waiver Number:</b>	UT.40183
	<b>Amendment Number</b> (if applicable):	<u>UT.40183.R04.01</u>
	<b>Effective Date:</b> (mm/dd/yy)	<u>07/01/15</u>

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

<input type="radio"/>	Model Waiver
<input checked="" type="radio"/>	Regular Waiver

E. **Proposed Effective Date:** 7/1/13

**Approved Effective Date** (*CMS Use*): 7/1/13

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*):

<input type="checkbox"/>	<b>Hospital</b> ( <i>select applicable level of care</i> )
<input type="radio"/>	<b>Hospital as defined in 42 CFR §440.10</b> If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

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	<input type="radio"/>	<b>Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160</b>
X		<b>Nursing Facility</b> ( <i>select applicable level of care</i> )
	X	<b>Nursing Facility as defined in 42 CFR §440.40 and 42 CFR §440.155</b> If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
	<input type="radio"/>	<b>Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140</b>
<input type="checkbox"/>		<b>Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)</b> If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID facility level of care:

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

Select one:

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

**H. Dual Eligibility for Medicaid and Medicare.**

Check if applicable:

<input checked="" type="checkbox"/>	<b>This waiver provides services for individuals who are eligible for both Medicare and Medicaid.</b>
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## 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.

**Purpose:**

To provide the choice of community alternatives for technology dependent, medically fragile individuals with complex medical conditions who would otherwise require placement in a Medicaid nursing facility.

**Goals:**

To prevent nursing facility placement or to facilitate the transition from an facility based setting to a home and community-based setting, for individuals who meet the waiver targeting criteria and choose to receive Medicaid home and community based services (HCBS) waiver and State plan services in the home and community.

**Objectives:**

To ensure statewide identification/screening of potential waiver recipients.

To afford choice between nursing facility and home and community-based settings.

To provide an equitable process for admission to the waiver.

To facilitate waiver recipient access to qualified Medicaid (HCBS waiver and State plan) providers.

To develop system responsiveness to recipient/legal representative's needs and preferences.

To prevent nursing facility admissions due to family/caregiver burnout.

**Organizational Structure:**

This home and community-based "model" waiver program is administered by the Utah Department of Health, the designated Single State Agency or State Medicaid Agency (SMA). The SMA exercises administrative discretion and retains the final authority and responsibility for the oversight and supervision of waiver issues, policies, rules and regulations related to the waiver.

The Division of Medicaid and Health Financing, Bureau of Authorization and Community Based Services (BACBS), is responsible for the administration and oversight of this Waiver program.

In fulfilling its obligations, BACBS has entered into separate agreements with two agencies under the umbrella of the State Medicaid Agency:

1) The Utah Department of Health, Division of Family Health and Preparedness, Bureau of Children with Special Health Care Needs (CSHCN), Utah's Maternal and Child Health (MCH) Title V Agency, is responsible for the day-to-day waiver administrative activities; and

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2) The Utah Department of Health, Division of Family Health and Preparedness, Bureau of Health Facility Licensing, Certification and Resident Assessment, (BHFLCRA) is responsible to perform quality assurance reviews of all enrolled Medicare/Medicaid certified home health agencies. The agreement held between the two agencies requires that BHFLCRA submits the results of its quality assurance reviews to the Division of Medicaid and Health Financing, Bureau of Authorization and Community Based Services.

These agencies perform delegated activities essential to ensure the proper and efficient operation of the waiver program and are delineated in Appendix A (3) of this plan.

Waiver services are provided by home health agencies and other willing and qualified providers enrolled by the SMA.

The RN Waiver Coordinators, CSHCN staff, perform the following functions to facilitate access to waiver services: determine level of care, refer cases for Medicaid financial eligibility determination, develop plans of care, assist in locating, referring and coordinating State plan and other services and monitor the ongoing needs of the client and the services delivered.

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### 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):*

<input checked="" type="radio"/>	<b>Yes. This waiver provides participant direction opportunities.</b> <i>Appendix E is required.</i>
<input type="radio"/>	<b>No. This waiver does not provide participant direction opportunities.</b> <i>Appendix E is not required.</i>

- 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.

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## 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*):

<input type="radio"/>	<b>Not Applicable</b>
<input type="radio"/>	<b>No</b>
<input checked="" type="radio"/>	<b>Yes</b>

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

<input checked="" type="radio"/>	<b>No</b>
<input type="radio"/>	<b>Yes</b>

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

<input type="checkbox"/>	<p><b>Geographic Limitation.</b> A waiver of statewide 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.</p> <p><i>Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:</i></p>
<input type="checkbox"/>	<p><b>Limited Implementation of Participant-Direction.</b> A waiver of statewide is requested in order to make <i>participant direction of services</i> as specified in <b>Appendix E</b> 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.</p> <p><i>Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:</i></p>

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## 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

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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.

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## 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

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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:

From May 22<sup>nd</sup>, 2015 through June 22<sup>nd</sup>, 2015, a copy of the draft State Implementation Plan was posted online at <http://health.utah.gov/ltc>. Public comment was accepted by mail, fax and online submission. In addition, on May 8<sup>th</sup>, the State presented information on the waiver renewal to the Utah Indian Health Advisory Board (UIHAB) which represents all federally recognized Tribal Governments within the State and on May 18<sup>th</sup>, a summary of the changes was supplied to the Medical Care Advisory Committee (MCAC).

Non-electronic and electronic forums were used to distribute notice of the waiver renewal to the public including: email; listservs; online postings and hard-copies.

At the conclusion of the public comment period, the State collected, summarized and responded to input received by providing explanations as to whether changes were made or not based on the comment.

**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.

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## 7. Contact Person(s)

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

<b>Last Name:</b>	Hales			
<b>First Name:</b>	Tonya			
<b>Title:</b>	Director, Bureau of Authorization and Community Based Services			
<b>Agency:</b>	Department of Health, Division of Medicaid and Health Financing			
<b>Address :</b>	PO Box 143112			
<b>Address 2:</b>				
<b>City:</b>	Salt Lake City			
<b>State:</b>	UTAH			
<b>Zip:</b>	84114-3112			
<b>Phone:</b>	(801) 538-9136	<b>Ext:</b>		<input type="checkbox"/> <b>TTY</b>
<b>Fax:</b>	(801) 323-1588			
<b>E-mail:</b>	thales@utah.gov			

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

<b>Last Name:</b>				
<b>First Name:</b>				
<b>Title:</b>				
<b>Agency:</b>				
<b>Address:</b>				
<b>Address 2:</b>				
<b>City:</b>				
<b>State:</b>				
<b>Zip :</b>				
<b>Phone:</b>		<b>Ext:</b>		<input type="checkbox"/> <b>TTY</b>
<b>Fax:</b>				
<b>E-mail:</b>				

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## 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:**

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

<b>Last Name:</b>	Hales			
<b>First Name:</b>	Michael			
<b>Title:</b>	Department Deputy Director and Division Director			
<b>Agency:</b>	Department of Health, Division of Medicaid and Health Financing			
<b>Address:</b>	PO Box 143112			
<b>Address 2:</b>				
<b>City:</b>	Salt Lake City			
<b>State:</b>	UTAH			
<b>Zip:</b>	84114-3112			
<b>Phone:</b>	(801) 538-6689	<b>Ext:</b>		<input type="checkbox"/> <b>TTY</b>
<b>Fax:</b>	(801) 538-6860			
<b>E-mail:</b>	mthales@utah.gov			

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### **Attachment #1: Transition Plan**

Specify the transition plan for the waiver:

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

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

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

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

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

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

The SMA will complete the HCBS Settings Transition Plan for the Technology Dependent Waiver in a manner consistent with the overall approach developed and submitted to CMS in the Statewide HCBS Transition Plan. The Statewide HCBS Transition Plan was submitted to CMS on March 17, 2015.

An overview of this plan is as follows:

Public Notice and Comment Process:

1. Following the development/posting of the initial plan on October 22, 2014 the SMA accepted public comment through December 1, 2014.
2. Based on the feedback received, the SMA has completed revisions to the draft plan. A revised draft was posted for comment on February 2, 2015. Comment was accepted for an additional 30 day period and ended on March 5, 2015. Any future iterations of the plan will be made available for public comment for a minimum of 30 days with notice provided through various channels including: Newspaper articles; online forums such as emails/listservs/websites as well as hard copies.
3. The State will solicit public input on assessment and remediation tools as they are developed.
4. The SMA will retain and summarize all public comment received and modify the Transition Plan as it deems appropriate. These summaries are provided to CMS with an explanation of whether comments received led to modifications in the Transition Plan.

Assessment Process:

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1. The SMA will establish a Workgroup that will meet periodically to review draft documents, including evaluations tools, interim reports and progress through the stages of the Transition Plan. This group will be used to reach out to a broader group of stakeholders for feedback and to assist in the participation of public comment opportunities. The first meeting of this group was held on February 25, 2015.
2. The SMA conducted a review of HCBS Waiver sites of services and made preliminary categorization. The SMA has reported the results of the review of Tech Dependent Waiver providers in the Additional Needed Information (Optional) section below.
3. The state will send an informational letter to providers that describes appropriate HCBS setting requirements, and transition plan assessment steps that will include State review and provider self-assessment. The letter will describe provider's ability to remediate issues to come into compliance within deadlines and that technical assistance will be available throughout the process.
4. Utilizing tools from the CMS HCBS Settings Review Toolkit, The SMA will complete a categorization of settings to determine sites likely to be Fully Compliant, Not Yet Compliant or Not Compliant with HCBS characteristics. This process will include determining sites that are presumed to have institutional like qualities. These sites will be identified as requiring heightened scrutiny.
5. The SMA will create a Provider Self-Assessment Tool which will include questions to identify sites that may be presumed to have institutional like qualities. Providers categorized as Not Yet Compliant or Not Compliant will be required to complete and submit the results of their self-assessment to the SMA.
6. The SMA will modify tools used in contract/certification/licensing reviews of providers categorized as Not Yet Compliant or Not Compliant as well as for periodic reviews of existing and new providers to ensure compliance with the HCBS settings requirements. Tools will be modified to review compliance of enrolled providers on an ongoing basis thereafter.
7. A final categorization Compliant/Not Yet Compliant (including those requiring heightened scrutiny)/Not Compliant will be completed for all providers. Notification of these results will be given to each provider.

Remediation Strategies:

1. The SMA will modify HCBS Waiver provider enrollment documents to provide education and assure compliance with HCBS setting requirements prior to enrolling new providers. This process will include provider acknowledgement of the settings requirements. HCBS Provider Manuals will be revised to incorporate the settings requirements and clarify requirements in person-centered planning.
2. Based on the individual provider assessments the SMA, providers and stakeholders will collaborate to create a remediation plan for the provider, establish timelines and monitor progress made towards compliance.
3. For individual waiver clients, any modifications of conditions under 42 CFR §441.301 (c)(4)(vi)(A) through (D) are supported by a specific assessed need and justified in the individual client's person-centered service plan.
4. A determination/final disposition of sites identified as requiring heightened scrutiny will be completed.
5. The SMA will create a system to track provider progress toward, and completion of, an individual remediation plan. The system will have the ability to show compliance by individual waiver and for all HCBS waiver programs.
6. On-site reviews will be conducted for providers who have completed their remediation plans utilizing the compliance tools developed. The SMA will disenroll and/or sanction providers that have failed to implement the individual provider remediation plan or those determined through the heightened scrutiny process to have institutional like qualities that cannot be remediated.

Quarterly updates will be provided to CMS, providers and stakeholders until the remediation strategies have been completed.

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## Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

The State conducted its preliminary categorization by describing services as either “presumed to be compliant” or “requires additional review.” In addition, a listing of provider types and the number of providers has been supplied to help assess the scope of the in-depth reviews that will occur in the upcoming months.

The Department of Health took a conservative approach when designating providers as “presumed to be compliant”. The State only identified services as “presumed to be compliant” when the services are not dependent on the setting and that are direct services provided to the waiver participant. In addition, providers that offer multiple types of services, were categorized as “requires additional review” if the provider had any possibility of providing a service that may not be compliant.

Providers Presumed to be Compliant:

Financial Management Services (2 Providers)

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

Home Health Agency (15 Providers)

Home Health Agency Services are provided in the home to assure the participant’s health and safety in a manner that promotes independence.

In-Home Therapy (1 Provider)

In-Home Therapy is provided directly to the child to improve the child's development. The service is provided in the child’s home.

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# 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*):

<input type="radio"/>	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 ( <i>select one</i> ):	
<input type="radio"/>	The Medical Assistance Unit ( <i>specify the unit name</i> ) ( <i>Do not complete Item A-2</i> )	
<input checked="" type="radio"/>	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. ( <i>Complete item A-2-a</i> )	The Utah Department of Health, Division of Family Health and Preparedness, Bureau of Children with Special Health Care Needs (CSHCN) is responsible for the day-to-day waiver administrative activities.
<input type="radio"/>	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. ( <i>Complete item A-2-b</i> ).	

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.

The functions performed by CSHCN include:	
a.	Level of care determination.
b.	Plan of Care development and coordination of services.
c.	Identification of day-to-day administrative and operating issues.
d.	Provider recruitment.
e.	Outreach and information.
f.	Ensuring participant freedom of choice.
g.	Waiting list management.
h.	Coordination with institutional/hospital providers.
i.	Assisting the Medicaid agency in implementing the waiver's Quality Improvement Strategy.

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j. **Maintaining documentation.**  
 The roles and responsibilities of each agency are outlined in a written Memorandum of Agreement. BACBS uses a variety of methods to oversee the activities performed by CSHCN included annual monitoring to assure compliance with responsibilities, continuous and ongoing coordination and collaboration and technical assistance and participation in Quarterly Waiver Administrative and Operation Team meetings with CSHCN.

The functions performed by ~~BHFLCRABHFLC~~ include:

- a. Reporting results of licensing and survey audits
- b. Including a sample of waiver clients in audits performed
- c. Reporting any specific findings on waiver clients

The roles and responsibilities of each agency are outlined in a written Memorandum of Agreement. BACBS oversees the limited quality activities performed by ~~BHFLCRABHFLC~~, by assuring that BACBS continues to receive audit reports on an ongoing basis and continuous and ongoing coordination, collaboration and technical assistance.

**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) (*select one*):

<input type="radio"/>	<b>Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).</b> Specify the types of contracted entities and briefly describe the functions that they perform. <i>Complete Items A-5 and A-6.</i>
<input checked="" type="radio"/>	<b>No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).</b>

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**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*):

<input checked="" type="radio"/>		Not applicable
<input type="radio"/>		Applicable - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:
<input type="checkbox"/>		<p><b>Local/Regional non-state public agencies</b> conduct waiver operational and administrative functions at the local or regional level. There is an <b>interagency agreement or memorandum of understanding</b> 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). <i>Specify the nature of these agencies and complete items A-5 and A-6:</i></p>
<input type="checkbox"/>		<p><b>Local/Regional non-governmental non-state entities</b> 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 <b>contract(s)</b> under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). <i>Specify the nature of these entities and complete items A-5 and A-6:</i></p>

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

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

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

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

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

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## 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.*

<b>Performance Measure:</b>	Number and percentage of CHSCN reports specified in the implementation plan that were submitted to the SMA on time and in the correct format. <i>(Numerator = # of reports submitted to the SMA by CSHCN correctly; the denominator is the total number required reports).</i>		
<b>Data Source</b> (Select one) (Several options are listed in the on-line application): Other			
If 'Other' is selected, specify:			
Annual reviews			
	<b>Responsible Party for data collection/generation</b> (check each that applies)	<b>Frequency of data collection/generation:</b> (check each that applies)	<b>Sampling Approach</b> (check each that applies)

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	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input checked="" type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
	CSHCN RN Waiver Coordinators	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

**Add another Data Source for this performance measure**

**Data Aggregation and Analysis**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies)	<b>Frequency of data aggregation and analysis:</b> (check each that applies)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
CSHCN RN Waiver Coordinators	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

<b>Performance Measure:</b>	Number and percentage of documents submitted and approved by the SMA using the Document Submittal Protocol prior to implementation. <u>(Numerator = total # of documents submitted/approved correctly; denominator = total # of documents) correctly submitted for SMA review prior to implementation.)</u>
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**Data Source** (Select one) (Several options are listed in the on-line application): Other

If 'Other' is selected, specify:

Quarterly Meeting minutes, Correspondences(email, letters etc.) and Topic Specific Meeting minutes

	<b>Responsible Party for data collection/generation</b> (check each that applies)	<b>Frequency of data collection/generation:</b> (check each that applies)	<b>Sampling Approach</b> (check each that applies)
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	<i>applies)</i>		
	<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input checked="" type="checkbox"/> <i>100% Review</i>
	<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input type="checkbox"/> <i>Less than 100% Review</i>
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	<input type="checkbox"/> <i>Representative Sample; Confidence Interval =</i>
	<input checked="" type="checkbox"/> <i>Other Specify:</i>	<input type="checkbox"/> <i>Annually</i>	
	<i>CSHCN RN Waiver Coordinators</i>	<input checked="" type="checkbox"/> <i>Continuously and Ongoing</i>	<input type="checkbox"/> <i>Stratified: Describe Group:</i>
		<input type="checkbox"/> <i>Other Specify:</i>	
			<input type="checkbox"/> <i>Other Specify:</i>

**Add another Data Source for this performance measure**

**Data Aggregation and Analysis**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies)</i>	<b>Frequency of data aggregation and analysis:</b> <i>(check each that applies)</i>
<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>
<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>
<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>
<input checked="" type="checkbox"/> <i>Other Specify:</i>	<input checked="" type="checkbox"/> <i>Annually</i>
<i>CSHCN RN Waiver Coordinators</i>	<input type="checkbox"/> <i>Continuously and Ongoing</i>
	<input type="checkbox"/> <i>Other Specify:</i>

<b>Performance Measure:</b>	<i>Number and percentage of maximum allowable rates (MARs) for covered Waiver services approved by the SMA. (Numerator = total # of MARs approved; Denominator = total # of MARs).</i>
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**Data Source** (Select one) (Several options are listed in the on-line application): *Other*  
 If 'Other' is selected, specify:

*Rate Setting Meetings minutes, Approval documentation and Correspondence*

	<b>Responsible Party for data collection/generation</b> <i>(check each that applies)</i>	<b>Frequency of data collection/generation:</b> <i>(check each that applies)</i>	<b>Sampling Approach</b> <i>(check each that applies)</i>
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	<i>applies</i> )		
	<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input checked="" type="checkbox"/> <i>100% Review</i>
	<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input type="checkbox"/> <i>Less than 100% Review</i>
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	<input type="checkbox"/> <i>Representative Sample; Confidence Interval =</i>
	<input checked="" type="checkbox"/> <i>Other Specify:</i>	<input type="checkbox"/> <i>Annually</i>	
	<i>CSHCN RN Waiver Coordinators</i>	<input checked="" type="checkbox"/> <i>Continuously and Ongoing</i>	<input type="checkbox"/> <i>Stratified: Describe Group:</i>
		<input type="checkbox"/> <i>Other Specify:</i>	
			<input type="checkbox"/> <i>Other Specify:</i>

**Add another Data Source for this performance measure**

**Data Aggregation and Analysis**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies)</i>	<b>Frequency of data aggregation and analysis:</b> <i>(check each that applies)</i>
<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>
<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>
<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>
<input type="checkbox"/> <i>Other Specify:</i>	<input type="checkbox"/> <i>Annually</i>
	<input type="checkbox"/> <i>Continuously and Ongoing</i>
	<input type="checkbox"/> <i>Other Specify:</i>

<b>Performance Measure:</b>	<i>Number and percentage of recipients who have been denied access to Medicaid waiver program, who were provided timely notice of appeal rights. (Numerator = total # of notices sent; Denominator = total # of notices required).</i>
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**Data Source** (Select one) (Several options are listed in the on-line application): *Other*

If 'Other' is selected, specify:

*Tech Waiver application denial records and recipient records*

	<b>Responsible Party for data collection/generation</b>	<b>Frequency of data collection/generation:</b> <i>(check each that</i>	<b>Sampling Approach</b> <i>(check each that applies)</i>
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	<i>(check each that applies)</i>	<i>applies)</i>	
	<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input checked="" type="checkbox"/> <i>100% Review</i>
	<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input type="checkbox"/> <i>Less than 100% Review</i>
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	<input type="checkbox"/> <i>Representative Sample; Confidence Interval =</i>
	<input checked="" type="checkbox"/> <i>Other Specify:</i>	<input type="checkbox"/> <i>Annually</i>	
	<i>CSHCN RN Waiver Coordinators</i>	<input checked="" type="checkbox"/> <i>Continuously and Ongoing</i>	<input type="checkbox"/> <i>Stratified: Describe Group:</i>
		<input type="checkbox"/> <i>Other Specify:</i>	
			<input type="checkbox"/> <i>Other Specify:</i>

**Add another Data Source for this performance measure**

**Data Aggregation and Analysis**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies)</i>	<b>Frequency of data aggregation and analysis:</b> <i>(check each that applies)</i>
<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>
<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>
<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>
<input checked="" type="checkbox"/> <i>Other Specify:</i>	<input checked="" type="checkbox"/> <i>Annually</i>
<i>CSHCN RN Waiver Coordinators</i>	<input type="checkbox"/> <i>Continuously and Ongoing</i>
	<input type="checkbox"/> <i>Other Specify:</i>

<b>Performance Measure:</b>	<i>Number and percentage of recipients 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 = total # of notices sent; Denominator = total # of notices required).</i>
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**Data Source** (Select one) (Several options are listed in the on-line application): *Other*

If 'Other' is selected, specify:

*Recipient records*

	<b>Responsible Party for</b>	<b>Frequency of data</b>	<b>Sampling Approach</b>
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	<b>data collection/generation</b> (check each that applies)	<b>collection/generation:</b> (check each that applies)	(check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval =
	<input checked="" type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	
	CSHCN RN Waiver Coordinator	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

**Add another Data Source for this performance measure**

**Data Aggregation and Analysis**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies)	<b>Frequency of data aggregation and analysis:</b> (check each that applies)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
CSHCN RN Waiver Coordinator	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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.

**BACBS demonstrates ultimate administrative authority and responsibility for the operation of the Tech**

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Dependent Waiver program through numerous activities including the issuance of policies, rules, and regulations relating to the waiver as well as the review/approval of documents, provider manuals, bulletins, rates and training that affect any aspect of the Tech Dependent Waiver operations. BACBS also conducts quarterly meetings with staff from CSHCN, monitors compliance with the interagency Memorandum of Agreement, conducts annual quality assurance reviews of the Tech Dependent Waiver program and provides technical assistance to CSHCN and other entities within the state that affect the operation of the waiver program.

BACBS verifies compliance with the Administrative Authority performance measures at least annually. BACBS is the entity responsible for official communication with CMS for all issues related to the Tech Dependent Waiver.

**b. Methods for Remediation/Fixing Individual Problems**

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

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

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

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

**ii Remediation Data Aggregation**

<b><i>Remediation-related Data Aggregation and Analysis (including trend</i></b>	<b><i>Responsible Party (check each that applies)</i></b>	<b><i>Frequency of data aggregation and analysis: (check each that</i></b>
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<i>identification)</i>		<i>applies)</i>
	<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>
	<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>
	<input type="checkbox"/> <i>Other</i> <i>Specify:</i>	<input checked="" type="checkbox"/> <i>Annually</i>
		<input type="checkbox"/> <i>Continuously and Ongoing</i>
		<input type="checkbox"/> <i>Other</i> <i>Specify:</i>

**c. Timelines**

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

<input checked="" type="radio"/>	<b>No</b>
<input type="radio"/>	<b>Yes</b>

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

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# 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
<input type="checkbox"/>	<b>Aged or Disabled, or Both - General</b>			
	<input type="checkbox"/> Aged (age 65 and older)			<input type="checkbox"/>
	<input type="checkbox"/> Disabled (Physical)			
	<input type="checkbox"/> Disabled (Other)			
<input checked="" type="checkbox"/>	<b>Aged or Disabled, or Both - Specific Recognized Subgroups</b>			
	<input type="checkbox"/> Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/> HIV/AIDS			<input type="checkbox"/>
	<input checked="" type="checkbox"/> Medically Fragile	0	20	<input type="checkbox"/>
	<input checked="" type="checkbox"/> Technology Dependent	0	20	<input type="checkbox"/>
<input type="checkbox"/>	<b>Intellectual Disability or Developmental Disability, or Both</b>			
	<input type="checkbox"/> Autism			<input type="checkbox"/>
	<input type="checkbox"/> Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/> Mental Retardation			<input type="checkbox"/>
<input type="checkbox"/>	<b>Mental Illness (check each that applies)</b>			
	<input type="checkbox"/> Mental Illness			<input type="checkbox"/>
	<input type="checkbox"/> Serious Emotional Disturbance			

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

Technology dependent, medically fragile individuals who meet the State's nursing facility level of care criteria and:

- Are under the age of 21 at time of admission. Recipients who enter the waiver before the age of 21 are allowed to remain in the waiver as long as they continue to meet the other additional targeting criteria;
- Qualify for Medicaid based on one of the categorical or medically needy eligibility options specified in Appendix B-4;
- Have at least one caregiver trained (or willing to be trained) and available to provide care, and be cared for in a home that is safe and can accommodate the necessary medical equipment and personnel needed to assure the individual's safety;
- Requires services so inherently complex that they can only be safely and effectively performed by, or under the direction of a skilled nursing professional;
- Must be dependent on one or more of the following technologies:
  - a. daily dependence on a mechanical ventilator;
  - b. daily dependence on Bi-level Positive Airway Pressure (Bi-PAP) for 18 hours or more a day;

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**Appendix B: Participant Access and Eligibility**

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- c. daily dependence on tracheostomy-based respiratory support;
- d. daily dependence on Continuous Positive Airway Pressure (C-PAP) or Bi-level Positive Airway Pressure (Bi-PAP) for less than 18 hours per day; and
- e. dependence on intravenous administration of nutritional substances or medications through a central line, which the physician anticipates will be necessary for a period of at least six months.

**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*):

<input type="radio"/>	Not applicable. There is no maximum age limit
<input checked="" type="radio"/>	The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit. <i>Specify:</i>
	There is no transition plan for this waiver. Recipients who enter the waiver before the age of 21 are allowed to remain in the waiver as long as they continue to meet the additional targeting criteria.

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## 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:

<input checked="" type="checkbox"/>	<b>No Cost Limit.</b> The State does not apply an individual cost limit. <i>Do not complete Item B-2-b or Item B-2-c.</i>	
<input type="checkbox"/>	<b>Cost Limit in Excess of Institutional Costs.</b> 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. <i>Complete Items B-2-b and B-2-c.</i> The limit specified by the State is ( <i>select one</i> ):	
<input type="checkbox"/>	%	A level higher than 100% of the institutional average Specify the percentage:
<input type="checkbox"/>	Other ( <i>specify</i> ):	
<input type="checkbox"/>	<b>Institutional Cost Limit.</b> 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. <i>Complete Items B-2-b and B-2-c.</i>	
<input type="checkbox"/>	<b>Cost Limit Lower Than Institutional Costs.</b> 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. <i>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.</i>	
The cost limit specified by the State is ( <i>select one</i> ):		
<input type="checkbox"/>	<b>The following dollar amount:</b> Specify dollar amount:	
The dollar amount ( <i>select one</i> ):		
<input type="checkbox"/>	<b>Is adjusted each year that the waiver is in effect by applying the following formula:</b> Specify the formula:	
<input type="checkbox"/>	<b>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.</b>	

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<input type="radio"/>	The following percentage that is less than 100% of the institutional average:		
<input type="radio"/>	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:

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**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*):

<input type="checkbox"/>	The participant is referred to another waiver that can accommodate the individual's needs.
<input type="checkbox"/>	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:
<input type="checkbox"/>	Other safeguard(s) (Specify):

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## 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:

<b>Table: B-3-a</b>	
<b>Waiver Year</b>	<b>Unduplicated Number of Participants</b>
<b>Year 1</b>	140
<b>Year 2</b>	140
<b>Year 3</b>	140
<b>Year 4</b> (only appears if applicable based on Item 1-C)	<u>149</u>
<b>Year 5</b> (only appears if applicable based on Item 1-C)	<u>149</u>

- 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*):

<input type="radio"/>	<b>The State does not limit the number of participants that it serves at any point in time during a waiver year.</b>
<input checked="" type="radio"/>	<b>The State limits the number of participants that it serves at any point in time during a waiver year.</b>

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

<b>Table B-3-b</b>	
<b>Waiver Year</b>	<b>Maximum Number of Participants Served At Any Point During the Year</b>
<b>Year 1</b>	130
<b>Year 2</b>	130
<b>Year 3</b>	130
<b>Year 4</b> (only appears if applicable based on Item 1-C)	<u>139</u>
<b>Year 5</b> (only appears if applicable based on Item 1-C)	<u>139</u>

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- 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*):

<input type="radio"/>	<b>Not applicable. The state does not reserve capacity.</b>	
<input checked="" type="radio"/>	<b>The State reserves capacity for the following purpose(s).</b> Purpose(s) the State reserves capacity for:	
<b>Table B-3-c</b>		
	<b>Purpose</b> (provide a title or short description to use for lookup):	<b>Purpose</b> (provide a title or short description to use for lookup):
	Children with Spinal Muscular Atrophy Type I	
	<b>Purpose</b> (describe):	<b>Purpose</b> (describe):
	Terminally ill children with a diagnosis of Spinal Muscular Atrophy Type I are generally diagnosed shortly after birth with a life expectancy of only two years.	
	<b>Describe how the amount of reserved capacity was determined:</b>	<b>Describe how the amount of reserved capacity was determined:</b>
	Capacity was determined based on historical applicant and recipient data.	
<b>Waiver Year</b>	<b>Capacity Reserved</b>	<b>Capacity Reserved</b>
<b>Year 1</b>	5	
<b>Year 2</b>	5	
<b>Year 3</b>	5	
<b>Year 4</b> (only if applicable based on Item 1-C)	5	
<b>Year 5</b> (only if applicable based on Item 1-C)	5	

- 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*):

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<input checked="" type="radio"/>	<b>The waiver is not subject to a phase-in or a phase-out schedule.</b>
<input type="radio"/>	<b>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 <i>intra-year</i> limitation on the number of participants who are served in the waiver.</b>

**e. Allocation of Waiver Capacity.**

Select one:

<input checked="" type="radio"/>	<b>Waiver capacity is allocated/managed on a statewide basis.</b>
<input type="radio"/>	<b>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:</b>

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

<b>WAITING LIST/PRIORITY FOR ADMISSION</b>	
When the number of applicants for this waiver exceeds the number of approved openings, a waiting list will be established. With the exceptions noted below, priority for admission to the waiver from the waiting list will be given to the applicant with the highest numerical ranking based on the following:	
<b>TARGETING CONDITION (S) WEIGHT FACTOR</b>	
Ventilator dependent	18
Bi-PAP>18hrs/day	9
Trach dependent	8
C-PAP or Bi-PAP<18hrs/day	2*
Central line	2*
* In considering these conditions, if the applicant is receiving skilled nursing care 3 or more times per week, add 2 points; if the applicant requires enteral feeding (via nasogastric, gastrostomy or jejunal tube) or total parenteral nutrition, add 1 point.	
Length of time on the waiting list will be used in determining who is selected if more than one applicant has the same “highest” score.	
Exception to the above: RN Waiver Coordinators employed by CSHCN will have discretion to consider extraordinary psychosocial or medical needs of an applicant/family when establishing priority for admission to the waiver. In such cases, documentation will be maintained by CSHCN to include: 1) a description of the specific, extraordinary psycho-social/medical need(s) of the applicant/family member; 2) feasible alternatives (including formal and informal support systems and services) considered/available at the time to ameliorate the extraordinary need(s) and maintain the child in the community while waiting for waiver coverage; 3) an estimate of the likelihood of “imminent” out-of-home placement (institutional or non-institutional) of the child if waiver admission is delayed; 4) the RN Waiver Coordinator’s judgment regarding the potential risks to the	

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applicant's/caregiver's health, safety and welfare if waiver admission is delayed.

Discretionary priority for admission will only be authorized when CSHCN documentation indicates one or more of the following: (1) the applicant/care-giver lacks any feasible/available family or community-based support; (2) the applicant is at imminent risk of out-of-home placement; or (3) there is a likelihood that the health, safety and welfare of the applicant/caregiver will be compromised by delaying admission; and (4) there are no others ahead of the applicant on the waiting list with equal or greater 'priority needs'.

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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		

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

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

<input type="radio"/>	§1634 State
<input checked="" type="radio"/>	SSI Criteria State
<input type="radio"/>	209(b) State

**2. Miller Trust State.**

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

<input checked="" type="radio"/>	No
<input type="radio"/>	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:*

<b><i>Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)</i></b>	
<input checked="" type="checkbox"/>	Low income families with children as provided in §1931 of the Act
<input checked="" type="checkbox"/>	SSI recipients
<input type="checkbox"/>	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
<input type="checkbox"/>	Optional State supplement recipients
<input checked="" type="checkbox"/>	Optional categorically needy aged and/or disabled individuals who have income at: ( <i>select one</i> )
<input checked="" type="radio"/>	100% of the Federal poverty level (FPL)
<input type="radio"/>	% of FPL, which is lower than 100% of FPL Specify percentage:
<input checked="" type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
<input type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
<input type="checkbox"/>	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)
<input type="checkbox"/>	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)
<input type="checkbox"/>	Medically needy in 209(b) States (42 CFR §435.330)
<input type="checkbox"/>	Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
<input checked="" type="checkbox"/>	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) <i>specify:</i>
	§1902 (a)(10)(A)(i)(IV) and §1902(1)(1)(B); §1902(a)(10)(A)(i)(VI) and § 1902(1)(1)(C); §1902(a)(10)(A)(i)(VII) and §1902 (1)(1)(D); §1903(a)(10)(A)(ii)(I); §1902(a)(10)(A)(ii)(VIII).

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<i>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</i>	
<input type="radio"/>	<b>No.</b> 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.
<input checked="" type="radio"/>	<b>Yes.</b> The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. <i>Select one and complete Appendix B-5.</i>
<input type="radio"/>	All individuals in the special home and community-based waiver group under 42 CFR §435.217
<input checked="" type="radio"/>	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 ( <i>check each that applies</i> ):
<input type="checkbox"/>	A special income level equal to (select one):
<input checked="" type="checkbox"/>	300% of the SSI Federal Benefit Rate (FBR)
<input type="checkbox"/>	% A percentage of FBR, which is lower than 300% (42 CFR §435.236) Specify percentage:
<input type="checkbox"/>	\$ A dollar amount which is lower than 300% Specify percentage:
<input type="checkbox"/>	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
<input type="checkbox"/>	Medically needy without spend down in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
<input type="checkbox"/>	Medically needy without spend down in 209(b) States (42 CFR §435.330)
<input type="checkbox"/>	Aged and disabled individuals who have income at: ( <i>select one</i> )
<input type="checkbox"/>	100% of FPL
<input type="checkbox"/>	% of FPL, which is lower than 100%
<input type="checkbox"/>	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) <i>specify:</i>

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## 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.*

<input type="checkbox"/>	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 <i>spousal</i> post-eligibility rules under §1924 of the Act. <i>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.</i>
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*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).*

<input checked="" type="checkbox"/>	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 ( <i>select one</i> ):
<input checked="" type="checkbox"/>	Use <i>spousal</i> post-eligibility rules under §1924 of the Act. <i>Complete Items B-5-b-2 (SSI State and §1634) or B-5-c-2 (209b State) and Item B-5-d.</i>
<input type="checkbox"/>	Use <i>regular</i> post-eligibility rules under 42 CFR §435.726 (SSI State and §1634) ( <i>Complete Item B-5-b-1</i> ) or under §435.735 (209b State) ( <i>Complete Item B-5-c-1</i> ). <i>Do not complete Item B-5-d.</i>
<input type="checkbox"/>	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. <i>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.</i>

**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.**

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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:

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

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<b>iii. Allowance for the family (select one):</b>	
<input type="radio"/>	<b>Not Applicable (see instructions)</b>
<input type="radio"/>	<b>AFDC need standard</b>
<input type="radio"/>	<b>Medically needy income standard</b>
<input type="radio"/>	<b>The following dollar amount:</b> \$ <input type="text"/> <p>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.</p>
<input type="radio"/>	<b>The amount is determined using the following formula:</b> Specify: <input type="text"/>
<input type="radio"/>	<b>Other</b> Specify: <input type="text"/>
<b>iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:</b>	
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:	
<input type="radio"/>	<b>Not applicable (see instructions) Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.</b>
<input type="radio"/>	<b>The State does not establish reasonable limits.</b>
<input type="radio"/>	<b>The State establishes the following reasonable limits</b> Specify: <input type="text"/>

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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:

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

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<input type="radio"/>	Medically needy income standard
<input type="radio"/>	The following dollar amount: \$ <input type="text"/> If this amount changes, this item will be revised. Specify dollar amount:
<input type="radio"/>	The amount is determined using the following formula: <i>Specify:</i> <input type="text"/>
<b>iii. Allowance for the family (select one)</b>	
<input type="radio"/>	Not applicable ( <i>see instructions</i> )
<input type="radio"/>	AFDC need standard
<input type="radio"/>	Medically needy income standard
<input type="radio"/>	The following dollar amount: \$ <input type="text"/> 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. Specify dollar amount:
<input type="radio"/>	The amount is determined using the following formula: <i>Specify:</i> <input type="text"/>
<input type="radio"/>	Other (specify): <input type="text"/>
<b>iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.735:</b>	
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.	
<i>Select one:</i>	
<input type="radio"/>	Not applicable ( <i>see instructions</i> ) <i>Note: If the State protects the maximum amount for the waiver participant, not applicable must be checked.</i>
<input type="radio"/>	The State does not establish reasonable limits.
<input type="radio"/>	The State establishes the following reasonable limits ( <i>specify</i> ): <input type="text"/>

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

State:	<input type="text"/>
Effective Date	<input type="text"/>

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:

<b>i. Allowance for the needs of the waiver participant (select one):</b>		
<input type="radio"/>	The following standard included under the State plan (Select one):	
<input type="radio"/>	<b>SSI standard</b>	
<input type="radio"/>	<b>Optional State supplement standard</b>	
<input type="radio"/>	<b>Medically needy income standard</b>	
<input type="radio"/>	<b>The special income level for institutionalized persons</b> (select one):	
<input type="radio"/>	<b>300% of the SSI Federal Benefit Rate (FBR)</b>	
<input type="radio"/>	%	<b>A percentage of the FBR, which is less than 300%</b> Specify the percentage:
<input type="radio"/>	\$	<b>A dollar amount which is less than 300%.</b> Specify dollar amount:
<input type="radio"/>	%	<b>A percentage of the Federal poverty level</b> Specify percentage:
<input type="radio"/>	<b>Other standard included under the State Plan</b> Specify:	
<input type="radio"/>	<b>The following dollar amount</b> Specify dollar amount:	\$ _____ If this amount changes, this item will be revised.
<input checked="" type="radio"/>	<b>The following formula is used to determine the needs allowance:</b> Specify: In order to determine total income, the allowance for the needs of the waiver recipient is 100% of the HHS Poverty Guidelines for one person plus an amount of earned income up to the substantial gainful activity level of earnings defined in Section 223(d)(4) of the Compilation of the Social Security Laws in effect April 4, 2012 will be used. If dependent family members live in a community setting, the State will recognize that expenses may be higher due to the waiver recipient incurring additional costs related to supporting the dependent family members. An allowance may be deducted when making the eligibility determination in consideration of these additional expenses. This additional allowance 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 CFR 435.726(c)(3).	
<input type="radio"/>	<b>Other</b> Specify:	

State:	
Effective Date	

<b>ii. Allowance for the spouse only</b> ( <i>select one</i> ):		
<input checked="" type="radio"/>	<b>Not Applicable</b>	
<input type="radio"/>	<b>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:</b> <i>Specify:</i>	
<b>Specify the amount of the allowance</b> ( <i>select one</i> ):		
<input type="radio"/>	<b>SSI standard</b>	
<input type="radio"/>	<b>Optional State supplement standard</b>	
<input checked="" type="radio"/>	<b>Medically needy income standard</b>	
<input type="radio"/>	<b>The following dollar amount:</b> Specify dollar amount:	\$ <input type="text"/> If this amount changes, this item will be revised.
<input type="radio"/>	<b>The amount is determined using the following formula:</b> <i>Specify:</i>	
<b>iii. Allowance for the family</b> ( <i>select one</i> ):		
<input type="radio"/>	<b>Not Applicable</b> ( <i>see instructions</i> )	
<input type="radio"/>	<b>AFDC need standard</b>	
<input type="radio"/>	<b>Medically needy income standard</b>	
<input type="radio"/>	<b>The following dollar amount:</b> Specify dollar amount:	\$ <input type="text"/> 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.
<input type="radio"/>	<b>The amount is determined using the following formula:</b> <i>Specify:</i>	
<input type="radio"/>	<b>Other</b> <i>Specify:</i>	
<b>iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:</b>		
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:		
<input type="radio"/>	<b>Not applicable</b> ( <i>see instructions</i> ) <i>Note: If the State protects the maximum amount for the waiver</i>	

State:	
Effective Date	

	<i>participant, not applicable must be selected.</i>
<input type="radio"/>	<b>The State does not establish reasonable limits.</b>
<input checked="" type="radio"/>	<b>The State establishes the following reasonable limits</b> <i>Specify:</i>
	The limits specified in Utah's title XIX State plan for post-eligibility income deductions under 42 CFR 435.725, 435.726, 435.832, and Sec. 1924 of the Social Security Act. The limits are defined on supplement 3 to Attachment 2.6A.

State:	
Effective Date	

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

**c-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:

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

State:	
Effective Date	

<i>Specify:</i>		
<b>Specify the amount of the allowance (<i>select one</i>):</b>		
<input type="radio"/>	<b>The following standard under 42 CFR §435.121:</b> <i>Specify:</i>	
<input type="radio"/>	<b>Optional State supplement standard</b>	
<input type="radio"/>	<b>Medically needy income standard</b>	
<input type="radio"/>	<b>The following dollar amount:</b> Specify dollar amount:	\$ <input type="text"/> If this amount changes, this item will be revised.
<input type="radio"/>	<b>The amount is determined using the following formula:</b> <i>Specify:</i>	
<b>iii. Allowance for the family (<i>select one</i>):</b>		
<input type="radio"/>	<b>Not Applicable (<i>see instructions</i>)</b>	
<input type="radio"/>	<b>AFDC need standard</b>	
<input type="radio"/>	<b>Medically needy income standard</b>	
<input type="radio"/>	<b>The following dollar amount:</b> Specify dollar amount:	\$ <input type="text"/> 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.
<input type="radio"/>	<b>The amount is determined using the following formula:</b> <i>Specify:</i>	
<input type="radio"/>	<b>Other</b> <i>Specify:</i>	
<b>iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:</b>		
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:		
<input type="radio"/>	<b>Not applicable (<i>see instructions</i>)</b> <i>Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.</i>	

State:	
Effective Date	

<input type="radio"/>	<b>The State does not establish reasonable limits.</b>
<input type="radio"/>	<b>The State establishes the following reasonable limits</b> <i>Specify:</i>

State:	
Effective Date	

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

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

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

<b>i. Allowance for the personal needs of the waiver participant</b>		
<i>(select one):</i>		
<input type="radio"/>	<b>SSI Standard</b>	
<input type="radio"/>	<b>Optional State supplement standard</b>	
<input type="radio"/>	<b>Medically needy income standard</b>	
<input type="radio"/>	<b>The special income level for institutionalized persons</b>	
<input type="radio"/>	%	Specify percentage:
<input type="radio"/>	<b>The following dollar amount:</b>	\$ _____ If this amount changes, this item will be revised
<input checked="" type="radio"/>	<b>The following formula is used to determine the needs allowance:</b>	
	<i>Specify formula:</i>	
	The allowance for the personal needs of the waiver recipient is: 100% of the HHS Poverty Guidelines for one person plus an amount of earned income up to the substantial gainful activity level of earnings defined in Section 223(d)(4) of the Compilation of the Social Security Laws in effect April 4, 2012, to determine countable earned income.	
<input type="radio"/>	<b>Other</b>	
	<i>Specify:</i>	
<b>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.</b>		
Select one:		
<input type="radio"/>	<b>Allowance is the same</b>	
<input checked="" type="radio"/>	<b>Allowance is different.</b>	
	<i>Explanation of difference:</i>	
	The State has added an additional amount to the allowance for the personal needs of a waiver recipient 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 CFR 435.726(c)(3).	
<b>iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:</b>		

State:	
Effective Date	

- 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:

<input type="radio"/>	<b>Not applicable (see instructions)</b> <i>Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.</i>
<input type="radio"/>	<b>The State does not establish reasonable limits.</b>
<input checked="" type="radio"/>	<b>The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.</b>

**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.**

State:	
Effective Date	

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:

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

State:	
Effective Date	

<input type="radio"/>	<b>Optional State supplement standard</b>	
<input type="radio"/>	<b>Medically needy income standard</b>	
<input type="radio"/>	<b>The following dollar amount:</b> Specify dollar amount:	\$ <input type="text"/> If this amount changes, this item will be revised.
<input type="radio"/>	<b>The amount is determined using the following formula:</b> <i>Specify:</i>	
	<input type="text"/>	
<b>iii. Allowance for the family (select one):</b>		
<input type="radio"/>	<b>Not Applicable (see instructions)</b>	
<input type="radio"/>	<b>AFDC need standard</b>	
<input type="radio"/>	<b>Medically needy income standard</b>	
<input type="radio"/>	<b>The following dollar amount:</b> Specify dollar amount:	\$ <input type="text"/> 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.
<input type="radio"/>	<b>The amount is determined using the following formula:</b> <i>Specify:</i>	
	<input type="text"/>	
<input type="radio"/>	<b>Other</b> <i>Specify:</i>	
	<input type="text"/>	
<b>iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:</b>		
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:		
<input type="radio"/>	<b>Not applicable (see instructions) Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.</b>	
<input type="radio"/>	<b>The State does not establish reasonable limits.</b>	
<input type="radio"/>	<b>The State establishes the following reasonable limits</b> <i>Specify:</i>	
	<input type="text"/>	

State:	<input type="text"/>
Effective Date	<input type="text"/>

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:

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

State:	
Effective Date	

<b>Specify the amount of the allowance (select one):</b>		
<input type="radio"/>	<b>The following standard under 42 CFR §435.121:</b> <i>Specify:</i>	
<input type="radio"/>	<b>Optional State supplement standard</b>	
<input type="radio"/>	<b>Medically needy income standard</b>	
<input type="radio"/>	<b>The following dollar amount:</b> Specify dollar amount:	\$ <input type="text"/> If this amount changes, this item will be revised.
<input type="radio"/>	<b>The amount is determined using the following formula:</b> <i>Specify:</i>	
<b>iii. Allowance for the family (select one):</b>		
<input type="radio"/>	<b>Not Applicable (see instructions)</b>	
<input type="radio"/>	<b>AFDC need standard</b>	
<input type="radio"/>	<b>Medically needy income standard</b>	
<input type="radio"/>	<b>The following dollar amount:</b> Specify dollar amount:	\$ <input type="text"/> 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.
<input type="radio"/>	<b>The amount is determined using the following formula:</b> <i>Specify:</i>	
<input type="radio"/>	<b>Other</b> <i>Specify:</i>	
<b>iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:</b>		
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:		
<input type="radio"/>	<b>Not applicable (see instructions) Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.</b>	
<input type="radio"/>	<b>The State does not establish reasonable limits.</b>	

State:	
Effective Date	

○	<b>The State establishes the following reasonable limits</b> <i>Specify:</i>

State:	
Effective Date	

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

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

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

<b>i. Allowance for the personal needs of the waiver participant</b>		
<i>(select one):</i>		
<input type="radio"/>	<b>SSI Standard</b>	
<input type="radio"/>	<b>Optional State supplement standard</b>	
<input type="radio"/>	<b>Medically needy income standard</b>	
<input type="radio"/>	<b>The special income level for institutionalized persons</b>	
<input type="radio"/>	%	Specify percentage:
<input type="radio"/>	<b>The following dollar amount:</b>	\$ _____ If this amount changes, this item will be revised
<input type="radio"/>	<b>The following formula is used to determine the needs allowance:</b>	
	<i>Specify formula:</i>	
<input type="radio"/>	<b>Other</b>	
	<i>Specify:</i>	
<b>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.</b>		
Select one:		
<input type="radio"/>	<b>Allowance is the same</b>	
<input type="radio"/>	<b>Allowance is different.</b>	
	<i>Explanation of difference:</i>	
<b>iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:</b>		
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.		
<i>Select one:</i>		
<input type="radio"/>	<b>Not applicable (see instructions) Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.</b>	
<input type="radio"/>	<b>The State does not establish reasonable limits.</b>	

State:	
Effective Date	

○	<b>The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.</b>
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State:	
Effective Date	

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

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

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

<b>i.</b>	<b>Minimum number of services.</b> The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
<b>ii.</b>	<b>Frequency of services.</b> The State requires (select one):
<input type="radio"/>	<b>The provision of waiver services at least monthly</b>
<input checked="" type="radio"/>	<b>Monthly monitoring of the individual when services are furnished on a less than monthly basis</b> If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency: <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">Quarterly</div>

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

<input type="radio"/>	<b>Directly by the Medicaid agency</b>
<input type="radio"/>	<b>By the operating agency specified in Appendix A</b>
<input type="radio"/>	<b>By an entity under contract with the Medicaid agency.</b> <i>Specify the entity:</i> <div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>
<input checked="" type="radio"/>	<b>Other</b> <i>Specify:</i> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">CSHCN</div>

- 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:

CSHCN employs or contracts with RN Waiver Coordinators who must: <ul style="list-style-type: none"> <li>• 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</li> <li>• Have at least five years paid professional experience in the field of pediatric nursing and at</li> </ul>
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State:	
Effective Date	

least one year experience in utilization management, discharge planning or care coordination.

- 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/recipient must meet the criteria for nursing facility level of care according to R414-502-3 - 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.

In addition, the applicant/recipient must meet the following targeting criteria for participation in the technology dependent waiver program.

- Under the age of 21 at time of admission;
- Qualify for Medicaid based on an approved categorical or medically needy group specified in the waiver plan;
- Have one or more caregivers trained (or willing to be trained) and available to provide care, and be cared for in a home that is safe and can accommodate the necessary medical equipment and personnel needed to assure the child’s safety;
- Require services so inherently complex that they can only be safely and effectively performed by, or under the direction of, a skilled nursing professional; and
- Must be dependent on one or more of the following technologies:

- a. daily dependence on a mechanical ventilator;
- b. daily dependence on Bi-level Positive Airway Pressure (Bi-PAP) for 18 hours or more a day;
- c. daily dependence on tracheostomy-based respiratory support (or, at reevaluation, dependence within the past 6 months on tracheostomy-based respiratory support);
- d. daily dependence on Continuous Positive Airway Pressure (C-PAP) or Bi-level Positive Airway Pressure (Bi-PAP) for less than 18 hours per day;
- e. dependence on intravenous administration of nutritional substances or medications through a central line, which the physician anticipates will be necessary for a period of at least six months.

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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*):

<input type="radio"/>	<b>The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.</b>
<input checked="" type="radio"/>	<p><b>A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.</b></p> <p>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.</p> <p>The MDS Assessment (MDS) is the tool used to determine level of care for facility based care under the State plan. As a result, the MDS includes information more pertinent to a residential facility setting addressing structural problems related to performance of ADLs (Activities of Daily Living) in a facility, discharge potential and overall status and therapy supplement.</p> <p>For the Tech Dependent Waiver, the Technology Dependent Waiver Comprehensive Assessment (Comprehensive Assessment) is the instrument administered to assist in determining nursing facility level of care and eligibility based on the criteria set forth for admission to this waiver program. It considers the applicant’s prior history, risk factors, functional status, mental and behavioral status, nutritional status, medical information and treatments, growth and development, vision status and natural supports in addition to the type of technology dependence. The RN Waiver Coordinators are responsible for collecting the needed information and for making the initial level of care determinations. The RN Waiver Coordinators are trained by the State Medicaid Agency on the eligibility requirements for nursing facility admission and eligibility requirements based on specific targeting criteria for this waiver.</p> <p>Both the MDS and the Comprehensive Assessment include data fields necessary to measure the individual’s level of care as defined in the State Medicaid nursing facility admission criteria R414-502-3.</p>

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:

<p>A preliminary level of care screening is conducted and documented by an RN Waiver Coordinator employed by CSHCN for each waiver applicant for whom there is a reasonable indication that waiver and other Medicaid State plan services may be needed in the near future. Information obtained from the referent (generally hospital or nursing facility personnel) must provide sufficient detail concerning the applicant’s current medical condition, required technology, and current and needed services and supports for the RN Waiver Coordinator to make a preliminary determination regarding the applicant’s level of care. There is currently a waiting list for this waiver. An applicant’s name will only be added to the waiting list when the information obtained and screened by the RN Waiver Coordinator provides sufficient evidence that the applicant meets the targeted nursing facility level of care criteria. Priority for admission to the waiver is given to the applicant on the waiting list with the highest “numerical ranking” based on targeting condition weight factor criteria defined in Appendix B-3 (f).</p> <p>Formal initial level of care evaluations are conducted by an RN Waiver Coordinator and completed during an on-site visit when the initial Comprehensive Assessment is completed. The RN Waiver</p>
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Coordinator assesses the applicant’s current medical condition and reviews collected medical documentation including the type(s) of technology required and associated health/safety risk factors. The services and supports available to the applicant and those potentially needed to assure the individual’s health and welfare are identified. Additionally, an assessment is conducted of the applicant’s (and caregiver’s) current situation including existing services, formal supports, and additional services and supports required to prevent the applicant’s institutionalization. The initial assessment and collected documentation must be sufficient in scope to support a determination regarding the applicant’s targeted nursing facility level of care.

Enrolled recipients’ targeted nursing facility level of care must be reevaluated at least every 12 months (“within the month due”). Reassessments are conducted by an RN Waiver Coordinator, completed during a reassessment home visit and include the following:

- a. a reassessment of the recipient’s current medical condition;
- b. a review of recent medical documentation, home health agency Form 485, and any changes in the type(s) of technology required and associated health and safety risks;
- c. identifying the waiver and State plan services and supports currently authorized and used, and those potentially needed in order to continue to (re)assure the individual’s health and welfare; and
- d. a reassessment of the recipient’s (and caregiver’s) current situation including non-waiver/non-State plan services and formal/informal supports required to prevent institutionalization if the recipient/legal representative chooses continued home and community-based services.

Reassessments are used as the basis for re-certifying that the recipient still meets the targeted nursing facility level of care and are conducted in accordance with the time frames stipulated in the approved waiver and verified by a completed, signed level of care form.

- 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*):

<input type="radio"/>	<b>Every three months</b>
<input type="radio"/>	<b>Every six months</b>
<input type="radio"/>	<b>Every twelve months</b>
<input checked="" type="radio"/>	<b>Other schedule</b>
	<i>Specify the other schedule:</i>
	Level of care re-evaluations must occur at least annually – 12 months from entry into the HCBS Waiver program or within 12 months of the most current level of care evaluation – and completed during the calendar month in which it is due.

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

<input type="radio"/>	<b>The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.</b>
<input type="radio"/>	<b>The qualifications are different.</b>
	<i>Specify the qualifications:</i>

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- 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 recipient's Plan of Care.

- 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 CSHCN.

## 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.*

<b>Performance Measure:</b>	<i>Number and percentage of new recipients that have been determined to meet Nursing Facility level of care prior to admission to the waiver. (Numerator = # of new recipients meeting level of care requirements;</i>
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<i>Denominator = total # of new enrollees).</i>			
<b>Data Source</b> (Select one) (Several options are listed in the on-line application):			
If 'Other' is selected, specify: <u>Other</u>			
<b>Level of Care forms</b>			
	<b>Responsible Party for data collection/generation</b> (check each that applies)	<b>Frequency of data collection/generation:</b> (check each that applies)	<b>Sampling Approach</b> (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input checked="" type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
	CSHCN RN Waiver Coordinator	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

**Add another Data Source for this performance measure**

**Data Aggregation and Analysis**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies)	<b>Frequency of data aggregation and analysis:</b> (check each that applies)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
CSHCN RN Waiver Coordinator	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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.**

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**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.

<b>Performance Measure:</b>	Number and percentage of Tech Dependent 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. <u>(Numerator = # of annual LOCs completed timely; Denominator = total # of annual LOCs required)</u>		
<b>Data Source (Select one) (Several options are listed in the on-line application):</b>			
If 'Other' is selected, specify:			
<b>Initial and Annual Level of Care/Freedom of Choice forms</b>			
	<b>Responsible Party for data collection/generation</b> (check each that applies)	<b>Frequency of data collection/generation:</b> (check each that applies)	<b>Sampling Approach</b> (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval =
	<input checked="" type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	95% Confidence Level, 5% Margin of Error
	CSHCN RN Waiver Coordinators	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

**Add another Data Source for this performance measure**

**Data Aggregation and Analysis**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies)	<b>Frequency of data aggregation and analysis:</b> (check each that applies)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

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<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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.

<b>Performance Measure:</b>	Number and Percentage of Tech Dependent Waiver recipients whose level of care screenings and evaluations were documented using the Initial and Annual level of care/Freedom of Choice form. <i>(Numerator = # of LOC forms correctly documenting LOC criteria; Denominator = total # of LOC/Freedom of Choice forms completed)</i>		
<b>Data Source</b> (Select one) (Several options are listed in the on-line application):			
If 'Other' is selected, specify:			
<b>Initial and Annual Level of Care/Freedom of Choice forms</b>			
	<b>Responsible Party for data collection/generation</b> (check each that applies)	<b>Frequency of data collection/generation:</b> (check each that applies)	<b>Sampling Approach</b> (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review

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	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error	
	<input checked="" type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually		
	CSHCN RN Waiver Coordinators	<input type="checkbox"/> Continuously and Ongoing		<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:		
				<input type="checkbox"/> Other Specify:

**Add another Data Source for this performance measure**

**Data Aggregation and Analysis**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies)	<b>Frequency of data aggregation and analysis:</b> (check each that applies)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

<b>Performance Measure:</b>	Number and Percentage of Level of Care evaluations (initial or annual) which were completed accurately based on Level of Care criteria. <u>(Numerator=# of LOC evals completed accurately; Denominator=Total # of LOC completed)</u>
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**Data Source** (Select one) (Several options are listed in the on-line application): Records review, off-site

If 'Other' is selected, specify:

	<b>Responsible Party for data collection/generation</b> (check each that applies)	<b>Frequency of data collection/generation:</b> (check each that applies)	<b>Sampling Approach</b> (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review

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	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	95% Confidence Level, 5% Margin of Error
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

**Add another Data Source for this performance measure**

**Data Aggregation and Analysis**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies)	<b>Frequency of data aggregation and analysis:</b> (check each that applies)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

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

Individuals who request services through the Tech Dependent Waiver are screened for level of care, ranked according to the targeting condition weight factor criteria and placed on the waiting list. When the individual is taken off of the waiting list, an RN Waiver Coordinator determines if the individual continues to need services from the Tech Dependent Waiver program. For all individuals who have been taken off the waiting list and require services, an evaluation for level of care is conducted by the RN Waiver Coordinator.

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CSHCN is the entity that will conduct and submit level of care reviews to BACBS.

**b. Methods for Remediation/Fixing Individual Problems**

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

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

*ii Remediation Data Aggregation*

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

<b>Remediation-related Data Aggregation and Analysis (including trend identification)</b>	<b>Responsible Party (check each that applies)</b>	<b>Frequency of data aggregation and analysis: (check each that applies)</b>
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
	<input checked="" type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually
	CSHCN RN Waiver Coordinators	<input type="checkbox"/> Continuously and Ongoing
		<input type="checkbox"/> 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.*

<input checked="" type="radio"/>	No
<input type="radio"/>	Yes

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

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## 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/recipients or their legal representatives are afforded the choice between waiver services and facility based care during their initial evaluation and during each annual reevaluation. They are informed of feasible alternatives and offered the choice between/among waiver services and (available) providers during initial and periodic assessments performed by an RN Waiver Coordinator from CSHCN whenever there is a change in their documented service needs or when they have indicated they are dissatisfied with their current provider.

Recipients and/or their legal representative’s choice between waiver and nursing facility services is evidenced by their selection and signature on the Initial and Annual Freedom of Choice Certification form.

Recipients and/or their legal representative’s choice between available waiver services and providers is documented by the CSHCN RN Waiver Coordinators in the recipient’s progress notes. This evidence is retained to demonstrate that available options were discussed, that the recipient/legal representative had the information necessary to make such a choice, and affirmed their choice(s) of providers by their signature on the Plan of Care form.

- 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 CSHCN in each recipient case file.

Recipients and/or their legal representative’s choice between available waiver services and providers is affirmed on the Plan of Care and documented in the recipient case file.

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

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

Medicaid providers are required to provide foreign language interpreters for Medicaid clients who have limited English proficiency. Waiver recipients, their families and legal representatives are entitled to the same access to an interpreter to assist in making and attending appointments for qualified procedures on behalf of the recipient. Providers must notify recipients, their families and legal representatives that interpretive services are available at no charge. The State Medicaid Agency encourages clients to use professional services rather than relying on a family member or 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 recipients. Eligible individuals may access translation services by calling the Medicaid Helpline.

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

[http://health.utah.gov/umb/forms/pdf/mg\\_w\\_cover.pdf](http://health.utah.gov/umb/forms/pdf/mg_w_cover.pdf)

Other resources to assure access include the AT&T language line, accessible for Medicaid related calls to the Utah Department of Health, the State contract with Pentskiff Interrupters for joint home visits with RN Waiver Coordinators and community advocacy agencies with bilingual staff.

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# 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:*

<b>Statutory Services</b> ( <i>check each that applies</i> )		
Service	Included	Alternate Service Title (if any)
Case Management	<input type="checkbox"/>	
Homemaker	<input type="checkbox"/>	
Home Health Aide	<input type="checkbox"/>	
Personal Care	<input type="checkbox"/>	
Adult Day Health	<input type="checkbox"/>	
Habilitation	<input type="checkbox"/>	
Residential Habilitation	<input type="checkbox"/>	
Day Habilitation	<input type="checkbox"/>	
Prevocational Services	<input type="checkbox"/>	
Supported Employment	<input type="checkbox"/>	
Education	<input type="checkbox"/>	
Respite	<input checked="" type="checkbox"/>	Skilled Nursing Respite Care
Day Treatment	<input type="checkbox"/>	
Partial Hospitalization	<input type="checkbox"/>	
Psychosocial Rehabilitation	<input type="checkbox"/>	
Clinic Services	<input type="checkbox"/>	
Live-in Caregiver (42 CFR §441.303(f)(8))	<input type="checkbox"/>	
<b>Other Services</b> ( <i>select one</i> )		
<input type="radio"/>	Not applicable	
<input type="radio"/>	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute ( <i>list each service by title</i> ):	
a.	Family Support Services	
b.	In-Home Feeding Therapy	

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**Appendix C: Participant Services**  
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c.	
d.	
e.	
f.	
g.	
h.	
i.	

**Extended State Plan Services (select one)**

<input type="radio"/>	Not applicable
<input checked="" type="radio"/>	The following extended State plan services are provided ( <i>list each extended State plan service by service title</i> ):
a.	Extended Private Duty Nursing
b.	Extended Home Health Aide
c.	

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

<input type="checkbox"/>	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.
<input type="checkbox"/>	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.
<input type="radio"/>	Not applicable

Support	Included	Alternate Service Title (if any)
Information and Assistance in Support of Participant Direction	<b>X</b>	Family Directed Support
Financial Management Services	<b>X</b>	Financial Management Services

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

a.	
b.	
c.	

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**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).

Skilled Nursing Respite Care						
HCBS Taxonomy						
Category 1:	Sub-Category 1:					
Category 2:	Sub-Category 2:					
Category 3:	Sub-Category 3:					
Category 4:	Sub-Category 4:					
<b>Service Definition (Scope):</b>						
<p>Skilled Nursing Respite Care is an intermittent service provided on behalf of an eligible individual to relieve the primary caregiver from the stress of providing continuous care, thereby avoiding premature or unnecessary nursing facility admission. Skilled nursing respite care may be provided by a Medicaid enrolled Home Health Agency or through the Family Directed Service model. Skilled nursing respite care coverage includes an initial RN assessment by an RN Waiver Coordinator from CSHCN to establish a new client.</p> <p>Skilled Nursing Respite Care is provided in a private residence or other setting(s) in the community, outside of the recipient's home, but only when the legally responsible recipient or guardian, the CSHCN RN Waiver Coordinator and the respite care provider (individual or agency) have all agreed and stipulated in the Plan of Care that the alternative setting(s) is safe and can accommodate the necessary medical equipment and personnel needed to care for the child safely.</p>						
<b>Specify applicable (if any) limits on the amount, frequency, or duration of this service:</b>						
Limits on the amount, frequency and/or duration are specified in the individual's Plan of Care and based on assessed needs.						
<b>Service Delivery Method</b> <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed		
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/>	Relative	<input type="checkbox"/>	Legal Guardian
Provider Specifications						
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:		
		Registered Nurses licensed in the State of Utah		Home Health Agencies		
Provider Qualifications						

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Provider Type:	License ( <i>specify</i> )	Certificate ( <i>specify</i> )	Other Standard ( <i>specify</i> )
Registered Nurses licensed in the State of Utah	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, 1953 as amended.		-Current RN license -Background and Criminal Investigation check -Nursing Malpractice Insurance/Individual Professional Liability Insurance -Basic CPR certification -Enrolled with a Financial Management Agency -Demonstrate ability to perform the necessary skilled nursing functions to safely care for the recipient
Home Health Agencies	Licensed Home Health Agencies in accordance with Utah Administrative Rules, R-432-700.	Medicare Certified	Enrolled as a Medicaid waiver provider as described in Utah Code Annotated Title 58, Chapter 31b: Registered Nurses Licensed Practical Nurses Health Care Assistant (Certified Nursing Assistant)

<b>Verification of Provider Qualifications</b>		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Registered Nurses licensed in the State of Utah	<b>Financial Management Agency</b>	<b>Upon hire and annually thereafter</b>
Home Health Agencies	<b>State Medicaid Agency</b>	<b>Upon enrollment and annually thereafter</b>

<b>Extended Home Health Aide</b>	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

State:	
Effective Date	

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<b>Service Definition (Scope):</b>			
<p>Extended Home Health Aide services will be provided under the waiver when Home Health Aide services are required on the same day as a State plan home health nursing service and may be provided at the same time. The scope and nature of these services do not differ from home health aide services furnished under the State plan and are defined in the same manner as provided in the approved State plan. The provider qualifications specified in the State plan apply. The additional amount of services that may be provided through the waiver is limited to the duration or frequency determined necessary through the comprehensive needs assessment process and delineated in the individual's Plan of Care, but is not otherwise limited by definition in terms of duration or frequency.</p> <p>The home health aide shall not perform duties defined as the practice of nursing according to Utah Code 58-31B. When providing Home Health Aide services for recipients under the waiver program, a paid nursing professional, a trained parent or legal guardian, or a designated caregiver trained by the parent, guardian or responsible person must be present in the home. The home health aide shall not be left alone to care for the technology dependent/medically fragile recipient.</p>			
<b>Specify applicable (if any) limits on the amount, frequency, or duration of this service:</b>			
<p>Extended home health aide services will only be authorized when ordered on the same day or at the same time as home health nursing services covered under the State plan. The State plan home health benefit does not allow home health aide services to be provided on the same day or at the same time as home health nursing services. Limits on the amount, frequency, and/or duration are specified in the individual's Plan of Care and based on assessed needs.</p>			
<b>Service Delivery Method</b> <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> <b>Provider managed</b>
<b>Specify whether the service may be provided by</b> <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/> <b>Relative</b> <input type="checkbox"/> <b>Legal Guardian</b>
<b>Provider Specifications</b>			
<b>Provider Category(s)</b> <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/> <b>Agency. List the types of agencies:</b>
			Home Health Agencies
<b>Provider Qualifications</b>			
<b>Provider Type:</b>	<b>License</b> <i>(specify)</i>	<b>Certificate</b> <i>(specify)</i>	<b>Other Standard</b> <i>(specify)</i>
Home Health Agencies	Medicaid/Medicare Certified Licensed Home Health Agencies in accordance with Utah Administrative Rule R-432-700-22	Home Health Certified Nursing Assistants shall have received a certificate of completion for the employment position. The curriculum or the comparable challenge exam shall be offered under the direction of the Utah Board of Education.	Enrolled as a waiver provider who employs qualified Certified Nursing Assistants who have demonstrated ability to provide direct personal assistance to waiver recipients.

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		If the employee does not have a certificate of completion for the position at the time of employment, completion of the course of study or challenge exam shall occur within six months of the date of hire.	

<b>Verification of Provider Qualifications</b>		
<b>Provider Type:</b>	<b>Entity Responsible for Verification:</b>	<b>Frequency of Verification</b>
Home Health Agencies	<b>State Medicaid Agency</b>	<b>Upon enrollment and annually thereafter</b>

<b>Extended Private Duty Nursing</b>	
<b>HCBS Taxonomy</b>	
Category 1:	Sub-Category 1:
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
<b>Service Definition (Scope):</b>	
<p>Extended private duty nursing services are provided in addition to private duty nursing services furnished under the approved State plan. These services are provided when private duty nursing services furnished under the approved State plan limits are exhausted. The scope and nature of these services do not differ from private duty nursing services furnished under the State plan and are defined in the same manner as provided in the approved State plan. The provider qualifications specified in the State plan apply. The additional amount of services that may be provided through the waiver is limited to the duration or frequency determined necessary through the comprehensive needs assessment process and delineated in the individual's Plan of Care, but is not otherwise limited by definition in terms of duration or frequency.</p> <p>Providers shall submit medical documentation (Home Health Agency Form 485, the Medicaid approved PDN acuity grid and skilled nursing assessment form, nursing notes and other relevant documentation) which demonstrate the need for the service to an RN Waiver Coordinator.</p>	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	

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Extended private duty nursing services will only be ordered after full utilization of available State plan services. Limits on the amount, frequency and/or duration are specified in the individual's Plan of Care and are based on assessed needs.

<b>Service Delivery Method</b> (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/>	Relative
	<input type="checkbox"/>		<input type="checkbox"/>	Legal Guardian

**Provider Specifications**

Provider Category(s) (check one or both):	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
				Home Health Agencies

**Provider Qualifications**

Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Home Health Agencies	Licensed Home Health Agency	Medicare Certified	R-432-700 Home Health Agency Enrolled as a Medicaid waiver provider As described in Utah Code Annotated Title 58, Chapter 31b: Registered Nurses Licensed Practical Nurses

**Verification of Provider Qualifications**

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Health Agencies	State Medicaid Agency	Upon enrollment and annually thereafter

**Family Directed Support**

HCBS Taxonomy	
Category 1:	Sub-Category 1:
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Service Definition (Scope):	

State:	
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This service is designed to ensure waiver families are prepared to manage their own respite service and providers. Family Directed Support services include:

- a) information to ensure that the recipient/family understands the responsibilities in directing their own care.
- b) instruction in how to effectively communicate with service providers;
- c) instruction in the management of service providers including interviewing, selecting, scheduling, termination, time sheeting, and evaluating performance;
- d) information on individual rights, filing grievances, and risk management;
- e) advocacy training;
- f) developing emergency plans; and
- g) developing forms and maintaining documentation.

Family Directed Support services do not include educational, vocational or prevocational components.

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

Family Directed Support service is limited to recipients/families who direct some or all of their waiver respite service. Limits on the amount, frequency, and/or duration are specified in the individual's Plan of Care and based on assessed needs.

<b>Service Delivery Method</b> (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
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Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative	<input type="checkbox"/>	Legal Guardian
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**Provider Specifications**

Provider Category(s) (check one or both):	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
		Clinical Social Worker licensed in the State of Utah		Family Counseling Centers
				Financial Management Service Agencies

**Provider Qualifications**

Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Family Counseling Centers	Current Business License		Enrolled as a Medicaid waiver provider. Demonstrated ability to perform Family Directed Support functions. Clinical Social Worker licensed in the State of Utah per Utah Code 58-60, Part 2.
<b>Financial Management Service Agencies</b>	Certified Public Accountant per Utah Code R58-26a, UCA, and R156-26A, UCA		Enrolled as a Medicaid waiver provider. Compliance with State and local licensing, accreditation and certification requirements (Utah Code R58-26a).
<b>Clinical Social Worker licensed in the State of Utah</b>	Clinical Social Worker licensed in the State of Utah per Utah Code 58-60 Part 2.		Enrolled as a Medicaid waiver provider. Demonstrated ability to perform Family Directed Support functions. Licensed in the state of Utah as a Clinical Social Worker.

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Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Family Counseling Centers	State Medicaid Agency	Upon enrollment and annually thereafter
Financial Management Service Agencies	State Medicaid Agency	Upon enrollment and annually thereafter
Clinical Social Worker licensed in the State of Utah	State Medicaid Agency	Upon enrollment and annually thereafter

Financial Management Services				
HCBS Taxonomy				
Category 1:	Sub-Category 1:			
Category 2:	Sub-Category 2:			
Category 3:	Sub-Category 3:			
Category 4:	Sub-Category 4:			
Service Definition (Scope):				
This service will be authorized in conjunction with waiver services under the approved family-directed services model. Services rendered under this definition include those to facilitate the employment of approved and qualified providers by the individual or family. Services include: (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 family and RN Waiver Coordinators within CSHCN.				
Specify applicable (if any) limits on the amount, frequency, or duration of this service:				
Limits on the amount, frequency and/or duration are specified in the individual's Plan of Care and based on assessed needs.				
<b>Service Delivery Method</b> (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative
	<input type="checkbox"/>		<input type="checkbox"/>	Legal Guardian
Provider Specifications				
Provider Category(s)	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
				Financial Management Services Agency

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<i>(check one or both):</i>			
<b>Provider Qualifications</b>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Financial Management Services Agency	Licensed Public Accounting Agency, Certified Public Accountants per Utah Code R58-26a.		-Enrolled as a Medicaid waiver provider. -Compliance with State and local licensing, accreditation and certification requirements (Utah Code R58-26a).
<b>Verification of Provider Qualifications</b>			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification	
Financial Management Services Agency	<b>State Medicaid Agency</b>	<b>Upon enrollment and annually thereafter</b>	

Family Support Services	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
<b>Service Definition (Scope):</b>	
<p>Family Support Services include counseling and child life services. These supportive services are provided to the waiver recipient and/or family members and are designed to guide and help them cope with the recipient's illness and the related stress that accompanies the continuous, daily care required by a seriously ill recipient. Enabling the waiver recipient and family members to manage their stress improves the likelihood that the technology dependent/medically fragile recipient will continue to be cared for at home, thereby preventing premature and otherwise unnecessary nursing facility admission.</p> <p>Counseling services are supportive in nature and assist family members with psychosocial and emotional issues, life events, stress and coping, preventative health behaviors, community, sibling and family related issues.</p> <p>Child life services provide individuals with a language to express themselves which bridges age, ability and</p>	

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cultural boundaries. Within the safety of a therapeutic relationship, images are created through drawing, painting, collage, writing, clay or sand play. Young children, or children with limitations due to medical conditions, often find it challenging to express themselves verbally, but through play they can show what they think, feel and how they experience and understand their world. The provider carefully selects a variety of play and other expressive materials to help the child bring into the open fears, fantasies, and feelings about challenging situations in their lives. Methods are designed according to age, developmental level stage, natural inclinations and unique struggles. Through this active expression, inner strengths are discovered that can help the child and family deal with past experiences, cope with present life situation and promote effective coping and self-healing.

Family Support Services include a comprehensive assessment and a treatment plan developed and/or reviewed and approved by a licensed/certified clinician in accordance with their scope of practice.

Family Support Services are available as necessary to the waiver recipient and family members. Family members are defined as the persons who live with or provide care to the client, and may include a parent, spouse, siblings, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the recipient. Services must be included in the Plan of Care.

The recipient or family members who may be suffering from a serious emotional or mental illness or disorder should be referred to an appropriate mental health care provider; family members who are also eligible for Medicaid should be referred to a Medicaid mental health provider in accordance with the imprinted information on their medical card.

Family Support Services may be provided in the home or other community locations (as authorized in the Plan of Care).

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

Limits on the amount, frequency and/or duration are specified in the individual's Plan of Care and based on assessed needs.

<b>Service Delivery Method</b> (check each that applies):	X	Participant-directed as specified in Appendix E	X	Provider managed
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative
	<input type="checkbox"/>		<input type="checkbox"/>	Legal Guardian

**Provider Specifications**

Provider Category(s) (check one or both):	X	Individual. List types:	X	Agency. List the types of agencies:
		Certified Child Life Specialist via the Family Directed Services model		Family Counseling Centers
		Individual Enrolled as a Medicaid Provider		Home Health Agencies
		Social Worker via the Family Directed Services model		

**Provider Qualifications**

Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Certified Child Life Specialist via the Family Directed Services		Certified Child Life Specialist with a minimum of a bachelor's degree in a	Background and Criminal Investigation check. Enrolled with a Financial Management Agency.

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model		related field.	Individual Professional Liability Insurance. Three years of experience in pediatric Child Life and demonstrated ability to perform Family Support Services.
Individual Enrolled as a Medicaid Provider	Clinical Social Worker licensed in the State of Utah in accordance with Utah Code 58-60, Part 2.		Enrolled as a Medicaid waiver provider. Three years of experience in pediatric social work and demonstrated ability to perform Family Support Counseling Services.
Social Worker via the Family Directed Services model	Clinical Social Worker licensed in the State of Utah in accordance with Utah Code 58-60, Part 2.		Background and Criminal Investigation check. Enrolled with a Financial Management Agency. Individual Professional Liability Insurance. Three years of experience in pediatric social work and demonstrated ability to perform Family Support Services.
Family Counseling Centers	Licensed Family Counseling Center		Enrolled as a Medicaid waiver provider who employs or contracts with: Clinical Social Workers licensed in the State of Utah in accordance with Utah Code 58-60, Part 2; OR Certified Child Life Specialists with a minimum of a bachelor's degree in a related field.
Home Health Agencies	Licensed Home Health Agencies in accordance with Utah Administrative Rule R-432-700.		Enrolled as a Medicaid waiver provider who employs or contracts with qualified Clinical Social Workers licensed in the State of Utah per Utah Code 58-60, Part 2.

<b>Verification of Provider Qualifications</b>		
<b>Provider Type:</b>	<b>Entity Responsible for Verification:</b>	<b>Frequency of Verification</b>
Certified Child Life Specialist via the Family Directed Services model	<b>State Medicaid Agency</b>	<b>Upon enrollment and annually thereafter</b>
Individual Enrolled as a Medicaid Provider	<b>State Medicaid Agency</b>	<b>Upon enrollment and annually thereafter</b>
Social Worker via the Family Directed Services model	<b>State Medicaid Agency</b>	<b>Upon enrollment and annually thereafter</b>
Family Counseling Centers	<b>State Medicaid Agency</b>	<b>Upon enrollment and annually thereafter</b>
Home Health Agencies	<b>State Medicaid Agency</b>	<b>Upon enrollment and</b>

State:	
Effective Date	

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**annually thereafter**

**In-Home Feeding Therapy**

<b>HCBS Taxonomy</b>			
Category 1:	Sub-Category 1:		
Category 2:	Sub-Category 2:		
Category 3:	Sub-Category 3:		
Category 4:	Sub-Category 4:		
<b>Service Definition (Scope):</b>			
In-Home Feeding Therapy is a service provided by qualified professionals to enhance the ability of an individual who cannot obtain adequate nutrition through ordinary means (oral intake of adequate food and nutritional substances). A licensed speech therapist or occupational therapist collaborates with the recipient's medical home and other professionals to assess function and provide options and instruction on promoting oral intake, evaluates self-feeding skills and modification of equipment for self-feeding and develops and instructs the caregiver on a home feeding program.			
<b>Specify applicable (if any) limits on the amount, frequency, or duration of this service:</b>			
Limits on the amount, frequency and/or duration are specified in the individual's Plan of Care and based on assessed needs.			
<b>Service Delivery Method</b> <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/> Relative <input type="checkbox"/> Legal Guardian
<b>Provider Specifications</b>			
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:
		Occupational Therapist (Family-directed)	CSHCN
		Speech Therapist (Family-directed)	Home Health Agencies
<b>Provider Qualifications</b>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Occupational Therapist (Family-directed)	Occupational Therapist licensed in the State of Utah in accordance with UCA Title 58, Chapter 42.		Background and Criminal Investigation check. Enrolled with a Financial Management Agency. Individual Professional Liability Insurance. and

State:	
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			Three years experience in pediatric occupational therapy with a demonstrated ability to perform in home feeding therapy.
Speech Therapist (Family-directed)	Speech Therapist licensed in the State of Utah in accordance with UCA Title 58, Chapter 41		Background and Criminal Investigation check. Enrolled with a Financial Management Agency. Individual Professional Liability Insurance. and Three years experience in pediatric speech therapy with a demonstrated ability to perform in home feeding therapy.
CSHCN			Enrolled as a Medicaid waiver provider and employs or contracts with qualified: Speech Therapist(s) licensed in the State of Utah in accordance with UCA Title 58, Chapter 41, with demonstrated ability to perform in home feeding therapy and/or Occupational Therapist(s) licensed in the State of Utah in accordance with UCA Title 58, Chapter 42, with demonstrated ability to perform in home feeding therapy
Home Health Agencies	Licensed Home Health Agencies in accordance with Utah Administrative Rule, R-432-700-22	Medicare Certified	Enrolled as a Medicaid waiver provider and employs or contracts with qualified: Speech Therapist(s) licensed in the State of Utah in accordance with UCA Title 58, Chapter 41, with demonstrated ability to perform in home feeding therapy and/or Occupational Therapist(s) licensed in the State of Utah in accordance with UCA Title 58, Chapter 42, with demonstrated ability to perform in home feeding therapy

**Verification of Provider Qualifications**

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Occupational Therapist (Family-directed)	State Medicaid Agency	Upon enrollment and annually thereafter
Speech Therapist (Family-directed)	State Medicaid Agency	Upon enrollment and annually thereafter
CSHCN	State Medicaid Agency	Upon enrollment and annually thereafter
Home Health Agencies	State Medicaid Agency	Upon enrollment and annually thereafter

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

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<input type="radio"/>	<b>Not applicable</b> – Case management is not furnished as a distinct activity to waiver participants.
<input checked="" type="radio"/>	<b>Applicable</b> – Case management is furnished as a distinct activity to waiver participants. Check each that applies:
<input type="checkbox"/>	As a waiver service defined in Appendix C-3 ( <i>do not complete C-1-c</i> )
<input type="checkbox"/>	As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option). <i>Complete item C-1-c.</i>
<input type="checkbox"/>	As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). <i>Complete item C-1-c.</i>
<input type="checkbox"/>	As an administrative activity. <i>Complete item C-1-c.</i>

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

Under an interagency Memorandum of Agreement, administrative case management activities will be performed by the RN Waiver Coordinators from CSHCN.

State:	
Effective Date	

## 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*):

<input checked="" type="checkbox"/>	<p><b>Yes.</b> 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):</p> <p>Criminal background investigations will be required for family directed 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.</p> <p>On an annual basis, the CSHCN RN Waiver Coordinators request records from the Financial Management Agency to ensure that all family directed providers have met the mandatory criminal background investigations requirement.</p>
<input type="checkbox"/>	<p><b>No.</b> Criminal history and/or background investigations are not required.</p>

- 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*):

<input type="checkbox"/>	<p><b>Yes.</b> 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):</p>
<input checked="" type="checkbox"/>	<p><b>No.</b> The State does not conduct abuse registry screening.</p>

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

<input checked="" type="checkbox"/>	<p><b>No.</b> Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. <i>Do not complete Items C-2-c.i – c.iii.</i></p>
<input type="checkbox"/>	<p><b>Yes.</b> 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). <i>Complete Items C-2-c.i –c.iii.</i></p>

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

State:	
Effective Date	

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

State:	
Effective Date	

**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.

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**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	<input type="checkbox"/>
Physical environment	<input type="checkbox"/>
Sanitation	<input type="checkbox"/>
Safety	<input type="checkbox"/>
Staff : resident ratios	<input type="checkbox"/>
Staff training and qualifications	<input type="checkbox"/>
Staff supervision	<input type="checkbox"/>
Resident rights	<input type="checkbox"/>
Medication administration	<input type="checkbox"/>
Use of restrictive interventions	<input type="checkbox"/>
Incident reporting	<input type="checkbox"/>
Provision of or arrangement for necessary health services	<input type="checkbox"/>

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:

--

State:	
Effective Date	

- 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:*

<input checked="" type="radio"/>	<b>No.</b> The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
<input type="radio"/>	<b>Yes.</b> 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 <i>extraordinary care</i> 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. <i>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.</i>

- 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:*

<input type="radio"/>	<b>The State does not make payment to relatives/legal guardians for furnishing waiver services.</b>
<input type="radio"/>	<b>The State makes payment to relatives/legal guardians under <i>specific circumstances</i> and only when the relative/guardian is qualified to furnish services.</b> 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. <i>Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.</i>
<input type="radio"/>	<b>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.</b> Specify the controls that are employed to ensure that payments are made only for services rendered.
<input checked="" type="radio"/>	Other policy. <i>Specify:</i>  The State will permit the provision of waiver services furnished by non-legally responsible relatives 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).

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The RN Waiver Coordinators will verify that services provided are appropriate and furnished in the best interest of the recipient at the time a formal review of the Plan of Care is completed, at least every six months or more frequently as necessary to ensure services continue to meet the needs of the waiver recipient and family. Additionally, on an annual basis, the SMA will complete a sample review of claims for services rendered to verify the service was authorized and did not exceed the amounts documented in the recipient's Plan of Care.

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

The State Medicaid Agency (SMA) will enter into a provider agreement with all willing providers who meet licensure, certification and/or other qualifications. CSHCN will recruit providers in areas throughout the state when a recipient living in that area is enrolled. The SMA also distributes a Technology Dependent Waiver frequently asked questions (FAQ) information sheet which includes contact information for providers interested in the program. 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://health.utah.gov/medicaid>

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 State Medicaid Agency in order to provide and bill for waiver services. Each new Medicaid Provider Application/Agreement must include all applicable licenses and certifications and must be reviewed by CSHCN and BACBS. When both agree that the provider meets the qualifications for waiver enrollment, BACBS will ensure the Medicaid Provider Application/Agreement is appropriately submitted and processed by the Bureau of Medicaid Operations, Division of Medicaid and Health Financing.

## 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**

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**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.

<b>Performance Measure:</b>	Number and percentage of agencies who meet required licensing standards. <b>(Numerator = # of provider agencies who meet requirements; Denominator = total # of provider agencies reviewed)</b>		
<b>Data Source</b> (Select one) (Several options are listed in the on-line application): Other			
If 'Other' is selected, specify:			
Provider applications and agreements, Provider reports documenting adherence to state standards and requirements, On-site observations, interviews and monitoring			
	<b>Responsible Party for data collection/generation</b> (check each that applies)	<b>Frequency of data collection/generation:</b> (check each that applies)	<b>Sampling Approach</b> (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input checked="" type="checkbox"/> Other Specify: CSHCN RN Waiver Coordinators and <b>BHFLCRAHFLCA</b>	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input checked="" type="checkbox"/> Other Specify: Upon enrollment; at least every 3 years; Each agency at least every two years	
			<input type="checkbox"/> Other Specify:

**Add another Data Source for this performance measure**

**Data Aggregation and Analysis**

<b>Responsible Party for data aggregation and analysis</b>	<b>Frequency of data aggregation and analysis:</b>
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State:	
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<i>(check each that applies)</i>	<i>(check each that applies)</i>
<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>
<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>
<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>
<input checked="" type="checkbox"/> <i>Other</i> <i>Specify: CSHCN RN</i> <i>Waiver Coordinators and</i> <b>BHFLCRAHFLCA</b>	<input checked="" type="checkbox"/> <i>Annually</i>
	<input type="checkbox"/> <i>Continuously and Ongoing</i>
	<input checked="" type="checkbox"/> <i>Other</i> <i>Specify: Upon receipt of each survey report</i>

**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.

<b>Performance Measure:</b>	Number and percentage of family directed service providers who meet the provider criteria as outlined in the State Implementation Plan. <b>(Numerator = # of providers who meet criteria; Denominator = total # of providers reviewed)</b>		
<b>Data Source (Select one) (Several options are listed in the on-line application):</b>			
If 'Other' is selected, specify:			
List of non HH providers, Utah's DOPL web-site to verify non HH agency provider licensure			
	<b>Responsible Party for data collection/generation</b> (check each that applies)	<b>Frequency of data collection/generation:</b> (check each that applies)	<b>Sampling Approach</b> (check each that applies)

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	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input checked="" type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	
	CSHCN RN Waiver Coordinators	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

**Add another Data Source for this performance measure**

**Data Aggregation and Analysis**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies)	<b>Frequency of data aggregation and analysis:</b> (check each that applies)
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
CSHCN RN Waiver Coordinators	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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

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

<b>Performance Measure:</b>	Number and percentage of families of recipients who provided individual training to Skilled Nursing Respite Care registered nurses hired under the family directed service model. <b>(Numerator = # of families in compliance; Denominator = total # of nurses reviewed)</b>		
<b>Data Source</b> (Select one) (Several options are listed in the on-line application):			
If 'Other' is selected, specify:			
<b>Plan of Care</b>			
	<b>Responsible Party for data collection/generation</b> (check each that applies)	<b>Frequency of data collection/generation:</b> (check each that applies)	<b>Sampling Approach</b> (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input checked="" type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
	CSHCN RN Waiver Coordinators	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

**Add another Data Source for this performance measure**

**Data Aggregation and Analysis**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies)	<b>Frequency of data aggregation and analysis:</b> (check each that applies)
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
CSHCN RN Waiver Coordinators	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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**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.*

BACBS conducts an annual review of the Tech Dependent Waiver program for each of the five waiver years. At a minimum, one comprehensive review will be conducted during this five year cycle. The other annual reviews will be focused reviews. The criteria for the focused reviews will be determined from review findings as well as other issues that develop during the review year.

**b. Methods for Remediation/Fixing Individual Problems**

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

Individual issues identified by CSHCN that affect the health and welfare of individual recipients are addressed immediately. Issues that are less immediate are corrected within designated time frames and are documented through BACBS’ final review report. These time frames are outlined in standard operating procedures or protocols or are stipulated on a case by case basis depending on the nature of a specific issue. When BACBS determines that an issue is resolved, notification is provided and documentation is maintained.

**ii Remediation Data Aggregation**

<b>Remediation-related Data Aggregation and Analysis (including trend identification)</b>	<b>Responsible Party (check each that applies)</b>	<b>Frequency of data aggregation and analysis: (check each that applies)</b>
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
	<input checked="" type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually
	CSHCN RN Waiver Coordinators and <b>BHFLCRAHFLCA</b>	<input type="checkbox"/> Continuously and Ongoing
		<input type="checkbox"/> Other: Specify:

**c. Timelines**

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

<input checked="" type="radio"/>	<b>No</b>
<input type="radio"/>	<b>Yes</b> Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

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## 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*).

<input checked="" type="checkbox"/>	<b>Not applicable – The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.</b>
<input type="checkbox"/>	<b>Applicable – The State imposes additional limits on the amount of waiver services.</b>

*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.*

<input type="checkbox"/>	<b>Limit(s) on Set(s) of Services.</b> 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. <i>Furnish the information specified above.</i>
<input type="checkbox"/>	<b>Prospective Individual Budget Amount.</b> There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. <i>Furnish the information specified above.</i>
<input type="checkbox"/>	<b>Budget Limits by Level of Support.</b> 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. <i>Furnish the information specified above.</i>
<input type="checkbox"/>	<b>Other Type of Limit.</b> The State employs another type of limit. <i>Describe the limit and furnish the information specified above.</i>
<input type="checkbox"/>	

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## 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, HCBS Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

As outlined in the HCBS Statewide Settings Transition Plan, the SMA has completed an initial analysis of the services offered on the Tech Dependent Waiver. The SMA has reported the results of the review of Tech Dependent Waiver providers in Module 1, Attachment #2, Additional Needed Information (Optional) section.

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# Appendix D: Participant-Centered Planning and Service Delivery

## Appendix D-1: Service Plan Development

<b>State Participant-Centered Service Plan Title:</b>	The Plan of Care
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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*):

<input checked="" type="checkbox"/>	<b>Registered nurse, licensed to practice in the State</b>
<input type="checkbox"/>	<b>Licensed practical or vocational nurse, acting within the scope of practice under State law</b>
<input type="checkbox"/>	<b>Licensed physician (M.D. or D.O)</b>
<input type="checkbox"/>	<b>Case Manager</b> (qualifications specified in Appendix C-1/C-3)
<input type="checkbox"/>	<b>Case Manager</b> (qualifications not specified in Appendix C-1/C-3). <i>Specify qualifications:</i>
<input type="checkbox"/>	<b>Social Worker</b> <i>Specify qualifications:</i>
<input checked="" type="checkbox"/>	<b>Other</b> <i>Specify the individuals and their qualifications:</i> RN Waiver Coordinators employed by, or under contract with CSHCN, and 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.  Required experience is five years paid professional experience in the field of pediatric nursing and at least one year experience in utilization management, discharge planning or care coordination.

b. **Service Plan Development Safeguards.**

*Select one:*

<input checked="" type="radio"/>	<b>Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.</b>
<input type="radio"/>	<b>Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.</b> The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. <i>Specify:</i>

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- 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 Plan of Care is developed in conjunction with the recipient, family/or their legal representatives and other individuals of the recipient’s choice. RN Waiver Coordinators describe each of the waiver services and offer the choice between/among waiver services and (available) providers. The waiver recipient, family/or legal representative and other individuals (when appropriate) of the recipient’s choice will be given a waiver brochure describing each of the waiver services for future reference. If the recipient/family has chosen family-directed care, information to assist in the planning process will also be provided. Waiver services are reviewed with the recipient, his or her family/legal representative, and others (when appropriate) by the RN Waiver Coordinator with each Plan of Care update. This waiver does not provide an option for recipients/legal representatives to solely direct the Plan of Care process.

- 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):

1. The Plan of Care is developed in consultation with recipient, his/her family and/or the recipient’s legal representative, the participant’s RN Waiver Coordinator and any other individuals of the waiver recipient’s choice. The recipient, his/her family and/or legal representative will be advised of service needs identified during the assessment process and given the opportunity to accept or decline waiver services offered to address those needs.
  
2. The RN Waiver Coordinator 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:
  - a) Health history including medical technology needs;
  - b) Physicians/clinicians and others involved in the recipient’s care;
  - c) Psychosocial information;
  - d) Functional limitations;
  - e) School and education;
  - f) Therapy and development;
  - g) Current home care services and providers;
  - h) Durable medical equipment providers;

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- i) Immunizations;
  - j) Allergy information;
  - k) Medical related treatments, hospitalizations and outpatient procedures, nutrition and mode of nutritional intake;
  - l) Financial, SSI and private insurance information;
  - m) Recipient needs, risks, preferences, and goals; and
  - n) Any identified health and safety risks.
3. The RN Waiver Coordinators describe all of the services included in the approved waiver. The waiver recipient, family/legal representative and other individuals of the recipient's choice will be given a waiver brochure describing each of the waiver services for future reference. If the recipient and family/legal representative chooses family-directed services, information to assist in the planning process will also be provided. The RN Waiver Coordinator reviews with the recipient, family/legal representative and others, all waiver services with each Plan of Care update.
4. Plan of Care development incorporates input received from the recipient and/or the recipient's legal representative during the home-visit and includes offering the recipient and/or legal representative the choice of waiver providers when more than one provider is available to deliver the services. The recipient and family/legal representative are an integral part of the waiver assessment and planning process. CSHCN continually assess changes in the recipient's family circumstances in order to identify additional needed services and supports that may be necessary.
5. RN Waiver Coordinators are responsible to oversee the coordination of all waiver services. Recipients and families/legal representatives may be referred to other non-waiver services included in the Plan of Care; however, RN Waiver Coordinators are not responsible for ensuring their delivery. When non-waiver services are needed to meet the needs of the recipient, CSHCN advocates and monitors the implementation of these needed non-waiver services.
6. When the needed waiver services are identified, the assignment of service implementation responsibilities will be discussed with the recipient and their family/legal representative. The recipient and their family/legal representative will be informed of the RN Waiver Coordinator's authority for only approving and coordinating waiver services. The RN Waiver Coordinator will support the recipient/family/legal representative to obtain other services but has no authority other than to link, refer or advocate for such services.
7. The Plan of Care must be reviewed and updated by the RN Waiver Coordinator as frequently as necessary to ensure it continues to meet the needs of the waiver recipient and family. Under this waiver, a formal review of the plan is required at least every six months and must be completed by the RN Waiver Coordinator during the calendar month in which it is due. However, because of the ever changing and complex medical and support needs of this waiver target population, Plans of Care are frequently reviewed at intervals of less than six months. For example, formal Plan of Care reviews for new waiver recipients and recipients with extraordinarily complex needs are typically scheduled at four-month rather than six-month intervals.
- Interim Plans of Care may be used when unforeseen circumstances occur and the RN Waiver Coordinator is unable to reassess the recipient's service needs within the specified time frame (at least every six months). This interim allowance will extend services until the formal Plans of Care can be developed with the recipient and/or legal representative/family. An interim Plan of Care will allow up to a maximum three-month extension of the formal plan.

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- 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 Waiver Coordinators 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 recipient and/or family. The State’s primary strategy for mitigating risks is to enroll only skilled licensed/certified providers for waiver services. 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 Waiver Coordinators regularly assess the amount and frequency of services as another method of mitigating identified risks. The RN Waiver Coordinators will assess for and help the recipient/family to identify informal supports available in addition to waiver and State plan supports and services including exploring the Family Directed 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.

Recipients/legal representatives 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 Waiver Coordinators provide any additional information needed to support the participant/legal guardian to make an informed choice. Freedom of choice of available providers is documented by the recipient/legal representative’s signature on the waiver Plan of Care.

- 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):

BACBS has final authority for oversight and approval of all waiver Plans of Care. BACBS conducts retrospective reviews of all new waiver recipients’ plans of care and a sample of continuing recipient’s plans.

- 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:

<input type="radio"/>	<b>Every three months or more frequently when necessary</b>
<input checked="" type="radio"/>	<b>Every six months or more frequently when necessary</b>
<input type="radio"/>	<b>Every twelve months or more frequently when necessary</b>
<input type="radio"/>	<b>Other schedule</b>
	<i>Specify the other schedule:</i>

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- 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*):

<input type="checkbox"/>	<b>Medicaid agency</b>
<input type="checkbox"/>	<b>Operating agency</b>
<input type="checkbox"/>	<b>Case manager</b>
<input checked="" type="checkbox"/>	<b>Other</b>
	<i>Specify:</i>
	CSHCN

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## 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 Waiver Coordinators are responsible for monitoring the implementation of the Plan of Care through a home visit every four to six months based on the complexity of the recipient and family needs. During the care plan development the RN Waiver Coordinators inform participant's/families of all available waiver providers and assist individuals to 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 Waiver Coordinators provide any additional information needed to support the participant/legal guardian to make an informed choice. Freedom of choice of available providers is documented by the recipient/legal representative's signature on the waiver Plan of Care.

Recipient access to services and problems with service delivery is assessed during home visits and interim contacts as initiated by the RN Waiver Coordinator, participant/legal representative or others, and documented in the recipient file. The RN Waiver Coordinators, home health agencies and other providers collaborate to assure services are meeting the needs of the recipient and family. If participant's/families want to change providers at any time, RN Waiver Coordinators facilitate the participant's/family's freedom of choice of provider. Recipients who receive less than one waiver service or case management activity per quarter are contacted at least quarterly to assess needs and risks. RN Waiver Coordinators assist the recipient and family in solving issues and problems through phone calls, scheduling case conferences and meetings with providers. Recipients/families are encouraged to call the RN Waiver Coordinators 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.

Formal evaluation of utilization of waiver services is done annually by BACBS to assure that the RN Waiver Coordinators 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.

Methods for reporting critical incidents to BACBS include:

- The Standard Operating Procedure for Critical Incidents and Events Reporting Requirements; and
- Meetings between BACBS and CSHCN which are held quarterly and more frequently as necessary to discuss problems and solutions.

- b. **Monitoring Safeguards.** *Select one:*

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<b>X</b>	<b>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.</b>
<b>O</b>	<p><b>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.</b></p> <p>The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. <i>Specify:</i></p>

**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.*

<b>Performance Measure:</b>	<i>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 <u>(Numerator=# of Plans of care that address all assessed needs; Denominator=Total # of Plans reviewed)</u></i>
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State:	
Effective Date	

<b>Data Source</b> (Select one) (Several options are listed in the on-line application):			
If 'Other' is selected, specify:			
<i>Recipient case file, On-site Record reviews</i>			
	<b>Responsible Party for data collection/generation</b> (check each that applies)	<b>Frequency of data collection/generation:</b> (check each that applies)	<b>Sampling Approach</b> (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	95% Confidence Level, 5% Margin of Error
	CSHCN RN Waiver Coordinators	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

**Add another Data Source for this performance measure**

**Data Aggregation and Analysis**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies)	<b>Frequency of data aggregation and analysis:</b> (check each that applies)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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.**

State:	
Effective Date	

**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.

<b>Performance Measure:</b>	Number and percentage of recipients for whom an assessment was completed prior to updating the Plan of Care. <i>(Numerator = # of assessment's completed prior to care plan updates; Denominator = total # of Plans of Care reviewed)</i>		
<b>Data Source</b> (Select one) (Several options are listed in the on-line application): Other			
If 'Other' is selected, specify:			
<b>Reassessment form</b>			
	<b>Responsible Party for data collection/generation</b> (check each that applies)	<b>Frequency of data collection/generation:</b> (check each that applies)	<b>Sampling Approach</b> (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval =
	<input checked="" type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	95% Confidence Level, 5% Margin of Error
	CSHCN RN Waiver Coordinators	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

**Add another Data Source for this performance measure**

**Data Aggregation and Analysis**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies)	<b>Frequency of data aggregation and analysis:</b> (check each that applies)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

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<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

<b>Performance Measure:</b>	Number and percentage of recipient case files containing evidence that Plans of Care are documented on the approved Plan of Care form which was signed by the recipient/legal representative before waiver services were provided. <u>(Numerator=Case files in compliance; Denominator=Total Case files reviewed)</u>		
<b>Data Source</b> (Select one) (Several options are listed in the on-line application): other	If 'Other' is selected, specify:		
<b>On-site Record reviews</b>			
	<b>Responsible Party for data collection/generation</b> (check each that applies)	<b>Frequency of data collection/generation:</b> (check each that applies)	<b>Sampling Approach</b> (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval =
	<input checked="" type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	95% Confidence Level, 5% Margin of Error
	CSHCN RN Waiver Coordinators	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

**Add another Data Source for this performance measure**

**Data Aggregation and Analysis**

<b>Responsible Party for data aggregation and analysis</b> (check each that)	<b>Frequency of data aggregation and analysis:</b> (check each that)
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State:	
Effective Date	

<i>applies</i>	<i>applies</i>
<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>
<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>
<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>
<input type="checkbox"/> <i>Other</i> <i>Specify:</i>	<input checked="" type="checkbox"/> <i>Annually</i>
	<input type="checkbox"/> <i>Continuously and Ongoing</i>
	<input type="checkbox"/> <i>Other</i> <i>Specify:</i>

**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.

<b>Performance Measure:</b>	Number and percentage <del>of changes to of</del> Plans of Care <del>which are updated/revised</del> when warranted by changes in the recipients’ and/or their legal representatives’/families’ needs. <u>(Numerator = # care plan revisions completed following a change in need; Denominator = total # of Plan of Care changes that were required)</u>		
<b>Data Source</b> (Select one) (Several options are listed in the on-line application): Other	If ‘Other’ is selected, specify:		
<b>On-Site Record reviews</b>			
	<b>Responsible Party for data collection/generation</b> (check each that applies)	<b>Frequency of data collection/generation:</b> (check each that applies)	<b>Sampling Approach</b> (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence

State:	
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			<i>Interval =</i>
	<input checked="" type="checkbox"/> <i>Other Specify:</i>	<input checked="" type="checkbox"/> <i>Annually</i>	<i>95% Confidence Level, 5% Margin of Error</i>
	<i>CSHCN RN Waiver Coordinators</i>	<input type="checkbox"/> <i>Continuously and Ongoing</i>	<input type="checkbox"/> <i>Stratified: Describe Group:</i>
		<input type="checkbox"/> <i>Other Specify:</i>	
			<input type="checkbox"/> <i>Other Specify:</i>

**Add another Data Source for this performance measure**

**Data Aggregation and Analysis**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies)</i>	<b>Frequency of data aggregation and analysis:</b> <i>(check each that applies)</i>
<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>
<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>
<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>
<input type="checkbox"/> <i>Other Specify:</i>	<input checked="" type="checkbox"/> <i>Annually</i>
	<input type="checkbox"/> <i>Continuously and Ongoing</i>
	<input type="checkbox"/> <i>Other Specify:</i>

<b>Performance Measure:</b>	<i>Number and percentage of Plans of Care which are reviewed at least every six months as specified in the waiver application. (Numerator = # of Plans of Care in compliance; Denominator = total # of care plans reviewed)</i>
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**Data Source** (Select one) (Several options are listed in the on-line application): *Record review, off-site*

*If 'Other' is selected, specify:*

	<b>Responsible Party for data collection/generation</b> <i>(check each that applies)</i>	<b>Frequency of data collection/generation:</b> <i>(check each that applies)</i>	<b>Sampling Approach</b> <i>(check each that applies)</i>
	<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input type="checkbox"/> <i>100% Review</i>
	<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input checked="" type="checkbox"/> <i>Less than 100% Review</i>

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Effective Date	

	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	95% Confidence Level, 5% Margin of Error
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

**Add another Data Source for this performance measure**

**Data Aggregation and Analysis**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies)</i>	<b>Frequency of data aggregation and analysis:</b> <i>(check each that applies)</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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.

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<b>Performance Measure:</b>	Number and percentage of recipients who received services in accordance with their Plan of Care including the type, amount, frequency and duration. <u>(Numerator = # of plans of care where amount/frequency/duration for all waiver services were provided; Denominator = # of care plans reviewed)</u>
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**Data Source** (Select one) (Several options are listed in the on-line application): Other  
 If 'Other' is selected, specify:

<b>On-Site Record reviews, claims data.</b>			
	<b>Responsible Party for data collection/generation</b> (check each that applies)	<b>Frequency of data collection/generation:</b> (check each that applies)	<b>Sampling Approach</b> (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval =
	<input checked="" type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	95% Confidence Level, 5% Margin of Error
	CSHCN RN Waiver Coordinators	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

**Add another Data Source for this performance measure**

**Data Aggregation and Analysis**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies)	<b>Frequency of data aggregation and analysis:</b> (check each that applies)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

State:	
Effective Date	

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.

<b>Performance Measure:</b>	Number and percentage of recipients who are offered the choice between nursing facility care and Tech Dependent Waiver services. <u>(Numerator = # of recipients where choice of service delivery was documented; Denominator = total # of recipients reviewed)</u>		
<b>Data Source</b> (Select one) (Several options are listed in the on-line application): Other			
If 'Other' is selected, specify: Initial and Annual Level of Care/Freedom of Choice certification			
	<b>Responsible Party for data collection/generation</b> (check each that applies)	<b>Frequency of data collection/generation:</b> (check each that applies)	<b>Sampling Approach</b> (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval =
	<input checked="" type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	95% Confidence Level, 5% Margin of Error
	CSHCN RN Waiver Coordinators	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Add another Data Source for this performance measure

State:	
Effective Date	

**Data Aggregation and Analysis**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies)	<b>Frequency of data aggregation and analysis:</b> (check each that applies)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

<b>Performance Measure:</b>	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. <u>(Numerator = # of recipients who were offered choice of service and providers when available; Denominator = # of recipients enrolled in the waiver)</u>
-----------------------------	---

**Data Source** (Select one) (Several options are listed in the on-line application): Records review, off-site  
If 'Other' is selected, specify:

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

State:	
Effective Date	

**Add another Data Source for this performance measure**

**Data Aggregation and Analysis**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies)</i>	<b>Frequency of data aggregation and analysis:</b> <i>(check each that applies)</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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.*

BACBS conducts an annual review of the Tech Dependent Waiver program for each of the five waiver years. At a minimum, one comprehensive review will be conducted during this five year cycle. The other annual reviews will be focused reviews. The criteria for the focused reviews will be determined from review findings as well as other issues that develop during the review year.

**b. Methods for Remediation/Fixing Individual Problems**

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

Individual issues identified that affect the health and welfare of individual recipients are addressed immediately. Issues that are less immediate are corrected within designated time frames and are documented through BACBS’ final review report. These time frames are outlined in standard operating procedures or protocols or are stipulated on a case by case basis depending on the nature of a specific issue. When BACBS determines that an issue is resolved, notification is provided and documentation is maintained.

**ii. Remediation Data Aggregation**

State:	
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<b>Remediation-related Data Aggregation and Analysis (including trend identification)</b>	<b>Responsible Party (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
	<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
		<input type="checkbox"/> Continuously and Ongoing
		<input type="checkbox"/> 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.*

<input checked="" type="radio"/>	No
<input type="radio"/>	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	

# Appendix E: Participant Direction of Services

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

<input checked="" type="checkbox"/>	<b>Yes. This waiver provides participant direction opportunities.</b> Complete the remainder of the Appendix.
<input type="checkbox"/>	<b>No. This waiver does not provide participant direction opportunities.</b> 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):

<input type="checkbox"/>	<b>Yes. The State requests that this waiver be considered for Independence Plus designation.</b>
<input checked="" type="checkbox"/>	<b>No. Independence Plus designation is not requested.</b>

## 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.

Family Directed Services means service delivery that is provided through a non-agency based provider. Under this method, families hire individual employees to perform certain services. The family is then responsible to manage the employee(s) including providing supervision, training, scheduling and assuring time sheet accuracy.

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

If the needs assessment process indicates the family would benefit from Family Directed Support, CSHCN will refer them to a provider qualified to provide the knowledge base for successfully directing their services.

The family hires and schedules the family directed providers for services authorized by CSHCN RN Waiver Coordinators. The family is responsible to review all employee timesheets for accuracy before submitting them to the FMS agency for payment. The FMS will send the employer and CSHCN RN Waiver Coordinators information at least monthly detailing the units of services used and the number of units remaining.

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

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Appendix E: Participant Direction of Services  
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<b>X</b>	<b>Participant – Employer Authority.</b> As specified in <i>Appendix E-2, Item a</i> , 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.
<input type="radio"/>	<b>Participant – Budget Authority.</b> As specified in <i>Appendix E-2, Item b</i> , 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.
<input type="radio"/>	<b>Both Authorities.</b> The waiver provides for both participant direction opportunities as specified in <i>Appendix E-2</i> . Supports and protections are available for participants who exercise these authorities.

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

<input checked="" type="checkbox"/>	Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
<input type="checkbox"/>	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.
<input type="checkbox"/>	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*):

<input type="checkbox"/>	Waiver is designed to support only individuals who want to direct their services.
<input checked="" type="checkbox"/>	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.
<input type="checkbox"/>	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 Waiver Coordinators will provide the recipient/family/legal representative with a description of the Family Directed Services model including written information detailing the services and providers available for Financial Management Services and Family Directed Support. The RN Waiver Coordinators will also explain the option to have all or a part of their authorized services delivered through the Family Directed 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 recipient/family to make an informed choice about their options. This information also outlines the benefits, potential liabilities and participant responsibilities if the option of Family Directed Services is chosen.

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

<input type="checkbox"/>	The State does not provide for the direction of waiver services by a representative.
<input checked="" type="checkbox"/>	The State provides for the direction of waiver services by representatives. Specify the representatives who may direct waiver services: ( <i>check each that applies</i> ):
<input checked="" type="checkbox"/>	Waiver services may be directed by a legal representative of the participant.

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<b>X</b>	<p><b>Waiver services may be directed by a non-legal representative freely chosen by an adult participant.</b> 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:</p> <p>Although RN Waiver Coordinators encourage the parent or primary caregiver to initiate the process of obtaining limited power of attorney or legal guardianship prior to the recipient turning 18 years of age, the State allows a parent or primary caregiver with whom the recipient resides, but has not yet obtained a limited power of attorney for medical decision-making or formal legal guardianship, to continue to direct waiver services when the person is freely chosen by the adult participant. RN Waiver Coordinators monitor to ensure that the representative functions in the best interest of the participant. In addition, individuals who direct services on behalf of waiver participants cannot be paid to provide services.</p>
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**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
Family Support Services	<b>X</b>	<input type="checkbox"/>
In-Home Feeding Therapy	<b>X</b>	<input type="checkbox"/>
Skilled Nursing Respite Care	<b>X</b>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

**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:*

<b>X</b>	<p><b>Yes. Financial Management Services are furnished through a third party entity.</b> <i>(Complete item E-1-i).</i>                  Specify whether governmental and/or private entities furnish these services. <i>Check each that applies:</i></p>
<input type="checkbox"/>	<b>Governmental entities</b>
<b>X</b>	<b>Private entities</b>
<input type="radio"/>	<p><b>No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.</b> <i>Do not complete Item E-1-i.</i></p>

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

<b>X</b>	<p>FMS are covered as the waiver service specified in Appendix C-1/C-3  <b>The waiver service entitled:</b></p>	Financial Management Services
<input type="radio"/>	<p><b>FMS are provided as an administrative activity.</b>  <i>Provide the following information</i></p>	

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<b>i.</b>	<p><b>Types of Entities:</b> Specify the types of entities that furnish FMS and the method of procuring these services:</p> <p>Financial Management Agencies enrolled as Medicaid providers complying with state and local licensing, accreditation and certification requirements per Utah Code R-58-26a. The state enrolls all willing and qualified providers.</p>																								
<b>ii.</b>	<p><b>Payment for FMS.</b> Specify how FMS entities are compensated for the administrative activities that they perform:</p> <p>Financial Management Agencies do not perform administrative activities. Under this waiver, FMS will be paid through the Medicaid fee-for-service system.</p>																								
<b>iii.</b>	<p><b>Scope of FMS.</b> Specify the scope of the supports that FMS entities provide (<i>check each that applies</i>):</p> <p>Supports furnished when the participant is the employer of direct support workers:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;"><input checked="" type="checkbox"/></td> <td><b>Assists participant in verifying support worker citizenship status</b></td> </tr> <tr> <td style="text-align: center;"><input checked="" type="checkbox"/></td> <td><b>Collects and processes timesheets of support workers</b></td> </tr> <tr> <td style="text-align: center;"><input checked="" type="checkbox"/></td> <td><b>Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance</b></td> </tr> <tr> <td style="text-align: center;"><input checked="" type="checkbox"/></td> <td> <p><b>Other</b> <i>Specify:</i></p> <p>Assist the employer in obtaining documentation of BCI check, CPR certification, professional malpractice insurance and current license/certification and maintain copies of these documents for a period not less than 3 years. Send the employer and CSHCN information at least monthly detailing the units of services used and the number of units remaining</p> </td> </tr> </table> <p>Supports furnished when the participant exercises budget authority:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;"><input type="checkbox"/></td> <td><b>Maintains a separate account for each participant’s participant-directed budget</b></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td><b>Tracks and reports participant funds, disbursements and the balance—of participant funds</b></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td><b>Processes and pays invoices for goods and services approved in the service plan</b></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td><b>Provide participant with periodic reports of expenditures and the status of the participant-directed budget</b></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td> <p><b>Other services and supports</b> <i>Specify:</i></p> </td> </tr> </table> <p>Additional functions/activities:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;"><input checked="" type="checkbox"/></td> <td><b>Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency</b></td> </tr> <tr> <td style="text-align: center;"><input checked="" type="checkbox"/></td> <td><b>Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency</b></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td><b>Provides other entities specified by the State with periodic reports of expenditures</b></td> </tr> </table>	<input checked="" type="checkbox"/>	<b>Assists participant in verifying support worker citizenship status</b>	<input checked="" type="checkbox"/>	<b>Collects and processes timesheets of support workers</b>	<input checked="" type="checkbox"/>	<b>Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance</b>	<input checked="" type="checkbox"/>	<p><b>Other</b> <i>Specify:</i></p> <p>Assist the employer in obtaining documentation of BCI check, CPR certification, professional malpractice insurance and current license/certification and maintain copies of these documents for a period not less than 3 years. Send the employer and CSHCN information at least monthly detailing the units of services used and the number of units remaining</p>	<input type="checkbox"/>	<b>Maintains a separate account for each participant’s participant-directed budget</b>	<input type="checkbox"/>	<b>Tracks and reports participant funds, disbursements and the balance—of participant funds</b>	<input type="checkbox"/>	<b>Processes and pays invoices for goods and services approved in the service plan</b>	<input type="checkbox"/>	<b>Provide participant with periodic reports of expenditures and the status of the participant-directed budget</b>	<input type="checkbox"/>	<p><b>Other services and supports</b> <i>Specify:</i></p>	<input checked="" type="checkbox"/>	<b>Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency</b>	<input checked="" type="checkbox"/>	<b>Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency</b>	<input type="checkbox"/>	<b>Provides other entities specified by the State with periodic reports of expenditures</b>
<input checked="" type="checkbox"/>	<b>Assists participant in verifying support worker citizenship status</b>																								
<input checked="" type="checkbox"/>	<b>Collects and processes timesheets of support workers</b>																								
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<input checked="" type="checkbox"/>	<p><b>Other</b> <i>Specify:</i></p> <p>Assist the employer in obtaining documentation of BCI check, CPR certification, professional malpractice insurance and current license/certification and maintain copies of these documents for a period not less than 3 years. Send the employer and CSHCN information at least monthly detailing the units of services used and the number of units remaining</p>																								
<input type="checkbox"/>	<b>Maintains a separate account for each participant’s participant-directed budget</b>																								
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<input checked="" type="checkbox"/>	<b>Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency</b>																								
<input type="checkbox"/>	<b>Provides other entities specified by the State with periodic reports of expenditures</b>																								

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		<b>and the status of the participant-directed budget</b>
	<input type="checkbox"/>	<b>Other</b> <i>Specify:</i>
<b>iv.</b>		<p><b>Oversight of FMS Entities.</b> 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.</p> <p>With each reassessment/Plan of Care 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 under utilization, the RN Waiver Coordinator will adjust service authorization based on assessed need and input from the recipient’s legal representative. Additionally, billing statements from the FMS and utilization data/expenditure data will be reviewed by the Medical Assistance Unit as part of its post-payment record review process. Discrepancies in service utilization and claims data will be resolved if over/under payments have occurred.</p>

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**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*):

<input type="checkbox"/>	<p><b>Case Management Activity.</b> Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.</p> <p><i>Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:</i></p>
<input checked="" type="checkbox"/>	<p><b>Waiver Service Coverage.</b> 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):</p>
	<b>Information and Assistance Provided through this Waiver Service Coverage</b>
(list of services from Appendix C-1/C-3)	<input type="checkbox"/>
<input type="checkbox"/>	<p><b>Administrative Activity.</b> Information and assistance in support of participant direction are furnished as an administrative activity.</p> <p><i>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:</i></p>

**k. Independent Advocacy** (*select one*).

<input checked="" type="checkbox"/>	<b>No. Arrangements have not been made for independent advocacy.</b>
<input type="checkbox"/>	<p><b>Yes.</b> Independent advocacy is available to participants who direct their services.</p> <p><i>Describe the nature of this independent advocacy and how participants may access this advocacy:</i></p>

**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/legal representative voluntarily terminates Family Directed Services, an RN Waiver Coordinator will re-evaluate their service needs and assist the participant/legal representative to find an agency or individual provider willing and available to provide the needed services. The transition to a new provider will include all aspects of the Plan of Care development including timeliness and the choice of willing and available providers. Service continuity is ensured and health and safety assured during the transition.

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- 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.

If an RN Waiver Coordinator determines that the participant/legal representative is unable to adequately perform and manage Family Directed Services to the extent that health and safety is jeopardized, the Plan of Care will be revised to address the agency-based services needed to keep the recipient safe and in the community. The transition to agency-based care will include all aspects of Plan of Care development including input from the participant/legal representative 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, family directed 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 health and welfare cannot be assured during the transition, interim nursing facility placement may be considered. If the recipient/legal representative disagrees with the involuntary termination of family directed support services, a written notice of agency action and information on hearing rights will be given to the recipient/legal representative by the RN Waiver Coordinator.

- 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.

<b>Table E-1-n</b>		
	<b>Employer Authority Only</b>	<b>Budget Authority Only or Budget Authority in Combination with Employer Authority</b>
<b>Waiver Year</b>	<b>Number of Participants</b>	<b>Number of Participants</b>
<b>Year 1</b>	20	
<b>Year 2</b>	25	
<b>Year 3</b>	30	
<b>Year 4</b> (only appears if applicable based on Item 1-C)	35	
<b>Year 5</b> (only appears if applicable based on Item 1-C)	35	

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## 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:*

<input type="checkbox"/>	<p><b>Participant/Co-Employer.</b> 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.</p> <p>Specify the types of agencies (a.k.a., “agencies with choice”) that serve as co-employers of participant-selected staff:</p>
<input checked="" type="checkbox"/>	<p><b>Participant/Common Law Employer.</b> 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.</p>

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:*

<input checked="" type="checkbox"/>	<b>Recruit staff</b>
<input type="checkbox"/>	<b>Refer staff to agency for hiring (co-employer)</b>
<input type="checkbox"/>	<b>Select staff from worker registry</b>
<input checked="" type="checkbox"/>	<b>Hire staff (common law employer)</b>
<input checked="" type="checkbox"/>	<b>Verify staff qualifications</b>
<input checked="" type="checkbox"/>	<p><b>Obtain criminal history and/or background investigation of staff</b> Specify how the costs of such investigations are compensated:</p> <p>The employee will be responsible to pay the costs associated with the background investigation.</p>
<input type="checkbox"/>	<b>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.</b>
<input checked="" type="checkbox"/>	<b>Determine staff duties consistent with the service specifications in Appendix C-1/C-3.</b>
<input type="checkbox"/>	<b>Determine staff wages and benefits subject to applicable State limits</b>
<input checked="" type="checkbox"/>	<b>Schedule staff</b>
<input checked="" type="checkbox"/>	<b>Orient and instruct-staff in duties</b>
<input checked="" type="checkbox"/>	<b>Supervise staff</b>
<input checked="" type="checkbox"/>	<b>Evaluate staff performance</b>
<input checked="" type="checkbox"/>	<b>Verify time worked by staff and approve time sheets</b>
<input checked="" type="checkbox"/>	<b>Discharge staff (common law employer)</b>

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<input type="checkbox"/>	<b>Discharge staff from providing services (co-employer)</b>
<input type="checkbox"/>	<b>Other</b> 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:*

<input type="checkbox"/>	<b>Reallocate funds among services included in the budget</b>
<input type="checkbox"/>	<b>Determine the amount paid for services within the State’s established limits</b>
<input type="checkbox"/>	<b>Substitute service providers</b>
<input type="checkbox"/>	<b>Schedule the provision of services</b>
<input type="checkbox"/>	<b>Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3</b>
<input type="checkbox"/>	<b>Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3</b>
<input type="checkbox"/>	<b>Identify service providers and refer for provider enrollment</b>
<input type="checkbox"/>	<b>Authorize payment for waiver goods and services</b>
<input type="checkbox"/>	<b>Review and approve provider invoices for services rendered</b>
<input type="checkbox"/>	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.

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**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.

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

<input type="radio"/>	<b>Modifications to the participant directed budget must be preceded by a change in the service plan.</b>
<input type="radio"/>	<p><b>The participant has the authority to modify the services included in the participantdirected budget without prior approval.</b></p> <p>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:</p>

**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:

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## 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.

Prior to making the choice of institutional care or home and community-based care, the individual or his/her legal representative will be informed if there is a waiting list for the waiver.

An applicant/recipient 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.

CSHCN will offer 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.
- The preliminary Plan of Care has been agreed to by all parties.

If waiver services are chosen, the recipient/legal representative 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 or his/her legal representative will be informed verbally and in writing by the RN Waiver Coordinators 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/legal representative 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.

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In addition to any and all hearing rights detailed in R410-14, eligible waiver applicants/recipients will be given an opportunity for a hearing, upon written request, if:

1. They are not offered the choice of nursing facility care or community-based (waiver) services;
2. Their scope, frequency and/or duration of waiver services are reduced/suspended or terminated;
3. They are denied the waiver services of their choice; or
4. They are 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 by CSHCN. Included in the formal written notice are specified timeframes for filing an appeal and informing participant/legal representative that services may continue during the appeal process. However, if as a result of the hearing, the action taken by the SMA is found to be correct, the participant/legal representative will be responsible to pay the costs of the services provided during the appeal period. Content, of the notices, conforms to Federal Regulation 42 CFR 431. Documentation of these notices is maintained in the recipient file.

Participant/legal representatives are referred by CSHCN to contact the Medicaid constituent services' representative to assist them with pursuing a fair hearing regarding an adverse action taken by the waiver program. RN Waiver Coordinators will assist participant/legal representatives with grievances and fair hearings concerning Medicaid State plan or private insurance benefits.

Annually, the participant/legal representative receives written information regarding their rights to a fair hearing and notification is documented on the Notice of Institutional Options and Rights to a Fair Hearing form.

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## Appendix F-2: Additional Dispute Resolution Process

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

<input checked="" type="checkbox"/>	<b>No. This Appendix does not apply</b>
<input type="checkbox"/>	<b>Yes. The State operates an additional dispute resolution process</b>

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

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## Appendix F-3: State Grievance/Complaint System

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

<input type="radio"/>	<b>No. This Appendix does not apply</b>
<input checked="" type="radio"/>	<b>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>

**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.
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**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).

<p>The State Medicaid Agency operates an internal complaint/grievance system under the direction of the State Medicaid Director's office. The Medicaid constituent services' representative receives complaints from clients, providers, family or other community or state 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.</p> <p>a) Types of complaints received may include 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 Tech Dependent Waiver and other Medicaid program requests.</p> <p>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.</p> <p>c) If the complaint/grievance is not resolved at the constituent service level the waiver recipient/family/legal representative 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 involves Civil Rights or discrimination situations, the recipient/legal representative are referred to the Regional Civil Rights Office to be reported in writing.</p>
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The Medicaid Member Guide informs the recipient/legal representative of their right to contact the Medicaid constituent services line to discuss issues or concerns. Additionally, the RN Waiver Coordinators provide written materials to the recipient/legal representative informing them of who to contact with grievances or complaints. Contacts include the names and numbers of the specific RN Waiver Coordinator, the Medicaid agency constituent services' representative, the Medicaid managed care health plan (when applicable) and their home health agency.

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# Appendix G: Participant Safeguards

## Appendix G-1: Response to Critical Events or Incidents

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

<input checked="" type="radio"/>	<b>Yes. The State operates a Critical Event or Incident Reporting and Management Process</b> <i>(complete Items b through e)</i>
<input type="radio"/>	<b>No. This Appendix does not apply</b> <i>(do not complete Items b through e).</i> <i>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.</i>

- 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 Utah State law, Utah Code Annotated Sections 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 waiver coordinators and providers, all of whom are professionally licensed and certified, 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, BACBS requires the recipient, their families, their legal representatives and/or their providers to notify CSHCN by phone, email or fax within 24 hours of the occurrence of all critical incidents. Depending on the nature/severity of the critical incident, CSHCN may investigate and remediate the incident internally or forward to BACBS for investigation/remediation. In addition, CSHCN 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 BACBS within ten business days of the report of the incident. BACBS provides final oversight of the investigations of all critical incidents. Critical incidents/events include:

- a) Abuse or Neglect that is either alleged or substantiated which results in the recipient's admission to a hospital;
- b) Attempted Suicides causing the recipient to be admitted to a hospital;
- c) Human Rights Violations;

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- d) Incidents Involving the Media or Referred by Elected Officials;
- e) Medication Errors that result in the participant's admission to a hospital;
- f) Missing Persons;
- g) Unexpected Deaths;
- h) Unexpected Hospitalization;
- i) Waste, Fraud or Abuse of Medicaid Funds; and/or
- j) Compromised Working or Living Environment.

**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, CSHCN staff will provide information to recipients/families/legal representatives related to laws and protections from abuse, neglect and exploitation. Under State law (Utah Code Annotated Sections 62-A-4a-403 Part 4 Child Abuse or Neglect Reporting Requirements and 62-A-3-305 Adult Reporting Requirement) professionals and the public are required to report instances of abuse, neglect and exploitation.

In addition, Family Directed Support providers will offer information and instruct recipient/families/legal representatives 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.

BACBS is the entity that receives reports of level one incidents. Within ten days of reporting these types of incidents to BACBS, CSHCN staff investigates the incident and submits 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.

BACBS 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 Plan of Care and/or budget have been made, if any systemic issues were identified and a plan to address systemic issues developed. BACBS then completes its portion of the Critical Incident Investigation document which includes a summary of

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the incident, remediation activities and BACBS findings and recommendations. At the conclusion of the investigation, recipients, their families, and/or their legal representatives are informed in writing of the investigation results within two weeks of the closure of the case by BACBS 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.

BACBS 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 BACBS critical incident data base. This information is analyzed and an annual report is submitted to the State Medicaid Director and CSHCN which describes the number of incidents by category, number of incidents that resulted in corrective action by CSHCN 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.

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**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.)*

<input checked="" type="radio"/>	<p><b>The State does not permit or prohibits the use of restraints</b></p> <p>Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:</p> <p>The Divisions of Child and Family Services and Adult and Aging Services receive referrals from professionals and the public when suspected incidents of inappropriate restraint or seclusion are identified.</p> <p>BACBS monitors for the use of any restraints or seclusion during annual formal reviews. BACBS reviews recipient records and conducts interviews with recipients/families/legal representatives to identify the use of restraints or seclusion.</p> <p>CSHCN is also responsible for ongoing monitoring of the recipients' health and welfare including ensuring that restraints or seclusion is not utilized. This is accomplished through home visits and telephone contacts with family members, legal representatives and providers. Face to face visits with recipients occur at a minimum of every six months.</p>
<input type="radio"/>	<p><b>The use of restraints is permitted during the course of the delivery of waiver services.</b></p> <p>Complete Items G-2-a-i and G-2-a-ii:</p>

**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**

<input checked="" type="radio"/>	<p><b>The State does not permit or prohibits the use of restrictive interventions</b></p> <p>Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:</p> <p>The Divisions of Child and Family Services and Adult and Aging Services receive referrals from professionals and the public when suspected incidents of inappropriate restrictive</p>
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	<p>interventions are identified.</p> <p>BACBS monitors for the use of any restrictive interventions during annual formal reviews. BACBS reviews recipient records and conducts interviews with recipients/families/legal representatives to identify the use of restrictive interventions.</p> <p>CSHCN is responsible for ongoing monitoring of the recipients' health and welfare including ensuring that restrictive interventions are not utilized. This is accomplished through home visits and telephone contacts with family members, legal representatives and providers. Face to face visits with recipients occur at a minimum of every six months.</p>
○	<p><b>The use of restrictive interventions is permitted during the course of the delivery of waiver services.</b> Complete Items G-2-b-i and G-2-b-ii.</p>

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- 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.)*

<input type="radio"/>	<b>The State does not permit or prohibits the use of seclusion</b> Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:
<input type="radio"/>	<b>The use of seclusion is permitted during the course of the delivery of waiver services.</b> 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:

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## 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:

<input checked="" type="radio"/>	<b>No. This Appendix is not applicable</b> <i>(do not complete the remaining items)</i>
<input type="radio"/>	<b>Yes. This Appendix applies</b> <i>(complete the remaining items)</i>

**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:*

<input type="radio"/>	Not applicable <i>(do not complete the remaining items)</i>
<input type="radio"/>	<b>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.</b> <i>(complete the remaining items)</i>

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

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

<input type="radio"/>	<p><b>Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).</b> <i>Complete the following three items:</i></p> <p>(a) Specify State agency (or agencies) to which errors are reported:</p> <p>_____</p> <p>(b) Specify the types of medication errors that providers are required to <i>record</i>:</p> <p>_____</p> <p>(c) Specify the types of medication errors that providers must <i>report</i> to the State:</p> <p>_____</p>
<input type="radio"/>	<p><b>Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.</b></p> <p>Specify the types of medication errors that providers are required to record:</p> <p>_____</p>

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.

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**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:***

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**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.

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

**Add another Data Source for this performance measure**

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**Data Aggregation and Analysis**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies)	<b>Frequency of data aggregation and analysis:</b> (check each that applies)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
CSHCN RN Waiver Coordinators and BHFLCRA	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

<b>Performance Measure:</b>	<b><u>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).</u></b>
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**Data Source** (Select one) (Several options are listed in the on-line application): Other  
If 'Other' is selected, specify:

<b>On-site Record reviews, Annual Critical Incident reports</b>			
	<b>Responsible Party for data collection/generation</b> (check each that applies)	<b>Frequency of data collection/generation:</b> (check each that applies)	<b>Sampling Approach</b> (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input checked="" type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	
	CSHCN RN Waiver Coordinators	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

**Add another Data Source for this performance measure**

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**Data Aggregation and Analysis**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies)	<b>Frequency of data aggregation and analysis:</b> (check each that applies)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

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

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

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

<b>Performance Measure:</b>	<b>Number and percentage of incidents/events that met the SMA critical incident criteria which were reported to BACBS. (Numerator = # of incidents in compliance; Denomintor = total # of reportable incidents)</b>		
<b>Data Source</b> (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		
	<b>Responsible Party for data collection/generation</b> (check each that applies)	<b>Frequency of data collection/generation:</b> (check each that applies)	<b>Sampling Approach</b> (check each that applies)

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	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval =
	<input checked="" type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	<u>95% Confidence Level, 5% Margin of Error</u>
	CSHCN RN Waiver Coordinators	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

**Add another Data Source for this performance measure**

**Data Aggregation and Analysis**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies)	<b>Frequency of data aggregation and analysis:</b> (check each that applies)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

<b>Performance Measure:</b>	<b>Number and percentage of incidents for which prevention strategies were developed and implemented when warranted. <u>(Numerator = # of incidents with prevention developed and implemented; Denominator = total # of reportable incidents)</u></b>		
<b>Data Source (Select one) (Several options are listed in the on-line application):</b> Other			
If 'Other' is selected, specify:			
<b>On-site Record reviews, Annual Critical Incident reports</b>			
	<b>Responsible Party for data collection/generation</b> (check each that applies)	<b>Frequency of data collection/generation:</b> (check each that applies)	<b>Sampling Approach</b> (check each that applies)

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	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval =
	<input checked="" type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	95% Confidence Level, 5% Margin of Error
	CSHCN RN Waiver Coordinators	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

**Add another Data Source for this performance measure**

**Data Aggregation and Analysis**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies)	<b>Frequency of data aggregation and analysis:</b> (check each that applies)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

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

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

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

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<b>Performance Measure:</b>	<b><u>Number and Percentage of incidents involving restrictive interventions (including restraints &amp; seclusion) that are reported and investigated. (Numerator = # of incidents investigated; Denominator = # of incidents identified requiring review)</u></b>
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**Data Source** (Select one) (Several options are listed in the on-line application): Other  
 If 'Other' is selected, specify:

<b>On-site Record reviews, Annual Critical Incident reports</b>			
	<b>Responsible Party for data collection/generation</b> (check each that applies)	<b>Frequency of data collection/generation:</b> (check each that applies)	<b>Sampling Approach</b> (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval =
	<input checked="" type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	
	CSHCN RN Waiver Coordinators	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

**Add another Data Source for this performance measure**

**Data Aggregation and Analysis**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies)	<b>Frequency of data aggregation and analysis:</b> (check each that applies)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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- 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.

<b>Performance Measure:</b>	<b>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)</b>		
<b>Data Source (Select one) (Several options are listed in the on-line application):</b> Other			
If 'Other' is selected, specify:			
<b>On-site Record reviews</b>			
	<b>Responsible Party for data collection/generation (check each that applies)</b>	<b>Frequency of data collection/generation: (check each that applies)</b>	<b>Sampling Approach (check each that applies)</b>
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input checked="" type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	
	CSHCN RN Waiver Coordinators	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Add another Data Source for this performance measure

**Data Aggregation and Analysis**

<b>Responsible Party for data aggregation and</b>	<b>Frequency of data aggregation and</b>
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State:	
Effective Date	

<b>analysis</b> (check each that applies)	<b>analysis:</b> (check each that applies)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

<b>Performance Measure:</b>	<b>Number and percentage of recipients' legal representatives/families that were provided with their RN Waiver Coordinator's phone number and the phone numbers for APS or CPS as appropriate. (Numerator = # of recipients provided with APS/CPS contact information; Denominator = total # of recipients reviewed)</b>
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**Data Source** (Select one) (Several options are listed in the on-line application): Other

If 'Other' is selected, specify:

**On-site Record reviews**

	<b>Responsible Party for data collection/generation</b> (check each that applies)	<b>Frequency of data collection/generation:</b> (check each that applies)	<b>Sampling Approach</b> (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input checked="" type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	
	CSHCN RN Waiver Coordinators	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Add another Data Source for this performance measure

**Data Aggregation and Analysis**

<b>Responsible Party for</b>	<b>Frequency of data</b>
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State:	
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<i><b>data aggregation and analysis</b></i> <i>(check each that applies)</i>	<i><b>aggregation and analysis:</b></i> <i>(check each that applies)</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

Referrals are made to law enforcement, Child Protective Services (CPS) and/or Adult Protective Services (APS) according to State laws. Prevention strategies are developed and implemented (when warranted) when abuse, neglect or exploitation are reported. Health and welfare needs are addressed and steps are taken to resolve concerns in a timely manner and are documented in the record. When a critical incident/event occurs, the recipient's legal representative/family and or their provider must notify CSHCN by phone, email, or fax within 24 hours of the occurrence. Depending on the nature/severity of the incident/event, CSHCN may investigate and remediate the incident/event internally or forward to BACBS for investigation/remediation. In addition, CSHCN must document the details of the incident/event on a Critical Incident Investigation form. For incidents/events meeting the criteria of a level one incident/event, the Critical Incident Investigation form must also be submitted to BACBS within ten business days of the report of the incident/event (Cases that are complicated and involve considerable investigation may require additional time to complete the Critical Incident Investigation document). BACBS provides final oversight of the investigations of all critical incidents/events.

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

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

Issues that are less immediate are corrected within designated time frames and are documented by CSHCN using the Critical Incident Investigation Document.

**ii. Remediation Data Aggregation**

	<b>Responsible Party</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> )
	<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
	<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
	<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
	<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> <b>Annually</b>
		<input type="checkbox"/> <b>Continuously and Ongoing</b>
		<input type="checkbox"/> <b>Other</b> 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.*

<input checked="" type="radio"/>	<b>No</b>
<input type="radio"/>	<b>Yes</b>

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

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## Appendix H: Quality Improvement Strategy

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

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

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

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

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**Quality Improvement Strategy: Minimum Components**

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

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

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

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

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

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

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**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 annual waiver review for each performance measure that is assessed that year. Using tables, the percentage of how well the performance measures are met for each fiscal year are displayed. Tables 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 recipients, financial considerations, the intensity of the problem and the other performance measures relating to assurance being evaluated. The Quality Improvement Committee consisting of staff from BACBS and CSHCN are responsible for collecting, analyzing and prioritizing improvement goals/projects.

ii. System Improvement Activities

<b>Responsible Party</b> ( <i>check each that applies</i> ):	<b>Frequency of monitoring and analysis</b> ( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Quality Improvement Committee</b>	<input checked="" type="checkbox"/> <b>Annually</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify:	<input type="checkbox"/> <b>Other</b> Specify:
<i>CSHCN RN Waiver Coordinators</i>	

**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.

BACBS has established a Quality Improvement Committee consisting of BACBS' Quality Assurance Team, and staff from CSHCN including the RN Waiver Coordinators, among others. The team meets quarterly 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 recipients and families, providers, agencies and others through the Medicaid Information Bulletin.

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

The Quality Improvement Strategy (QIS) will change and evolve as areas of improvement are identified and changes to the program are implemented. Because of these changes, the QIS will be periodically evaluated and updated to respond to the changes with different approaches and methods of data collection and analysis.

Trends in data aggregation results will trigger re-evaluations and system changes. The Quality Improvement Committee will be responsible to conduct ongoing evaluations and respond with new ideas and plans to continually improve the waiver system.

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# Appendix I: Financial Accountability

## APPENDIX I-1: Financial Integrity and Accountability

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

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) for services not authorized on the Plan of Care;
- 4) with inappropriate coding;
- 5) for claims billed in excess of maximum fee schedule rates; and
- 6) 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.*

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**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.*

<b>Performance Measure:</b>	<b>Number and percentage of paid claims which verify that services were rendered to a Tech Dependent Waiver recipient using approved waiver codes and rates. (Numerator = # of claims in compliance; Denominator = total # of paid claims)</b>		
<b>Data Source (Select one) (Several options are listed in the on-line application): Other</b>			
If 'Other' is selected, specify:			
<b>Financial records</b>			
	<b>Responsible Party for data collection/generation (check each that applies)</b>	<b>Frequency of data collection/generation: (check each that applies)</b>	<b>Sampling Approach (check each that applies)</b>
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval =

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	<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually		95% Confidence Level, 5% Margin of Error
		<input type="checkbox"/> Continuously and Ongoing		<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:		
				<input type="checkbox"/> Other Specify:

**Add another Data Source for this performance measure**

**Data Aggregation and Analysis**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies)	<b>Frequency of data aggregation and analysis:</b> (check each that applies)
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

<b>Performance Measure:</b>	<b>Number and percentage of paid claims that were authorized and did not exceed the amounts documented in the recipient's Plan of Care.</b> <u><b>(Numerator = # of claims in compliance; Denominator = total # of claims paid)</b></u>
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**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**

	<b>Responsible Party for data collection/generation</b> (check each that applies)	<b>Frequency of data collection/generation:</b> (check each that applies)	<b>Sampling Approach</b> (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other	<input checked="" type="checkbox"/> Annually	<input checked="" type="checkbox"/> 95% Confidence

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	<i>Specify:</i>		<i>Level, 5% Margin of Error</i>
		<input type="checkbox"/> <i>Continuously and Ongoing</i>	<input type="checkbox"/> <i>Stratified: Describe Group:</i>
		<input type="checkbox"/> <i>Other Specify:</i>	
			<input type="checkbox"/> <i>Other Specify:</i>

***Add another Data Source for this performance measure***

***Data Aggregation and Analysis***

<b><i>Responsible Party for data aggregation and analysis</i></b> <i>(check each that applies)</i>	<b><i>Frequency of data aggregation and analysis:</i></b> <i>(check each that applies)</i>
<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>
<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>
<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>
<input type="checkbox"/> <i>Other Specify:</i>	<input checked="" type="checkbox"/> <i>Annually</i>
	<input type="checkbox"/> <i>Continuously and Ongoing</i>
	<input type="checkbox"/> <i>Other Specify:</i>

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

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

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

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

<b><i>Performance Measure:</i></b>	<b><i>Number and percentage of participant claims in a representative sample paid for services that use approved waiver rates. (The numerator is the</i></b>
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**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

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

**Add another Data Source for this performance measure**

**Data Aggregation and Analysis**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies)	<b>Frequency of data aggregation and analysis:</b> (check each that applies)
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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***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.*

BACBS conducts an annual review of the Tech Dependent Waiver program for each of the five 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 or CSHCN 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 CSHCN.
2. CSHCN will review the Recovery of Funds form and return the signed form to BACBS.
3. Upon receipt of the Recovery of Funds form, BACBS will submit the Recovery of Funds form to Medicaid Operations.
4. Medicaid Operations will reprocess the MMIS claims to reflect the recovery.
5. Overpayments are returned to the federal government within required time frames.

**ii. Remediation Data Aggregation**

<b><i>Remediation-related Data Aggregation and Analysis</i></b>	<b><i>Responsible Party (check each that applies)</i></b>	<b><i>Frequency of data aggregation and analysis:</i></b>
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<b>(including trend identification)</b>		<i>(check each that applies)</i>
	<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
	<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
	<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
	<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> <b>Annually</b>
		<input type="checkbox"/> <b>Continuously and Ongoing</b>
		<input type="checkbox"/> <b>Other</b> 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.

<input checked="" type="radio"/>	<b>No</b>
<input type="radio"/>	<b>Yes</b>

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

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## 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.

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

~~Family Directed Support Services – Based on the rate paid for equivalent services in Utah's 1915(e) New Choices Waiver (Consumer Prep).~~

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

Skilled Nursing Respite Care (Individual) - Based on State plan private duty nursing reimbursement rates for equivalent agency-based providers reduced by 20 percent. To determine the individual provider rate in Utah's 1915 (c) waivers, the State deducts 20 percent of the agency rate for individual providers based on the concept that an individual does not have the same business overhead and administrative costs that an agency based provider has. .

Family Support Services - Based on our current approved waiver rate. The State will rebase this rate by June 30, 2014. The State will rebase the rate by reviewing 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 rate will be reviewed by rate-setting staff within Medicaid's Bureau of Coverage and Reimbursement Policy. Upon completion of the rebasing of the rate, the State will amend the waiver accordingly.

In-Home Feeding Therapy - Based on rate paid for State plan in-home speech language pathology reimbursement rates for equivalent providers.

Extended Home Health Aide - Based on current Medicaid fee schedule rates for equivalent services and providers.

Extended Private Duty Nursing - Based on State plan private duty nursing reimbursement rates for equivalent providers.

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)

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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 Tech Dependent 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):**

<input checked="" type="checkbox"/>	<b>No. State or local government agencies do not certify expenditures for waiver services.</b>
<input type="checkbox"/>	<b>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.</b> <i>Select at least one:</i>
<input type="checkbox"/>	<b>Certified Public Expenditures (CPE) of State Public Agencies.</b> 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). <i>(Indicate source of revenue for CPEs in Item I-4-a.)</i>
<input type="checkbox"/>	<b>Certified Public Expenditures (CPE) of Local Government Agencies.</b> 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). <i>(Indicate source of revenue for CPEs in Item I-4-b.)</i>

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- 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.

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## APPENDIX I-3: Payment

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

<input checked="" type="checkbox"/>	<b>Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).</b>
<input type="checkbox"/>	<b>Payments for some, but not all, waiver services are made through an approved MMIS.</b> 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.
<input type="checkbox"/>	<b>Payments for waiver services are not made through an approved MMIS.</b> 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:
<input type="checkbox"/>	<b>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.</b> 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*):

<input checked="" type="checkbox"/>	<b>The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.</b>
<input type="checkbox"/>	<b>The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.</b>
<input type="checkbox"/>	<b>The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.</b> 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:
<input type="checkbox"/>	<b>Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.</b> Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

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- 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:*

<input checked="" type="radio"/>	<b>No. The State does not make supplemental or enhanced payments for waiver services.</b>
<input type="radio"/>	<p><b>Yes. The State makes supplemental or enhanced payments for waiver services.</b> 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.</p>

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

<input type="radio"/>	<b>No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.</b>
<input checked="" type="radio"/>	<p><b>Yes. State or local government providers receive payment for waiver services. Complete item I-3-e.</b></p> <p>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. <i>Complete item I-3-e.</i></p>
	CSHCN for the provision of In-Home Feeding Therapy

- 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:*

<input checked="" type="radio"/>	<b>The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.</b>
<input type="radio"/>	<b>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.</b>

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<input type="radio"/>	<p><b>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.</b></p> <p>Describe the recoupment process:</p>

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:*

<input checked="" type="radio"/>	<p><b>Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.</b></p>
<input type="radio"/>	<p><b>Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.</b></p> <p>Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.</p>

g. **Additional Payment Arrangements**

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

<input checked="" type="radio"/>	<p><b>No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.</b></p>
<input type="radio"/>	<p><b>Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).</b></p> <p>Specify the governmental agency (or agencies) to which reassignment may be made.</p>

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

<input checked="" type="radio"/>	<p><b>No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.</b></p>
<input type="radio"/>	<p><b>Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.</b></p> <p>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:</p>

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

<input checked="" type="radio"/>	<b>The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.</b>
<input type="radio"/>	<p><b>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.</b></p> <p>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.</p>
<input type="radio"/>	<p><b>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.</b></p>

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## 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:*

<input checked="" type="checkbox"/>	<b>Appropriation of State Tax Revenues to the State Medicaid agency</b>
<input type="checkbox"/>	<b>Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.</b> 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:
<input type="checkbox"/>	<b>Other State Level Source(s) of Funds.</b> 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:*

<input checked="" type="checkbox"/>	<b>Not Applicable.</b> There are no local government level sources of funds utilized as the non-federal share.
<input type="checkbox"/>	<b>Applicable</b> <i>Check each that applies:</i>
<input type="checkbox"/>	<b>Appropriation of Local Government Revenues.</b> 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:
<input type="checkbox"/>	<b>Other Local Government Level Source(s) of Funds.</b> 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:

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- 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:*

<input checked="" type="radio"/>	<b>None of the specified sources of funds contribute to the non-federal share of computable waiver costs.</b>
<input type="radio"/>	<b>The following source(s) are used.</b> <i>Check each that applies.</i>
<input type="checkbox"/>	<b>Health care-related taxes or fees</b>
<input type="checkbox"/>	<b>Provider-related donations</b>
<input type="checkbox"/>	<b>Federal funds</b>
	For each source of funds indicated above, describe the source of the funds in detail:

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

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

<input checked="" type="radio"/>	<b>No services under this waiver are furnished in residential settings other than the private residence of the individual.</b>
<input type="radio"/>	<b>As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.</b>

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

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## 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:*

<input checked="" type="checkbox"/>	<p><b>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.</b></p>
<input type="checkbox"/>	<p><b>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.</b></p> <p>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:</p> <div style="border: 1px solid black; height: 40px; width: 100%; background-color: #e0e0e0;"></div>

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

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

<input type="radio"/>	<b>No. The State does not impose a co-payment or similar charge upon participants for waiver services.</b> <i>(Do not complete the remaining items; proceed to Item I-7-b).</i>
<input type="radio"/>	<b>Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.</b> <i>(Complete the remaining items)</i>

i. **Co-Pay Arrangement**

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

<i>Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):</i>	
<input type="checkbox"/>	<b>Nominal deductible</b>
<input type="checkbox"/>	<b>Coinsurance</b>
<input type="checkbox"/>	<b>Co-Payment</b>
<input type="checkbox"/>	<b>Other charge</b> <i>Specify:</i>

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

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

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

Waiver Service	Charge	
	Amount	Basis

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**iv. Cumulative Maximum Charges.**

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

<input type="radio"/>	<b>There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.</b>
<input type="radio"/>	<b>There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.</b> 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*:

<input checked="" type="checkbox"/>	<b>No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.</b>
<input type="checkbox"/>	<b>Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.</b> 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:

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# 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):			<u>Nursing Home</u>				
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	<u>\$28,857</u>	<u>\$80,107</u>	<u>\$108,964</u>	<u>\$144,152</u>	<u>\$49,748</u>	<u>\$193,900</u>	<u>\$84,936</u>
2	<u>\$30,725</u>	<u>\$80,003</u>	<u>\$110,728</u>	<u>\$147,035</u>	<u>\$50,743</u>	<u>\$197,778</u>	<u>\$87,050</u>
3	<u>\$32,593</u>	<u>\$79,934</u>	<u>\$112,527</u>	<u>\$149,976</u>	<u>\$51,758</u>	<u>\$201,734</u>	<u>\$89,207</u>
4	<u>\$32,865</u>	<u>\$79,900</u>	<u>\$112,765</u>	<u>\$152,975</u>	<u>\$52,793</u>	<u>\$205,768</u>	<u>\$93,003</u>
5	<u>\$33,203</u>	<u>\$79,904</u>	<u>\$113,107</u>	<u>\$156,035</u>	<u>\$53,849</u>	<u>\$209,884</u>	<u>\$96,776</u>

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## Appendix J-2: Derivation of Estimates

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

<b>Table J-2-a: Unduplicated Participants</b>			
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	140	140	
Year 2	140	140	
Year 3	140	140	
Year 4 (only appears if applicable based on Item 1-C)	<u>149</u>	<u>149</u>	
Year 5 (only appears if applicable based on Item 1-C)	<u>149</u>	<u>149</u>	

- 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) = 332 days  
 - Used the actual LOS for fiscal year 2011

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

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

- All calculations are based off the actual amounts for FY2011, from the 372 report
- Price per unit was increased 1% each year.
- Units Per User is the average units per user for FY2011 rounded to the next whole number
- June 2015 amendment to increase unduplicated count by 9 users and their associated costs

- 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:

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- All calculations are based off the actual amounts for FY2011
- Each subsequent year was increased 2%
- The state utilizes the MMIS Categories of Service and Provider Type functionality to account for and exclude the costs of prescribed drugs from D'

**iii. Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

- Used actual average nursing home cost per day for FY2011 (Last complete reporting period) and multiplied by actual PD waiver LOS to get fiscal year FY2011 base estimate.
- 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:

- Used actual average nursing home cost per day for FY2011 (Last complete reporting period) and multiplied by actual PD waiver LOS to get fiscal year FY2011 base estimate.
- 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	
Skilled Nursing Respite Care	manage components
Extended Home Health Aide	manage components
Extended Private Duty Nursing	manage components
Family Directed Support	manage components
Financial Management Services	manage components
Family Support Services	manage components
In-Home Feeding Therapy	manage components

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

<input type="radio"/>	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
<input type="radio"/>	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

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

Waiver Year: Year 1					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/Unit	Total Cost
Extended Home Health Aide	15 minute	4	514	\$5.32	\$10,938.00
Skilled Nursing Respite Care:					
Agency	15 minute	133	2395	\$8.65	\$2,755,328.00
Individual	15 minute	14	811	\$6.92	\$78,570.00
Extended Private Duty Nursing	15 minute	13	10080	\$8.65	\$1,133,496.00
Family Directed Support	per Session	8	4	\$56.60	\$1,811.00
Financial Management Services	Monthly	14	9	\$48.00	\$6,048.00
Family Support Services	15 minute	30	102	\$17.45	\$53,397.00
In-Home Feeding Therapy	15 minute	2	9	\$18.14	\$327.00
GRAND TOTAL:					\$4,039,915.00
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					140
FACTOR D (Divide grand total by number of participants)					\$28,857.00
AVERAGE LENGTH OF STAY ON THE WAIVER					317

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<b>Waiver Year: Year 2</b>					
<b>Waiver Service / Component</b>	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	<b>Unit</b>	<b># Users</b>	<b>Avg. Units Per User</b>	<b>Avg. Cost/ Unit</b>	<b>Total Cost</b>
Extended Home Health Aide	15 minute	4	514	\$5.32	\$10,938.00
Skilled Nursing Respite Care:					
Agency	15 minute	133	2395	\$8.65	\$2,755,328.00
Individual	15 minute	14	811	\$6.92	\$78,570.00
Extended Private Duty Nursing	15 minute	16	10080	\$8.65	\$1,395,072.00
Family Directed Support	per Session	8	4	\$56.60	\$1,811.00
Financial Management Services	Monthly	14	9	\$48.00	\$6,048.00
Family Support Services	15 minute	30	102	\$17.45	\$53,397.00
In-Home Feeding Therapy	15 minute	2	9	\$18.14	\$327.00
<b>GRAND TOTAL:</b>					<b>\$4,301,491.00</b>
<b>TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)</b>					<b>140</b>
<b>FACTOR D (Divide grand total by number of participants)</b>					<b>\$30,725.00</b>
<b>AVERAGE LENGTH OF STAY ON THE WAIVER</b>					<b>317</b>

State:	
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<b>Waiver Year: Year 3</b>					
<b>Waiver Service / Component</b>	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	<b>Unit</b>	<b># Users</b>	<b>Avg. Units Per User</b>	<b>Avg. Cost/ Unit</b>	<b>Total Cost</b>
Extended Home Health Aide	15 minute	4	514	\$5.32	\$10,938.00
Skilled Nursing Respite Care:					
Agency	15 minute	133	2395	\$8.65	\$2,755,328.00
Individual	15 minute	14	811	\$6.92	\$78,570.00
Extended Private Duty Nursing	15 minute	19	10080	\$8.65	\$1,656,648.00
Family Directed Support	per Session	8	4	\$56.60	\$1,811.00
Financial Management Services	Monthly	14	9	\$48.00	\$6,048.00
Family Support Services	15 minute	30	102	\$17.45	\$53,397.00
In-Home Feeding Therapy	15 minute	2	9	\$18.14	\$327.00
<b>GRAND TOTAL:</b>					<b>\$4,563,067.00</b>
<b>TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)</b>					<b>140</b>
<b>FACTOR D (Divide grand total by number of participants)</b>					<b>\$32,593.00</b>
<b>AVERAGE LENGTH OF STAY ON THE WAIVER</b>					<b>317</b>

State:	
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<b>Waiver Year: Year 4 (only appears if applicable based on Item 1-C)</b>					
<b>Waiver Service / Component</b>	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	<b>Unit</b>	<b># Users</b>	<b>Avg. Units Per User</b>	<b>Avg. Cost/ Unit</b>	<b>Total Cost</b>
<u>Extended Home Health Aide</u>	<u>15 minute</u>	<u>4</u>	<u>514</u>	<u>\$5.37</u>	<u>\$11,040.72</u>
<u>Skilled Nursing Respite Care:</u>	-	-	-	-	-
<u>Agency</u>	<u>15 minute</u>	<u>142</u>	<u>2395</u>	<u>\$8.74</u>	<u>\$2,972,386.60</u>
<u>Individual</u>	<u>15 minute</u>	<u>15</u>	<u>811</u>	<u>\$6.99</u>	<u>\$85,033.35</u>
<u>Extended Private Duty Nursing</u>	<u>15 minute</u>	<u>20</u>	<u>10080</u>	<u>\$8.74</u>	<u>\$1,761,984.00</u>
<u>Family Directed Support</u>	<u>per Session</u>	<u>9</u>	<u>4</u>	<u>\$57.17</u>	<u>\$2,058.12</u>
<u>Financial Management Services</u>	<u>Monthly</u>	<u>15</u>	<u>9</u>	<u>\$48.48</u>	<u>\$6,544.80</u>
<u>Family Support Services</u>	<u>15 minute</u>	<u>32</u>	<u>102</u>	<u>\$17.62</u>	<u>\$57,511.68</u>
<u>In-Home Feeding Therapy</u>	<u>15 minute</u>	<u>2</u>	<u>9</u>	<u>\$18.32</u>	<u>\$329.76</u>
GRAND TOTAL:					<u>\$4,896,889.03</u>
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					<u>149</u>
FACTOR D (Divide grand total by number of participants)					<u>\$32,865.03</u>
AVERAGE LENGTH OF STAY ON THE WAIVER					<u>317</u>

State:	
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<b>Waiver Year: Year 5 (only appears if applicable based on Item 1-C)</b>					
<b>Waiver Service / Component</b>	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	<b>Unit</b>	<b># Users</b>	<b>Avg. Units Per User</b>	<b>Avg. Cost/ Unit</b>	<b>Total Cost</b>
<u>Extended Home Health Aide</u>	<u>15 minute</u>	<u>4</u>	<u>514</u>	<u>\$5.42</u>	<u>\$11,143.52</u>
<u>Skilled Nursing Respite Care:</u>	-	-	-	-	-
<u>Agency</u>	<u>15 minute</u>	<u>142</u>	<u>2395</u>	<u>\$8.83</u>	<u>\$3,002,994.70</u>
<u>Individual</u>	<u>15 minute</u>	<u>15</u>	<u>811</u>	<u>\$7.06</u>	<u>\$85,884.90</u>
<u>Extended Private Duty Nursing</u>	<u>15 minute</u>	<u>20</u>	<u>10080</u>	<u>\$8.83</u>	<u>\$1,780,128.00</u>
<u>Family Directed Support</u>	<u>per Session</u>	<u>9</u>	<u>4</u>	<u>\$57.74</u>	<u>\$2,078.64</u>
<u>Financial Management Services</u>	<u>Monthly</u>	<u>15</u>	<u>9</u>	<u>\$48.96</u>	<u>\$6,609.60</u>
<u>Family Support Services</u>	<u>15 minute</u>	<u>32</u>	<u>102</u>	<u>\$17.80</u>	<u>\$58,099.20</u>
<u>In-Home Feeding Therapy</u>	<u>15 minute</u>	<u>2</u>	<u>9</u>	<u>\$18.50</u>	<u>\$333.00</u>
GRAND TOTAL:					<u>\$4,947,271.56</u>
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					<u>149</u>
FACTOR D (Divide grand total by number of participants)					<u>\$33,203.16</u>
AVERAGE LENGTH OF STAY ON THE WAIVER					<u>317</u>

State:	
Effective Date	









