

Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.5

Submitted by:

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

Brief Description:

State:	
Effective Date	

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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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. **Waiver Title** (optional): New Choices Waiver

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

<input type="radio"/>	New Waiver (3 Years)	CMS-Assigned Waiver Number (CMS Use):	
<input type="radio"/>	New Waiver (3 Years) to Replace Waiver #		
	CMS-Assigned Waiver Number (CMS Use):		
	<i>Attachment #1 contains the transition plan to the new waiver.</i>		
<input checked="" type="radio"/>	Renewal (5 Years) of Waiver #	0439	
<input type="radio"/>	Amendment to Waiver #		

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

<input type="radio"/>	Model Waiver. In accordance with 42 CFR §441.305(b), the State assures that no more than 200 individuals will be served in this waiver at any one time.
<input checked="" type="radio"/>	Regular Waiver , as provided in 42 CFR §441.305(a)

E.1 **Proposed Effective Date:** April 1, 2007

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

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

<input type="checkbox"/>	Hospital (select applicable level of care)
<input type="radio"/>	Hospital as defined in 42 CFR §440.10. If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
<input type="radio"/>	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
<input checked="" type="checkbox"/>	Nursing Facility (select applicable level of care)
<input type="radio"/>	As defined in 42 CFR §440.40 and 42 CFR §440.155. If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
<input type="radio"/>	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
<input type="checkbox"/>	Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150). If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR facility level of care:

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

<input type="checkbox"/>	Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I	
<input type="checkbox"/>	Waiver(s) authorized under §1915(b) of the Act. <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"/>	A program operated under §1932(a) of the Act. <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"/>	A program authorized under §1915(i) of the Act	
<input type="checkbox"/>	A program authorized under §1915(j) of the Act	
<input type="checkbox"/>	A program authorized under §1115 of the Act. <i>Specify the program:</i>	
<input checked="" type="checkbox"/>	Not applicable	

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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.

The Utah New Choices Waiver focuses on deinstitutionalization of Medicaid recipients residing in institutional settings (nursing facilities) into home and community based services settings. The waiver program is open to individuals who meet Medicaid financial eligibility criteria, nursing facility level of care criteria, and special targeting criteria. The special targeting criteria limits participation to individuals who at the time of application are:

- receiving Medicaid reimbursed nursing facility services on an extended stay basis of 90 days or greater;
- receiving Medicare or Medicaid reimbursed care in another type of Utah licensed medical institution, that is not an institution for mental disease (IMD), for a period of 30 days or greater; or
- receiving Medicaid reimbursed services through another of Utah's 1915(c) waivers and have been identified in need of immediate (or near immediate) nursing facility admission absent enrollment into this waiver program.

Recognizing the focus on deinstitutionalization, the waiver offers a full array of service to address the needs of individuals transitioning from institutional settings.

Waiver services allow and support individuals' choice of the method in which they receive services. Several waiver services are available to individuals through a consumer directed arrangement, while individuals preferring a more traditional method of service delivery will have the ability to choose this option as well.

The New Choices Waiver does not provide services to individuals in IMDs. The State assures that facilities in which services are provided are adequate to meet the health and welfare of the individuals served. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when provided as part of respite services in a facility approved by the State that is not a private residence. Wherever a PIHP, PAHP or a MCO is a provider of waiver services these providers will only operate on a fee-for-service basis for the provision of waiver services. The State Medicaid Agency assures that it has protocols and safeguards to prevent any potential duplication of services available through other authorities.

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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"/>	The waiver provides for participant direction of services. <i>Appendix E is required.</i>
<input type="radio"/>	Not applicable. The waiver does not provide for participant direction of services. <i>Appendix E is not completed.</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 overall systems improvement for this waiver.
- I. Financial Accountability.** Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** Appendix J contains the State’s demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

- A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

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

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

<input type="radio"/>	Yes (<i>complete remainder of item</i>)
<input checked="" type="radio"/>	No

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

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

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**.

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- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
 1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services.

Appendix B specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) under age 21 when the State has not included the optional Medicaid benefit cited in 42 CFR §440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected amount, frequency and duration and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial

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participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.51, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified throughout the application and in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:
- 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.

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

7. Contact Person(s)

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

First Name:	Tonya
Last Name	Hales
Title:	Director, Long Term Care Bureau
Agency:	Utah Division of Medicaid and Health Financing
Address 1:	P. O. Box 143101
Address 2:	
City	Salt Lake City
State	Utah
Zip Code	84114-3101
Telephone:	801-538-9136
E-mail	thales@utah.gov
Fax Number	801-538-6412

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

First Name:	Jason
Last Name	Stewart
Title:	Assistant Director, Long Term Care Bureau
Agency:	Utah Division of Medicaid and Health Financing
Address 1:	P. O. Box 143101
Address 2	
City	Salt Lake City
State	Utah
Zip Code	84114-3101
Telephone:	801-538-9144
E-mail	jasonstewart@utah.gov
Fax Number	801-323-1567

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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: _____ **Date:** _____
 State Medicaid Director or Designee

First Name:	Michael
Last Name	Hales
Title:	Director
Agency:	Utah Division of Medicaid and Health Financing
Address 1:	P.O. Box 143101
Address 2:	
City	Salt Lake City
State	Utah
Zip Code	84114-3101
Telephone:	801-538-6965
E-mail	mthales@utah.gov
Fax Number	801-538-6099

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Attachment #1: Transition Plan

Specify the transition plan for the waiver:

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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 checked="" 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 checked="" type="radio"/>	The Medical Assistance Unit (<i>name of unit</i>) (<i>do not complete Item A-2</i>):	Utah Division of Medicaid and Health Financing, Long Term Care Bureau	
<input type="radio"/>	Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit (<i>name of division/unit</i>). 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>):		
<input type="radio"/>	The waiver is operated by _____ a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (<i>Complete item A-2-b</i>).		

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

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

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

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

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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 (*check each that applies*):

<input type="checkbox"/>	<p>Local/Regional non-state public agencies conduct waiver operational and administrative functions at the local or regional level. There is an interagency agreement or memorandum of understanding between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). <i>Specify the nature of these agencies and complete items A-5 and A-6:</i></p>
<input type="checkbox"/>	<p>Local/Regional non-governmental non-state entities conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The contract(s) under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). <i>Specify the nature of these entities and complete items A-5 and A-6:</i></p>
<input checked="" type="checkbox"/>	<p>Not applicable – Local/regional non-state agencies do not perform waiver operational and administrative functions.</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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Appendix A: Waiver Administration and Operation
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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 an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<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..
- a.i *For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

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

Performance Measure #1:	The SMA and OA collaborate in the development of waiver applications, waiver amendments, rules and other official documents relative to the administration and operation of the waiver.		
<u>Data Source</u>	Responsible Party for data collection/generation <i>(check each that applies)</i>	Frequency of data collection/generation: <i>(check each that applies)</i>	Sampling Approach <i>(check each that applies)</i>
Meeting minutes			
Correspondences (email, letters etc.)			
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" 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 type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and	Frequency of data aggregation and	

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	<i>analysis</i> (check each that applies)	<i>analysis:</i> (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:	

Performance Measure #2:	The OA submits proposed rules and other documents, relating to the implementation of the waiver (including training curriculums and outreach materials), to the SMA for review and approval prior to implementation.		
Data Source Document Approval Forms OA Documents	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" 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 type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<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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Performance Measure #3:	The SMA approves maximum allowable rates (MARs) for covered waiver services.		
Data Source Approval documentation Correspondence	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" 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 type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<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:	

Performance Measure #4:	Prior to involuntary disenrollment from the waiver, the OA explores all reasonable alternatives and follows the Disenrollment Protocol. Final authority for involuntary disenrollment resides with the SMA.		
Data Source Disenrollment documents Correspondence between the SMA and OA	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)

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	<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input checked="" type="checkbox"/> <i>100% Review</i>
	<input checked="" 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 type="checkbox"/> <i>Other: Specify:</i>	<input type="checkbox"/> <i>Annually</i>	
		<input checked="" type="checkbox"/> <i>Continuously and Ongoing</i>	<input type="checkbox"/> <i>Stratified: Describe Groups</i>
		<input type="checkbox"/> <i>Other: Specify:</i>	
			<input type="checkbox"/> <i>Other: Describe</i>
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<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>	

Performance Measure #5:	Timely notice of appeal rights are provided to waiver applicants/participants who make one of the following claims: a) denied access to Medicaid waiver program, b) denied access to needed service while enrolled in the waiver or c) denied choice of provider if more than one qualified provider was available to render the service.		
Data Source <i>OA application denial records</i> <i>Participant records</i>	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input type="checkbox"/> <i>100% Review</i>
	<input checked="" type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input checked="" 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 = 5</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>Stratified: Describe Groups</i>
		<input checked="" type="checkbox"/> <i>Other: Specify: OA: Continuously and</i>	

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		<i>ongoing SMA: At a minimum every five years</i>	
			<input type="checkbox"/> <i>Other: Describe</i>
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	
	<input checked="" 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 checked="" type="checkbox"/> <i>Other: Specify: OA: Annually SMA: At a minimum every five years</i>	

Performance Measure #3:	The OA provides the SMA a copy of all quality assurance activities reports which include an analysis of findings, remediation and quality improvement activities.		
Data Source OA Reviews	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input checked="" type="checkbox"/> <i>100% Review</i>
	<input checked="" 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 type="checkbox"/> <i>Other: Specify:</i>	<input type="checkbox"/> <i>Annually</i>	
		<input checked="" type="checkbox"/> <i>Continuously and Ongoing</i>	<input type="checkbox"/> <i>Stratified: Describe Groups</i>
		<input type="checkbox"/> <i>Other: Specify:</i>	
			<input type="checkbox"/> <i>Other: Describe</i>
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that	Frequency of data aggregation and analysis: (check each that	

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	<i>applies</i>	<i>applies</i>	
	<input type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	
	<input checked="" 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>	

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

The SMA demonstrates ultimate administrative authority and responsibility for the operation of the New Choices Waiver Program through numerous activities including the issuance of policies, rules and regulations relating to the waiver and the approval of all protocols, documents and trainings that affect any aspect of the New Choices Waiver operations. Approvals are accomplished through a formal document approval process. The SMA conducts an annual review of the New Choices Waiver Program for each of the five waiver years. At a minimum, one comprehensive review will be conducted during this five year cycle. The comprehensive review will include participant and provider interviews. The other annual reviews will be focused reviews. The criteria for the focused reviews will be determined from the OA and SMA review findings as well as other issues that develop during the review year. The sample size for each review will be sufficient to provide a confidence level equal to 95% and a confidence interval equal to 5. The SMA is the entity responsible for official communication with CMS for all issues related to the New Choices Waiver.

b. Methods for Remediation/Fixing Individual Problems

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

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

b.ii Remediation Data Aggregation

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

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 type="radio"/>	Yes <i>(complete remainder of item)</i>
<input checked="" type="radio"/>	No

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 checked="" type="radio"/>	Aged or Disabled, or Both (<i>select one</i>)			
<input type="radio"/>	Aged or Disabled or Both – General (<i>check each that applies</i>)			
	<input checked="" type="checkbox"/> Aged (age 65 and older)			<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/> Disabled (Physical) (under age 65)	21		
	<input checked="" type="checkbox"/> Disabled (Other) (under age 65)	21		
<input type="radio"/>	Specific Recognized Subgroups (<i>check each that applies</i>)			
	<input type="checkbox"/> Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/> HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/> Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/> Technology Dependent			<input type="checkbox"/>
<input type="radio"/>	Mental Retardation or Developmental Disability, or Both (<i>check each that applies</i>)			
	<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="radio"/>	Mental Illness (<i>check each that applies</i>)			
	<input type="checkbox"/> Mental Illness (age 18 and older)			<input type="checkbox"/>
	<input type="checkbox"/> Mental Illness (under age 18)			

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

1. Participation in the New Choices Waiver is limited to individuals who at the time of admission:
 - (a) have reached the month after their 21st birthday;
 - (b) are receiving Medicaid reimbursed nursing facility care on an extended stay basis of 90 days or more;
 - (c) are currently receiving Medicare or Medicaid reimbursed care in another type of Utah licensed medical institution that is not an institution for mental disease (IMD), on an extended stay of at least 30 days, and will discharge to a nursing facility for an extended stay of at least 60 days absent enrollment into the waiver program; or
 - (d) are receiving Medicaid reimbursed services through another of Utah’s 1915(c) waivers and have been identified in need of immediate (or near immediate) nursing facility admission absent enrollment into this waiver program.
2. For individuals leaving acute care hospitals, specialty hospitals (non IMD), and Medicare skilled nursing facilities, participation is limited to those receiving a medical, non-psychiatric level of care.

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- 3. Individuals who meet the intensive skilled level of care as provided in R414-502 are not eligible for participation in the New Choices Waiver.
- 4. Individuals who meet the level of care criteria for admission to an Intermediate Care Facility for Individuals with Mental Retardation (ICF-MR) as provided in R414-502 are not eligible for participation in the New Choices Waiver.

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

<input checked="" type="radio"/>	Not applicable – There is no maximum age limit
<input type="radio"/>	The following transition planning procedures are employed for participants who will reach the waiver’s maximum age limit (<i>specify</i>):

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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="radio"/>	No Cost Limit. 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="radio"/>	Cost Limit in Excess of Institutional Costs. The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. <i>Complete Items B-2-b and B-2-c.</i> The limit specified by the State is (<i>select one</i>):		
<input type="radio"/>		%, a level higher than 100% of the institutional average	
<input type="radio"/>	Other (<i>specify</i>):		
<input type="radio"/>			
<input type="radio"/>	Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. <i>Complete Items B-2-b and B-2-c.</i>		
<input type="radio"/>	Cost Limit Lower Than Institutional Costs. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver. <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>		
<input type="radio"/>			
<input type="radio"/>	The cost limit specified by the State is (<i>select one</i>):		
<input type="radio"/>	The following dollar amount: \$		
<input type="radio"/>	The dollar amount (<i>select one</i>):		
<input type="radio"/>	Is adjusted each year that the waiver is in effect by applying the following formula:		
<input type="radio"/>			
<input type="radio"/>	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.		
<input type="radio"/>	The following percentage that is less than 100% of the institutional average:		%
<input type="radio"/>	Other – <i>Specify</i> :		
<input type="radio"/>			

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

--

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

<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) (<i>specify</i>):

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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:

Table: B-3-a	
Waiver Year	Unduplicated Number of Participants
Year 1	1200
Year 2	1200
Year 3	1200
Year 4 (renewal only)	1200
Year 5 (renewal only)	1200

- 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 checked="" type="radio"/>	The State does not limit the number of participants that it serves at any point in time during a waiver year.
<input type="radio"/>	The State limits the number of participants that it serves at any point in time during a waiver year. The limit that applies to each year of the waiver period is specified in the following table:

Table B-3-b	
Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4 (renewal only)	
Year 5 (renewal only)	

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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 checked="" type="radio"/>	Not applicable. The state does not reserve capacity.	
<input type="radio"/>	The State reserves capacity for the following purpose(s). For each purpose, describe how the amount of reserved capacity was determined:	
	The capacity that the State reserves in each waiver year is specified in the following table:	
	Table B-3-c	
	Purpose:	Purpose:
Waiver Year	Capacity Reserved	Capacity Reserved
Year 1		
Year 2		
Year 3		
Year 4 (renewal only)		
Year 5 (renewal only)		

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

<input checked="" type="radio"/>	The waiver is not subject to a phase-in or a phase-out schedule.
<input type="radio"/>	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.

- e. **Allocation of Waiver Capacity.** *Select one:*

<input checked="" type="radio"/>	Waiver capacity is allocated/managed on a statewide basis.
<input type="radio"/>	Waiver capacity is allocated to local/regional non-state entities. Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

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

No selection policies apply beyond the waiver targeting criteria described in Appendix B-1.

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

a. 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

a-2. **Miller Trust State.**

Indicate whether the State is a Miller Trust State.

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

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

<i>Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)</i>	
<input 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 checked="" 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
<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 checked="" type="checkbox"/>	Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
<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>
<i>Special home and community-based waiver group under 42 CFR §435.217) Note: When the special</i>	

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<i>home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed</i>			
<input type="radio"/>	No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.		
<input checked="" type="radio"/>	Yes. 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 checked="" type="checkbox"/>	A special income level equal to (select one):		
	<input checked="" type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)	
	<input type="radio"/>	%	of FBR, which is lower than 300% (42 CFR §435.236)
	<input type="radio"/>	\$	which is lower than 300%
<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 spenddown 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="radio"/>	100% of FPL	
	<input type="radio"/>	%	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 State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

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

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

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

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

i. Allowance for the needs of the waiver participant (select one):		
<input type="radio"/>	The following standard included under the State plan (select one)	
	<input type="radio"/>	SSI standard
	<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"/>	% of the FBR, which is less than 300%
	<input type="radio"/>	\$ which is less than 300%.
	<input type="radio"/>	% of the Federal poverty level
<input type="radio"/>	Other standard included under the State Plan (specify):	

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<input type="radio"/>	The following dollar amount:	\$	If this amount changes, this item will be revised.
<input type="radio"/>	The following formula is used to determine the needs allowance:		
<input type="radio"/>	Other (specify):		
ii. Allowance for the spouse only (select one):			
<input type="radio"/>	SSI standard		
<input type="radio"/>	Optional State supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The following dollar amount:	\$	If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:		
<input type="radio"/>	Not applicable (<i>see instructions</i>)		
iii. Allowance for the family (select one):			
<input type="radio"/>	AFDC need standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The following dollar amount:	\$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:		
<input type="radio"/>	Other (specify):		
<input type="radio"/>	Not applicable (<i>see instructions</i>)		
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:			
a. Health insurance premiums, deductibles and co-insurance charges			
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <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>):		

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

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

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<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.
<input type="radio"/>	The amount is determined using the following formula: <input type="text"/>
<input type="radio"/>	Other (specify): <input type="text"/>
<input type="radio"/>	Not applicable (<i>see instructions</i>)
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.735:	
a. Health insurance premiums, deductibles and co-insurance charges	
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <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"/>

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

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

i. Allowance for the needs of the waiver participant (select one):		
<input type="radio"/>	The following standard included under the State plan (select one)	
<input type="radio"/>	SSI standard	
<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"/>	%	of the FBR, which is less than 300%
<input type="radio"/>	\$	which is less than 300%.
<input type="radio"/>	%	of the Federal poverty level
<input type="radio"/>	Other standard included under the State Plan (specify):	
<input type="radio"/>		
<input type="radio"/>	The following dollar amount:	\$ If this amount changes, this item will be revised.
<input checked="" type="radio"/>	The following formula is used to determine the needs allowance:	
	Up to \$125 of any earned income plus an additional general disregard equal to the federal poverty limit for a household of one; plus a shelter cost deduction for actual mortgage & related costs (property taxes, insurance, etc.) or rent, not to exceed \$300; & a utility cost deduction of \$158 for households which have a heating or cooling expense, or \$79 for a household which does not have a heating or cooling expense but has any other utility (water, phone, electricity, etc.).	
<input type="radio"/>	Other (specify):	
<input type="radio"/>		
ii. Allowance for the spouse only (select one):		
<input type="radio"/>	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:	
	Specify the amount of the allowance:	
<input type="radio"/>	SSI standard	
<input type="radio"/>	Optional State supplement standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount:	\$ If this amount changes, this item will be revised.

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<input type="radio"/>	The amount is determined using the following formula:
<input checked="" type="radio"/>	Not applicable (<i>see instructions</i>)
iii. Allowance for the family (<i>select one</i>):	
<input type="radio"/>	AFDC need standard
<input checked="" 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.
<input type="radio"/>	The amount is determined using the following formula:
<input type="radio"/>	Other (<i>specify</i>):
<input type="radio"/>	Not applicable (<i>see instructions</i>)
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:	
a. Health insurance premiums, deductibles and co-insurance charges	
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <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 checked="" type="radio"/>	The State establishes the following reasonable limits (<i>specify</i>):
	The State establishes the following reasonable limits: The limits specified in Utah's Title XIX State Plan for post-eligibility income deductions under 42 CFR 435.725, 435.726, 435.832 and Sec. 1924 of the Social Security Act. The limits are defined on supplement 3 to attachment 2.6A.

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

i. Allowance for the needs of the waiver participant (<i>select one</i>):	
<input type="radio"/>	The following standard included under the State plan (<i>select one</i>)
<input type="radio"/>	The following standard under 42 CFR §435.121:

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<input type="radio"/>	Optional State supplement standard
<input type="radio"/>	Medically needy income standard
<input type="radio"/>	The special income level for institutionalized persons (<i>select one</i>)
<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)
<input type="radio"/>	% of the FBR, which is less than 300%
<input type="radio"/>	\$ which is less than 300% of the FBR
<input type="radio"/>	% of the Federal poverty level
<input type="radio"/>	Other standard included under the State Plan (specify):
<input type="radio"/>	The following dollar amount: \$ If this amount changes, this item will be revised.
<input type="radio"/>	The following formula is used to determine the needs allowance:
<input type="radio"/>	Other (<i>specify</i>):
ii. Allowance for the spouse only (<i>select one</i>):	
<input type="radio"/>	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:
	Specify the amount of the allowance:
<input type="radio"/>	The following standard under 42 CFR §435.121:
<input type="radio"/>	Optional State supplement standard
<input type="radio"/>	Medically needy income standard
<input type="radio"/>	The following dollar amount: \$ If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:
<input type="radio"/>	Not applicable (<i>see instructions</i>)
iii. Allowance for the family (<i>select one</i>):	
<input type="radio"/>	AFDC need standard
<input type="radio"/>	Medically needy income standard
<input type="radio"/>	The following dollar amount: \$ The amount specified cannot exceed the higher

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	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"/>	The amount is determined using the following formula: <table border="1" data-bbox="310 352 1459 457"> <tr><td></td></tr> </table>	
<input type="radio"/>	Other (specify): <table border="1" data-bbox="310 495 1459 600"> <tr><td></td></tr> </table>	
<input type="radio"/>	Not applicable (<i>see instructions</i>)	
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR 435.735:		
a. Health insurance premiums, deductibles and co-insurance charges		
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <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>): <table border="1" data-bbox="298 1073 1459 1144"> <tr><td></td></tr> </table>	

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

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

i. Allowance for the personal needs of the waiver participant (<i>select one</i>):		
<input type="radio"/>	SSI Standard	
<input type="radio"/>	Optional State Supplement standard	
<input type="radio"/>	Medically Needy Income Standard	
<input type="radio"/>	The special income level for institutionalized persons	
<input type="radio"/>	%	of the Federal Poverty Level
<input type="radio"/>	The following dollar amount:	\$ _____ If this amount changes, this item will be revised
<input checked="" type="radio"/>	The following formula is used to determine the needs allowance: Up to \$125 of any earned income plus an additional general disregard equal to the federal poverty limit for a household of one; plus a shelter cost deduction for actual mortgage & related costs (property taxes, insurance, etc.) or rent, not to exceed \$300; & a utility cost deduction of \$158 for households which have a heating or cooling expense, or \$79 for a household which does not have a heating or cooling expense but has any other utility (water, phone, electricity, etc.).	
<input type="radio"/>	Other (<i>specify</i>): _____	
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. <i>Select one</i> :		
<input checked="" type="radio"/>	Allowance is the same	
<input type="radio"/>	Allowance is different. Explanation of difference: _____	
iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified section 1902(r)(1) of the Act:		
a. Health insurance premiums, deductibles and co-insurance charges.		
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <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 checked="" type="radio"/>	The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.	

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

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

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

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

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

<input type="radio"/>	Directly by the Medicaid agency (The SMA performs the initial level of care evaluation for entrance into the waiver program).
<input type="radio"/>	By the operating agency specified in Appendix A
<input checked="" type="radio"/>	By an entity under contract with the Medicaid agency. <i>Specify the entity</i> :
	Waiver Case Management agencies contracted with SMA to perform reevaluations of level of care.
<input type="radio"/>	Other (<i>specify</i>):

- 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:

Individuals performing the initial level of care evaluation are required to be Registered Nurses or Physicians licensed within the State of Utah.

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

Utah State administrative rule R414-502 delineates the nursing facility level of care criteria that must be met to qualify for the Medicaid State Plan nursing facility benefit. In accordance with R414-502, it must be determined whether an applicant has mental or physical conditions that can only be cared for in a nursing facility, or equivalent alternative Medicaid health care delivery program, by documenting at least two of the following factors exist:

- (a) due to diagnosed medical conditions, the applicant requires substantial physical assistance with activities of daily living above the level of verbal prompting supervision or setting up;
- (b) The attending physician has determined the applicant's level of dysfunction in orientation to person, place, or time requires nursing facility care; or equivalent care provided through an alternative Medicaid health delivery program; or
- (c) The medical condition and intensity of services indicate that care need of the applicant cannot be safely met in a less structured setting, or without the services and supports of an alternative Medicaid health care delivery program.

- 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"/>	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
<input checked="" type="radio"/>	A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan. Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.
	The InterRAI MINIMUM DATA SET- HOME CARE (MDS-HC©) serves as the standard comprehensive assessment instrument for this waiver and includes all the data fields necessary to measure the individual's level of care as defined in the State's Medicaid nursing facility admission criteria. Persons responsible for collecting the needed information and for making level of care determinations are trained by staff of the SMA in the proper application of the MDS-HC instrument and the proper analysis of the MDS-HC data to perform level of care evaluations.

- 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:

Initial level of care evaluations:

- 1) For applicants who are currently receiving Medicaid reimbursed nursing facility services on an extended stay basis, and therefore have already had a level of care determination performed by the SMA under the nursing facility admission process, the prior determination will be considered as conditionally meeting the waiver level of care determination requirement. Within fourteen working days of having received a referral, the applicant selected case management provider will validate that the individual continues to meet level of care requirements during the completion of the initial waiver comprehensive needs assessment, using the standard instrument/tool described in Appendix B-6(e). In the event the conditional determination is not validated by the case

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management provider, the individual will be advised through a written notice of agency action that the waiver eligibility criteria has not been met and offered an opportunity for a fair hearing.

- 2) For applicants who have not had level of care eligibility previously determined through the nursing facility admission process, a Department of Health RN will conduct a review of the standard instrument/tool to determine level of care.

Level-of-care reevaluations:

The contracted case management provider will validate that the individual continues to meet level of care requirements during the completion of the annual (at a minimum) comprehensive reassessment of the participant's needs, using the standard instrument/tool described in Appendix B-6(e), (MDS-HC). In the event the reevaluation indicates the participant no longer meets nursing facility level of care, a Department of Health RN will be contacted by the case management provider to conduct a review of the standard instrument/tool to determine level of care. If a participant is determined to not meet the nursing facility admission criteria, the individual will be advised through a written notice of agency action that the waiver eligibility criteria has not been met and offered an opportunity for a fair hearing. The contracted case management provider will be required to maintain a separate up to date record listing all MDS-HC's and the dates they were completed. This record must be made available to the Long Term Care Bureau, Department of Health, upon request. Records will be reviewed as a component of the quality assurance monitoring completed by the SMA.

- 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"/>	Every three months
<input type="radio"/>	Every six months
<input type="radio"/>	Every twelve months
<input checked="" type="radio"/>	Other schedule (<i>specify</i>):
	The Participant's level of care is screened at the time a substantial change in the participant's health status occurs to determine whether the participant's resultant health status constitutes an ongoing nursing facility level of care, including at the conclusion of an inpatient stay in a medical institution.
	A full level of care reevaluation is conducted whenever indicated by a health status change screening and at a minimum within 12 consecutive months of the last recorded level of care determination.

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

<input checked="" type="radio"/>	The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
<input type="radio"/>	The qualifications are different. The qualifications of individuals who perform reevaluations are (<i>specify</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*):

The level of care reevaluation and tracking process will be included as a standard requirement for all case management providers enrolled as waiver providers. Case management providers will be required to develop and maintain a tracking system to insure that reevaluations occur in a timely manner. Timeliness of reevaluations will periodically be reviewed by the Operating Agency and as part of the SMA Quality Assurance program.

- 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:

Records of level of care evaluations and reevaluations will be maintained in the participant's waiver case record maintained by the case management provider.

Quality Improvement: Level of Care

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

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

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

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

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

Performance Measure #1:	The number and percentage of initial evaluations for level of care in a representative sample that are conducted for applicants who meet New Choices Waiver guidelines for enrollment.		
<u>Data Source</u>	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
New Choices Waiver Records			
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100%

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			<i>Review</i>
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	<input checked="" type="checkbox"/> <i>Representative Sample; Confidence Interval = 5</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>Stratified: Describe Groups</i>
		<input checked="" type="checkbox"/> <i>Other: Specify: OA: Continuously and Ongoing SMA: At a minimum every 5 years</i>	
			<input type="checkbox"/> <i>Other: Describe</i>
<i>Data Aggregation and Analysis</i>	<i>Responsible Party for data aggregation and analysis (check each that applies)</i>	<i>Frequency of data aggregation and analysis: (check each that applies)</i>	
	<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	
	<input checked="" 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 checked="" type="checkbox"/> <i>Other: Specify: OA: Annually SMA: At a minimum every five years.</i>	

<i>Performance Measure #2:</i>	<i>The number and percentage of new participants in a representative sample who are admitted to the New Choices Waiver that meet nursing facility LOC.</i>		
<i>Data Source</i>	<i>Responsible Party for data collection/generation (check each that applies)</i>	<i>Frequency of data collection/generation: (check each that applies)</i>	<i>Sampling Approach (check each that applies)</i>
<i>LOC determination form</i>			
<i>MDS-HC</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 checked="" type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input checked="" 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 = 5</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>Stratified: Describe Groups</i>

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		<input checked="" type="checkbox"/> Other: Specify: OA: Continuously and Ongoing SMA: At a minimum every 5 years	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input checked="" 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 checked="" type="checkbox"/> Other: Specify: OA: Annually SMA: At a minimum every five years.	

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

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

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

Performance Measure #1:	The number and percentage of participants in a representative sample for whom a full level of care re-evaluation was conducted, at a minimum of annually (within the calendar month of the last level of care evaluation).		
Data Source LOC determination forms	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)

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MDS-HC			
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" 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 = 5
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input checked="" type="checkbox"/> Other: Specify: OA: Continuously and Ongoing SMA: At a minimum every 5 years	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input checked="" 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 checked="" type="checkbox"/> Other: Specify: OA: Annually SMA: At a minimum every five years.	

Performance Measure #2:	The number and percentage of participants in a representative sample for whom level of care was screened at the time a substantial change in health status occurred, including at the conclusion of an inpatient stay in a medical institution, to determine if the individual continued to meet nursing facility level of care.		
Data Source LOC determination forms MDS-HC Participant Records	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)

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	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input checked="" 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 = 5
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input checked="" type="checkbox"/> Other: Specify: OA: Annually SMA: At a minimum every 5 years	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input checked="" 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 checked="" type="checkbox"/> Other: Specify: OA: Annually SMA: At a minimum every five years.	

Performance Measure #3:	The number and percentage of participants in a representative sample for which a full level of care re-evaluation was conducted when indicated by a health status change screening.		
Data Source	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
LOC determination forms			
MDS-HC			
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input checked="" 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 = 5
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	

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		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input checked="" type="checkbox"/> Other: Specify: OA: Annually SMA: At a minimum every 5 years	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input checked="" 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 checked="" type="checkbox"/> Other: Specify: OA: Annually SMA: At a minimum every five years.	

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

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

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

Performance Measure #1:	The number and percentage of participants in a representative sample for whom an assessment for level of care was conducted by a qualified registered nurse or physician licensed in the state.		
Data Source	Responsible Party for data collection/generation	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
MDS-HC			

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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 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>
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	<input checked="" type="checkbox"/> <i>Representative Sample; Confidence Interval = 5</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>Stratified: Describe Groups</i>
		<input checked="" type="checkbox"/> <i>Other: Specify: At a minimum every 5 years</i>	
			<input type="checkbox"/> <i>Other: Describe</i>
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis <i>(check each that applies)</i>	Frequency of data aggregation and analysis: <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 checked="" type="checkbox"/> <i>Other: Specify: At a minimum every five years.</i>	

Performance Measure #2:	The number and percentage of participants, in a representative sample for whom the Level of Care Determination Form accurately documents the LOC criteria based on the MDS-HC assessment		
Data Source	Responsible Party for data collection/generation <i>(check each that applies)</i>	Frequency of data collection/generation: <i>(check each that applies)</i>	Sampling Approach <i>(check each that applies)</i>
LOC determination forms			
MDS-HC			
Participant Records			
	<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 checked="" type="checkbox"/> <i>Less than 100%</i>

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			<i>Review</i>
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	<input checked="" type="checkbox"/> <i>Representative Sample; Confidence Interval = 5</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>Stratified: Describe Groups</i>
		<input checked="" type="checkbox"/> <i>Other: Specify: SMA: At a minimum every five years.</i>	
			<input type="checkbox"/> <i>Other: Describe</i>
<i>Data Aggregation and Analysis</i>	<i>Responsible Party for data aggregation and analysis (check each that applies)</i>	<i>Frequency of data aggregation and analysis: (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 checked="" type="checkbox"/> <i>Other: Specify: SMA: At a minimum every five years.</i>	

<i>Performance Measure #3:</i>	<i>The number and percentage of participants in a representative sample for whom the Form 927, “Home and Community-Based Waiver Referral Form” documented the effective date of the applicant’s Medicaid eligibility determination and the effective date of the applicant’s level of care eligibility determination.</i>		
<i>Data Source</i>	<i>Responsible Party for data collection/generation (check each that applies)</i>	<i>Frequency of data collection/generation: (check each that applies)</i>	<i>Sampling Approach (check each that applies)</i>
<i>Participant records Form 927</i>			
	<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input type="checkbox"/> <i>100% Review</i>
	<input checked="" type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input checked="" type="checkbox"/> <i>Less than 100% Review</i>
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	<input checked="" type="checkbox"/> <i>Representative Sample; Confidence Interval = 5</i>
	<input type="checkbox"/> <i>Other: Specify:</i>	<input type="checkbox"/> <i>Annually</i>	
		<input type="checkbox"/> <i>Continuously and</i>	<input type="checkbox"/> <i>Stratified:</i>

State:	
Effective Date	

		<i>Ongoing</i>		<i>Describe Groups</i>
		<input checked="" type="checkbox"/> <i>Other: Specify:</i> <i>OA: Continuously and Ongoing</i> <i>SMA: At a minimum every 5 years</i>		
				<input type="checkbox"/> <i>Other: Describe</i>
<i>Data Aggregation and Analysis</i>	<i>Responsible Party for data aggregation and analysis</i> <i>(check each that applies)</i>	<i>Frequency of data aggregation and analysis:</i> <i>(check each that applies)</i>		
	<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>		
	<input checked="" 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 checked="" type="checkbox"/> <i>Other: Specify:</i> <i>OA: Annually</i> <i>SMA: At a minimum every 5 years.</i>		

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

All individuals who request New Choices Waiver services and who meet minimum requirements are evaluated by an R.N. using the Minimum Data Set for Home Care (MDS-HC) tool to determine if the applicant meets nursing facility level of care. For applicants who are currently receiving Medicaid reimbursed nursing facility services on an extended stay basis, and therefore have already had a level of care determination performed by the SMA under the nursing facility admission process, the prior determination will be considered as conditionally meeting the waiver level of care determination requirement. Within fourteen working days of having received a referral, the applicant selected case management provider will validate that the individual continues to meet level of care requirements by completing the initial waiver comprehensive needs assessment, using the standard instrument/tool described in Appendix B-6(e). In the event the conditional determination is not validated by the case management provider, the individual will be advised through a written notice of agency action that the waiver eligibility criteria has not been met and offered an opportunity for a fair hearing.

For applicants who have not had level of care eligibility previously determined through the nursing facility admission process, a Department of Health RN will conduct a review of the standard instrument/tool to determine level of care. Based on the MDS-HC assessment, the level of care criteria is documented on the Level of Care Determination Form.

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The SMA conducts an annual review of the New Choices Waiver program for each of the five waiver years. At a minimum, one comprehensive review will be conducted during this five year cycle. The comprehensive review will include participant and provider interviews. The other annual reviews will be focused reviews. The criteria for the focused reviews will be determined from the OA and SMA review findings as well as other issues that develop during the review year. The sample size for each review will be sufficient to provide a confidence level equal to 95% and a confidence interval equal to 5.

b. Methods for Remediation/Fixing Individual Problems

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

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

b.ii Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	Responsible Party (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
	<input checked="" 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 checked="" type="checkbox"/> Other: Specify: OA: Annually. SMA: At a minimum every five years.

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 Level of Care that are currently non-operational.

<input type="radio"/>	Yes (complete remainder of item)
<input checked="" type="radio"/>	No

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

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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).

1. The State Medicaid Agency’s LTC Health Program Specialist who is responsible for assisting the waiver applicant in completing the eligibility determination and enrollment process will provide information to the individual about the types of services available through the waiver and through the Medicaid nursing facility program as part of a pre-enrollment education and screening process.
2. When an individual is determined to be likely to require the nursing facility level of care and the LTC Health Program Representative determines that the individual can adequately be served in the community, the person or the person’s legal representative is:
 - a. Informed of any feasible alternatives under the waiver; and
 - b. Given the choice of either institutional or home and community-based services.
3. The individual is informed that the State Medicaid Agency provides an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to nursing facility institutional care.
4. A standard form will be signed by the participant to indicate the provision of choice.

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

Freedom of Choice forms will be maintained in the participant’s waiver case record maintained by the case management provider and also in the records maintained by the LTC Health Program Specialists.

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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):

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

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

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Appendix C: Participant Services

Appendix C-1: Summary of Services Covered

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

Statutory Services (check each that applies)		
Service	Included	Alternate Service Title (if any)
Case Management	<input checked="" type="checkbox"/>	
Homemaker	<input checked="" type="checkbox"/>	
Home Health Aide	<input type="checkbox"/>	
Personal Care	<input type="checkbox"/>	
Adult Day Health	<input checked="" type="checkbox"/>	Adult Day Care
Habilitation	<input checked="" type="checkbox"/>	
Residential Habilitation	<input type="checkbox"/>	
Day Habilitation	<input type="checkbox"/>	
Expanded Habilitation Services as provided in 42 CFR §440.180(c):		
Prevocational Services	<input type="checkbox"/>	
Supported Employment	<input type="checkbox"/>	
Education	<input type="checkbox"/>	
Respite	<input checked="" type="checkbox"/>	
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"/>	
Other Services (select one)		
<input type="radio"/>	Not applicable	
<input checked="" 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.	Adult Residential Services a) Adult host homes b) Assisted living facilities	

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	b) Licensed community residential care facilities c) Certified community residential care facilities		
b.	Attendant Care Services		
c.	Caregiver Training		
d.	Chore Services		
e.	Environmental Accessibility Adaptations a) Home Modifications b) Vehicle Modifications		
f.	Home Delivered Meals		
g.	Community Transition Services		
h.	Medication Assistance Services a) Medication Reminder System b) Medication Set-up		
i.	Personal Emergency Response System a) Purchase, Rental and Repair b) Installation, Testing and Removal c) Response Center Service Fee		
j.	Assistive Technology Devices		
k.	Specialized Behavioral Health Services		
Extended State Plan Services (select one)			
<input type="radio"/>	Not applicable		
<input checked="" type="radio"/>	The following extended State plan services are provided (list each extended State plan service by service title):		
a.	Supportive Maintenance (Home Health Aide) Services		
Supports for Participant Direction (check each that applies)			
<input checked="" type="radio"/>	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	<input checked="" type="checkbox"/>	Consumer Preparation Services
	Financial Management Services	<input checked="" type="checkbox"/>	

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

a.	
b.	
c.	

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

<input checked="" 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. NOTE: Pursuant to CMS-2237-IFC this selection is no longer available for 1915(c) waivers.</i>
<input type="checkbox"/>	Not applicable – Case management is not furnished as a distinct activity to waiver participants. <i>Do not 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:

Any enrolled Medicaid waiver case management provider, meeting the qualifications described in Appendix C-3 of this application, may conduct case management functions on behalf of waiver participants.

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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="radio"/>	<p>Yes. Criminal history and/or background investigations are required. Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):</p> <p style="padding-left: 40px;">The Utah Code, Section 26-21-9.5, requires that a Bureau of Criminal Identification screening, referred to as BCI, and a child or disabled or elderly adult licensing information system screening be conducted on each person who provides direct care to a patient for the following covered health care facilities:</p> <ul style="list-style-type: none"> (1) Home health care agencies; (2) Hospice agencies; (3) Nursing Care facilities; (4) Assisted Living facilities; (5) Small Health Care facilities; and (6) End Stage Renal Disease Facilities. <p style="padding-left: 40px;">Prior to, or within ten days of initially hiring an individual to provide care to an elderly adult or a disabled person in the home of the elderly adult or disabled person, a covered employer may submit the employed individual's information to the department.</p>
<input type="radio"/>	<p>No. 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="radio"/>	<p>Yes. The State maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):</p> <div style="border: 1px solid black; height: 40px; width: 100%;"></div>
<input checked="" type="radio"/>	<p>No. 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 type="radio"/>	<p>No. 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 checked="" type="radio"/>	<p>Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are</p>

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

Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit
Licensed Community Residential Care Facility	Adult Residential Services	No Limit
Assisted Living Facilities	Adult Residential Services	No Limit

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- 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.

Basic Utah licensing requirements for health care facilities regulated by the Utah Department of Health mandate that non-institutional facilities that serve four or more individuals provide single occupancy accommodations to their residents, except in the case where two individuals choose to share the living accommodation. Required features include space and equipment for food preparation and private and semi-private toilet facilities. In addition, provision is made for shared dining, internal group and individual activities, and opportunities to participate in community activities. Similar standards are required for residential treatment facilities licensed by the Department of Human Services Office of Licensing.

Beyond these basic licensing provisions for privacy and community integration, current State policy does not prescribe an arbitrary maximum size to qualify for Medicaid reimbursement as a non-institutional residential living setting or attempt to differentiate the quality of a waiver participant’s residential experience solely on the basis of size, number of occupants, or other physical plant design factors. Instead, the SMA encourages and fosters the development of a vast array of community based settings that are responsive to the needs and desires of the full spectrum of Medicaid participants eligible for participation in the New Choices Waiver. The State’s approach is to promote home and community based character by providing a wide variety of options from which to choose, affording participants ongoing opportunities to transition across residential options based upon the participant’s needs and individual preferences. With regard to larger residential settings, enrolled providers will to the greatest extent possible provide consumers with choices about their individual schedules and the living arrangements will be such that consumers have private living space, are at liberty to decide how they want to structure their schedules and activities and have access to their own amenities.

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

Standard	Facility Type	Facility Type	Facility Type	Facility Type
	Licensed Community Residential Facilities and Assisted Living Facilities			
Admission policies	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Safety	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Medication administration	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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:

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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"/>	No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
<input type="radio"/>	Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services. Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of <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"/>	The State does not make payment to relatives/legal guardians for furnishing waiver services.
<input type="radio"/>	The State makes payment to relatives/legal guardians under <i>specific circumstances</i> and only when the relative/guardian is qualified to furnish services. Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. <i>Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.</i>
<input type="radio"/>	Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-3. Specify any limitations on the types of relatives/legal guardians who may furnish services. Specify the controls that are employed to ensure that payments are made only for services rendered. <i>Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.</i>
<input checked="" type="radio"/>	Other policy. <i>Specify:</i> The State will permit the provision of waiver services furnished by relatives who are not legally responsible individuals whenever the relative is qualified to provide services as specified in Appendix C-3.

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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 SMA will enter into a provider agreement with all willing providers who meet licensure, certification and/or other qualifications. The SMA will employ various strategies to enlist providers as New Choices Waiver service providers including: Printing periodic articles in the Medicaid Information Bulletin, meeting with various provider groups including the Utah Assisted Living Association, the Utah Health Care Association and the Utah Association of Community Services Providers, and sending solicitation letters out to providers that are currently enrolled to provide services in Utah's other 1915(c) Home and Community Based Waiver Programs.

Interested providers will be required to complete a Medicaid provider agreement and all required documentation verifying provider qualification to the SMA. The application and documentation will then be reviewed by SMA staff for completeness. Upon approval of the application, it will be sent to the DMHF, Bureau of Medicaid Operations for processing. Upon assignment of a Medicaid Provider Number, the SMA will send the provider confirmation of their provider number, billing instructions, and a waiver provider manual. Provider training will be provided based upon the various provider types.

Quality Improvement: Qualified Providers

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

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

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

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

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

Performance Measure #1:	Number and percentage of licensed health care facilities, in a representative sample that maintain substantial compliance with State and Federal Regulations.		
<u>Data Source</u>	Responsible Party for data	Frequency of data collection/generation:	Sampling Approach (check each that

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Bureau of Licensing Records	collection/generation (check each that applies)	(check each that applies)	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: DOH Bureau of Licensing	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input checked="" type="checkbox"/> Other: Specify: At a minimum every 2 years	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<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 type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input checked="" type="checkbox"/> Other: Specify: At a minimum every 2 years	

Performance Measure #2:	The number and percentage of provider files, in a representative sample that contain the Medicaid Application with Attachment A, current business licenses and/or professional licenses.		
Data Source OA Files	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100%

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			<i>Review</i>
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	<input checked="" type="checkbox"/> <i>Representative Sample; Confidence Interval = 5</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>Stratified: Describe Groups</i>
		<input checked="" type="checkbox"/> <i>Other: Specify: OA: Continuously and Ongoing SMA: At a minimum every 5 years</i>	
			<input type="checkbox"/> <i>Other: Describe</i>
<i>Data Aggregation and Analysis</i>	<i>Responsible Party for data aggregation and analysis (check each that applies)</i>	<i>Frequency of data aggregation and analysis: (check each that applies)</i>	
	<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	
	<input checked="" 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 checked="" type="checkbox"/> <i>Other: Specify: OA: Annually SMA: at a minimum every five years.</i>	

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

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

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

<i>Performance Measure #1:</i>	<i>The number and percentage of Independent Living Facilities in a representative sample that receive an initial and/or annual certification</i>
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<i>from the LTCB</i>			
<u>Data Source</u>	<i>Responsible Party for data collection/generation (check each that applies)</i>	<i>Frequency of data collection/generation: (check each that applies)</i>	<i>Sampling Approach (check each that applies)</i>
OA Files			
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" 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 = 5
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input checked="" type="checkbox"/> Other: Specify: OA: Continuously and Ongoing SMA: At a minimum every 5 years	
			<input type="checkbox"/> Other: Describe
<i>Data Aggregation and Analysis</i>	<i>Responsible Party for data aggregation and analysis (check each that applies)</i>	<i>Frequency of data aggregation and analysis: (check each that applies)</i>	
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input checked="" 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 checked="" type="checkbox"/> Other: Specify: OA: Annually SMA: at a minimum every five years.	

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

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

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

Performance Measure #1:	The number and percentage of providers in a representative sample that receive annual New Choices Waiver training.		
<u>Data Source</u>	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
OA Files			
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" 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 = 5
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input checked="" type="checkbox"/> Other: Specify: OA: Annually SMA: At a minimum every 5 years	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input checked="" 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 checked="" type="checkbox"/> Other: Specify:	

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		OA: Annually SMA: at a minimum every five years.	

Performance Measure #2:	The number and percentage of Assisted Living Facilities in a representative sample that provided the annual training required by the Department of Health.		
<u>Data Source</u> OA Files	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<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 = 5
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input checked="" type="checkbox"/> Other: Specify: SMA: At a minimum every 5 years	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<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 type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input checked="" type="checkbox"/> Other: Specify: SMA: at a minimum every five years.	

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

The SMA conducts an annual review of the New Choices Waiver program for each of the five waiver years. At a minimum, one comprehensive review will be conducted during this five year cycle. The comprehensive review will include participant and provider interviews. The other annual reviews will be focused reviews. The criteria for the focused reviews will be determined from the OA and SMA review findings as well as other issues that develop during the review year. The sample size for each review will be sufficient to provide a confidence level equal to 95% and a confidence interval equal to 5.

b. Methods for Remediation/Fixing Individual Problems

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

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

b.ii Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	Responsible Party (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
	<input checked="" 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:

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 type="radio"/>	Yes (complete remainder of item)
<input checked="" type="radio"/>	No

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-3: Waiver Services Specifications

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

Service Specification	
Service Title:	Case Management
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input checked="" type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
<p>Services that assist participants in gaining access to needed waiver service and other Medicaid State Plan services, as well as needed medical, social, educational, and other services, regardless of the funding source. Case Management consists of the following activities:</p> <ul style="list-style-type: none"> a) Complete the initial comprehensive assessment and periodic reassessments to determine the services and supports required by the participant to prevent unnecessary institutionalization ; b) Perform reevaluations of participants' level of care; c) Complete the initial comprehensive service plan and periodic updates to address the participants identified needs; d) Research the availability of non-Medicaid resources needed by an individual to address needs identified through the comprehensive assessment process and assist the individual in gaining access to these resources; e) Assist the individual to gain access to available Medicaid State Plan services necessary to address identified needs; f) Assist the individual to select from available choices, an array of waiver services to address the identified needs and assist the individual to select from the available choice of providers to deliver each of the waiver services; g) Assist the individual to request a fair hearing if choice of waiver services or providers is denied; h) Monitor to assure the provision and quality of services identified in the individual's service plan; i) Support the individual/legal representative/family to independently obtain access to services when other funding sources are available; j) Monitoring the individual's health and safety status; k) Coordinate across Medicaid programs to achieve a holistic approach to care; l) Provide case management and transition planning services up to 180 days immediately prior to the date an individual transitions from a nursing facility to the waiver program; m) Provide discharge planning services to an individual disenrolling from the waiver; n) Perform internal quality assurance activities, addressing all performance measures. 	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
<p>In order to facilitate transition, case management services may be furnished up to 180 days prior to transition and providers may bill for this service once the participant enters into the waiver program.</p> <p>CMA's must provide supporting documentation to the OA if they request more than 12 units per month.</p> <p>Provider entities having the capacity to perform multiple case management functions must assure that the separation between the functions of the entity are clearly separated and their respective responsibilities well defined.</p>	

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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:
			Area Agencies on Aging
			Division of Services for People with Disabilities
			Independent Living Centers Certified Case Management Agencies
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/> Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Area Agencies on Aging	AAA employees with RN and SSW licensure		(a) Recognized Area Agency on Aging entity within the State (b) Medicaid provider enrolled to provide case management.
Division Services for People with Disabilities	DSPD employees with RN and SSW licensure		(a) Recognized Division of Service for People with Disabilities entity (b) Medicaid provider enrolled to provide case management.
Prepaid Inpatient Health Plans	PIHP employees with RN and SSW licensure		(a) Recognized Division of Service for People with Disabilities entity (b) Medicaid provider enrolled to provide case management. (c) Services provided under this waiver are paid to PIHPs on a fee-for-service basis only.
Independent Living Centers	ILC employees with RN and SSW licensure		(a) Independent Living Centers Recognized through the State Office of Rehabilitation (b) Medicaid provider enrolled to provide case management.
Accredited Case Management Agencies	Case Management Agency employees with RN and SSW licensure		(a) Case Management Agency accredited by DMHF approved organization. (b) Medicaid provider enrolled to provide case management.
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
Case Management Providers	Division of Medicaid and Health Financing, Long Term Care Bureau		Upon initial enrollment and routinely scheduled monitoring of waiver providers thereafter.

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Service Delivery Method		
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E
	<input checked="" type="checkbox"/>	Provider managed

Service Specification			
Service Title:	Homemaker		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input checked="" type="radio"/>	Service is included in approved waiver. There is no change in service specifications.		
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the approved waiver.		
Service Definition (Scope):			
Services consisting of the performance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
This service cannot be provided to consumers receiving Adult Residential Services or any other waiver service in which the tasks performed are duplicative of the homemaker services.			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>
		Self-directed services providers	Homemaker Agency and Home Health Agency
Specify whether the service may be provided by (check each that applies):			
	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>
			Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Agency Based - Homemaker	Current Business License		(a) Medicaid provider enrolled to provide Homemaker services (b) Demonstrated ability to perform the tasks ordered by the case management agency
Self-directed services – Homemaker			(a) Medicaid provider enrolled to provide Homemaker services (b) Demonstrated ability to perform the tasks ordered by the case

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			management agency
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
Homemaker Services	Division of Medicaid and Health Financing, Long Term Care Bureau		Upon initial enrollment and routinely scheduled monitoring of waiver providers thereafter.
Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

Service Specification			
Service Title:	Adult Day Care (Adult Day Health)		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input checked="" type="radio"/>	Service is included in approved waiver. There is no change in service specifications.		
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the approved waiver.		
Service Definition (Scope):			
Services generally furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the service plan, in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Transportation between the participant's place of residence and the adult day care site is not provided as a component of adult day care services and the cost of this transportation is not included in the rate paid to adult day care providers.			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies: Licensed Adult Day Care Facilities
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/> Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Licensed Adult Day Care Facilities	Adult Day Care Center: UAC R501-13-1-13 or R432-150-6 or R 432-270-29		Medicaid Provider enrolled to provide adult day care services.

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Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
Adult Day Care	Division of Medicaid and Health Financing, Long Term Care Bureau		Upon initial enrollment and routinely scheduled monitoring of waiver providers thereafter.
Service Delivery Method			
Service Delivery Method (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

Service Specification	
Service Title:	Habilitation Services
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input checked="" type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
<p>Habilitation Services are services designed to assist participants in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings.</p> <p>Specific services include the following:</p> <ol style="list-style-type: none"> restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment); social skills training in appropriate use of community services; development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion). 	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
<p>The following are specifically excluded from payment for habilitation services:</p> <ol style="list-style-type: none"> vocational services, prevocational services, supported employment services, and room and board. 	
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: Habilitation Providers
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/> Legally Responsible Person <input type="checkbox"/> Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):	

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Provider Type:	License (<i>specify</i>)	Certificate (<i>specify</i>)	Other Standard (<i>specify</i>)
Habilitation Services	R432-700 , Current Business License		Demonstrated ability to performs the tasks ordered on behalf of the waiver participant Medicaid Providers enrolled to provide habilitation services.
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
Habilitation Providers	Division of Medicaid and Health Financing, Long Term Care Bureau		Upon initial enrollment and routinely scheduled monitoring of waiver providers thereafter.
Service Delivery Method			
Service Delivery Method (<i>check each that applies</i>):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

Service Specification			
Service Title:	Respite Care Services		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input checked="" type="radio"/>	Service is included in approved waiver. There is no change in service specifications.		
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the approved waiver.		
Service Definition (Scope):			
Care provided to give relief to, or during the absence of, the normal care giver. Respite care may include hourly, daily and overnight support and may be provided in the individual's place of residence, a facility approved by the State which is not a private residence, or in the private residence of the respite care provider.			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Payments for respite services are not made for room and board except when provided as a part of respite care in a setting, approved by the State that is not the individual's private residence. In the case of respite care services that are rendered out of the consumer's private residence in a setting approved by the State, this service will be billed under a specific "Respite Care-Out of the home/Room and Board included" billing code. All instances in which respite care services are delivered for a period of six hours or more within a day shall be billed using a daily rate rather than hourly rates for this service. Each Residential Respite Care episode is limited to a period of 13 consecutive days or less not counting the day of discharge. The number of Residential Respite Care episodes may not exceed three in any calendar year.			
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:
		Self-Directed Services Employees	Home Health Agencies
			Licensed Health Care Facilities
			Licensed Residential Treatment Facilities
Specify whether the service may be provided by (<i>check each that applies</i>):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/> Relative/Legal Guardian

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Provider Qualifications (provide the following information for each type of provider):				
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)	
Home Health Agency	R432-700		Demonstrated ability to performs the tasks ordered on behalf of the waiver participant All providers: Medicaid provider enrolled to provide respite services.	
Adult Day Care	R501-13-1			
Nursing Facilities	R432-150			
Assisted Living Facilities	R432-270			
Residential Treatment Facility	R501-19-13			
Verification of Provider Qualifications				
Provider Type:	Entity Responsible for Verification:		Frequency of Verification	
Respite Care Services	Division of Medicaid and Health Financing, Long Term Care Bureau		Upon initial enrollment and routinely scheduled monitoring of waiver providers thereafter.	
Service Delivery Method				
Service Delivery Method (check each that applies):	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed

Service Specification	
Service Title:	Adult Residential Services
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input checked="" type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
<p>Personal care and supportive services (homemaker, chore, attendant services, meal preparation), including companion services, medication oversight (to the extent permitted under State law), including 24 hour on-site response capability to meet scheduled or unpredictable participant needs and to provide supervision, safety and security in conjunction with residing in a homelike, non-institutional setting. Services also include social and recreational programming, and medication assistance (to the extent permitted under State law). Services provided by third parties must be coordinated with the residential services provider.</p> <p>Service and support include 24 hour on-site response capability or other alternative emergency response</p>	

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arrangements determined appropriate to meet scheduled or predictable participant needs and to provide supervision, safety and security in conjunction with residing in a homelike, non-institutional setting.

Nursing and skilled therapy services are incidental, rather than integral to the provision of adult residential services.

Types of Adult Residential Services Providers:

- a) Adult host homes
- b) Assisted living facilities
- c) Licensed community residential care facilities
- d) Certified community residential care facilities*

* Certified community residential care facilities are those in which 3 or fewer individuals reside.

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

Separate payment is not made for homemaker services, chore services, or companion services furnished to a participant receiving adult residential services, since these services are integral to and inherent in the provision of adult residential services.

Payment is not made for 24-hour skilled care or supervision. Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. The methodology by which the costs of room and board are excluded from payments for adult residential services is described in Appendix I.

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:
				Adult Host Homes, Assisted Living Facilities, Licensed community residential care facilities, Certified community residential care facilities.

Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
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Provider Qualifications (provide the following information for each type of provider):

Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Adult Host Home	Current Business License		All Providers: Medicaid provider enrolled to provide adult residential services
Certified Community Residential Care Facilities	Current Business License	SMA or OA Certification	
Licensed Community Residential Care Facilities	R432-270 R432-200 R432-300 or R501-19		

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Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Adult Residential Services	Division of Medicaid and Health Financing, Long Term Care Bureau	Upon initial enrollment and routinely scheduled monitoring of waiver providers thereafter.
Service Delivery Method		
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/> Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

Service Specification		
Service Title:	Attendant Care Services	
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>		
<input checked="" type="radio"/>	Service is included in approved waiver. There is no change in service specifications.	
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.	
<input type="radio"/>	Service is not included in the approved waiver.	
Service Definition (Scope):		
Supportive and health-related services, specific to the needs of a participant with disabilities. Supportive services are those that reinforce an individual's strengths, while substituting or compensating for the absence, loss, diminution, or impairment of a physical or cognitive function. Attendant services incorporate and respond to the participant's preferences and priorities. Health-related services may include skilled or nursing care to the extent permitted by State law. Health related services are provided and supervised as required under State law, or the terms under which the specific attendant worker has been certified to furnish the service. Documentation of any delegation or assignment of nursing tasks or supervision will be maintained in the participant's service plan.		
Specify applicable (if any) limits on the amount, frequency, or duration of this service:		
This service cannot be provided to participants receiving Adult Residential Services or any other waiver service in which the tasks performed are duplicative of the attendant care services.		
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:
	Individual employees hired under the self-administered services method	Home Health Agency Personal Care Services Agency
Specify whether the service may be provided by <i>(check each that</i>	<input type="checkbox"/> Legally Responsible Person	<input type="checkbox"/> Relative/Legal Guardian

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<i>applies):</i>			
Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Attendant Care Services	R432-700		All providers: Medicaid providers enrolled to provide attendant care services
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
Attendant Care Services	Division of Medicaid and Health Financing, Long Term Care Bureau		Upon initial enrollment and routinely scheduled monitoring of waiver providers thereafter.
Service Delivery Method			
Service Delivery Method (check each that applies):	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

Service Specification	
Service Title:	Caregiver Training
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input checked="" type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
<p>Training and counseling services for individuals who provide unpaid support, training, companionship or supervision to participants. For purposes of this service, individual is defined as any person, family member, neighbor, friend, companion or co-worker who provides uncompensated care, training, guidance, companionship, or support to a person served on the waiver. Individuals who are employed to support the participant may not receive this service. Training includes instruction about treatment regimens and other services included in the service plan, use of equipment specified in the service plan, and includes updates as necessary to safely maintain the participant at home. All training the individuals who provide unpaid support to the participant must be included in the participant's service plan. The service covers the costs of registration and training fees associated with formal instruction in areas relevant to participant needs identified in the service plan.</p>	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
No limits	

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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:
			Formal training suppliers; home health agencies
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/> Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
As authorized by State law for specific training category	R156 or R432 as applicable (providers of training in categories requiring license under State law) Or Current business license (formal training suppliers)		(a) Demonstrated ability to perform the tasks ordered by the case management agency. (b) Medicaid provider enrolled to provide caregiver training
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
All Caregiver Training Suppliers	Division of Medicaid and Health Financing, Long Term Care Bureau		Upon initial enrollment and routinely scheduled monitoring of waiver providers thereafter.
Service Delivery Method			
Service Delivery Method (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

Service Title:	Chore Services
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input checked="" type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy	

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household chores such as washing floors, carpet cleaning, pest eradication, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access or egress.				
Specify applicable (if any) limits on the amount, frequency, or duration of this service:				
These services are provided only when neither the participant nor anyone else in the household is capable of performing or financially providing for them, and where no other caregiver, landlord, community/volunteer agency, or third party payer is capable or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, is examined prior to any authorization of service. Additionally this service is not available concurrent with any other waiver service in which the tasks performed are duplicative of chore services.				
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:
		Individual employees hired under the self-administered services method		Chore service providers
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):				
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)	
Chore Services	Current Business License		(a) Medicaid provider enrolled to provide chore services (b) demonstrated ability to perform the tasks ordered by case management provider	
Verification of Provider Qualifications				
Provider Type:	Entity Responsible for Verification:		Frequency of Verification	
Chore Services	Division of Medicaid and Health Financing, Long Term Care Bureau		Upon initial enrollment and routinely scheduled monitoring of waiver providers thereafter.	
Service Delivery Method				
Service Delivery Method (check each that applies):	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed

Service Title:	Environmental Accessibility Adaptations a) Home Modifications
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	b) Vehicle Modifications
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Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

- | | |
|----------------------------------|--|
| <input checked="" type="radio"/> | Service is included in approved waiver. There is no change in service specifications. |
| <input type="radio"/> | Service is included in approved waiver. The service specifications have been modified. |
| <input type="radio"/> | Service is not included in the approved waiver. |

Service Definition (Scope):

Equipment and/or physical adaptations to the individual’s residence or vehicle which are necessary to assure the health, welfare and safety of the individual or which enable the individual to function with greater independence in the home and in the community, and without which, the individual would require institutionalization. The equipment/adaptations are identified in the individual's service plan and the model and type of equipment are specified by a qualified individual. The adaptations may include purchase, installation, and repairs. Other adaptation and repairs may be approved on a case by case basis as technology changes or as an individual’s physical or environmental needs change. All services shall be provided in accordance with applicable State or local building codes and may include the following:

- Home
 - Authorized equipment/adaptations such as:
 - a. Ramps
 - b. Grab bars
 - c. Widening of doorways/hallways
 - d. Modifications of bathroom/kitchen facilities
 - e. Modification of electric and plumbing systems which are necessary to accommodate the medical equipment, care and supplies that are necessary for the welfare of the individual.
- Vehicle
 - Authorized vehicle adaptations such as:
 1. lifts
 2. door modifications
 3. steering/braking/accelerating/shifting modifications
 4. seating modifications
 5. safety/security modifications

The following are specifically excluded:

- a. Adaptations or improvements to the home or vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual;
- b. Adaptations that add to the total square footage of the home;
- c. Purchase or lease of a vehicle; and
- d. Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

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

Service Limit: The maximum allowable cost per environmental accessibility adaptation is \$2,000.00. At the point a waiver participant reaches the service limit, the care coordination team will conduct an evaluation to determine how the individual’s health and safety can continue to be assured through authorization for additional service beyond the limit or alternative arrangements that meet the individual’s needs while remaining in a community setting.

Provider Specifications

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Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
				Environmental adaptations suppliers
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>				
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>	
Environmental Adaptations Supplier	Current business license and Contractor's license when applicable		All providers: Demonstrated ability to perform the tasks ordered by the case management agency.	
Verification of Provider Qualifications				
Provider Type:	Entity Responsible for Verification:		Frequency of Verification	
Environmental Adaptations Supplier	Division of Medicaid and Health Financing, Long Term Care Bureau		Upon initial enrollment and routinely scheduled monitoring of waiver providers thereafter.	
Service Delivery Method				
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed

Service Title:	Home Delivered Meals
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input checked="" type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
Home Delivered Supplemental Meal provides a nutritionally sound and satisfying meal to individuals who are unable to prepare their own meals and who do not have a responsible party or volunteer caregiver available to prepare their meals for them.	
Elements of Home Delivered Supplemental Meal Category: The Home Delivered Supplemental Meal category includes a prepared meal component and a nutritional supplement component. Either component constitutes a	

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supplemental meal when provided in an amount that meets the nutritional needs of the individual. Each supplemental meal provided shall provide a minimum of 33 1/3 percent of the daily Recommended Dietary Allowances (RDA) and Dietary Reference Intake (DRI) as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences, Institute of Medicine and Mathematica Policy Research, Incorporated.

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

Meals provided as part of this service shall not constitute a "full nutritional regimen" (3 meals per day).

Provider Specifications

Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
				Restaurants, Health care facilities, Local Public agencies

Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
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Provider Qualifications *(provide the following information for each type of provider):*

Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Home Delivered Meals	Current business license		Compliance with UAC R70-530 All programs: Medicaid providers enrolled to provide home delivered meals

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Delivered Meals	Division of Medicaid and Health Financing, Long Term Care Bureau	Upon initial enrollment and routinely scheduled monitoring of waiver providers thereafter.

Service Delivery Method

Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
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Service Title: **Community Transition Services**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

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Service Definition (Scope):				
Provision of essential household items and services needed to establish basic living arrangements in a community setting that enable the individual to establish and maintain health and safety. Essential household items include basic furnishings, kitchen and bathroom equipment and goods, communication devices, and security devices. This service also includes moving expenses, one-time non-refundable fees to establish utility services and other services essential to the operation of the residence, and services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy.				
Specify applicable (if any) limits on the amount, frequency, or duration of this service:				
Reimbursement for the cost of rent or food is not a covered expense under this service. Reimbursable items are limited to only those household items that are essential. Reimbursement for the cost of refundable fees or deposits is not a covered expense under this service.				
The maximum allowable cost for this service is \$1,000.00. At the point a waiver participant reaches the allowable cost limit, the operating agency will conduct an evaluation to determine authorization of any additional service.				
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:
				Suppliers of household furnishings, equipment and supplies.
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):				
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)	
Institutional Transition Suppliers	Current business license if applicable			
Verification of Provider Qualifications				
Provider Type:	Entity Responsible for Verification:		Frequency of Verification	
Institutional Transition Suppliers	Division of Medicaid and Health Financing, Long Term Care Bureau		Upon initial enrollment and routinely scheduled monitoring of waiver providers thereafter.	
Service Delivery Method				
Service Delivery Method (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed

Service Title:	Medication Administration Assistance Services
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Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

<input checked="" type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the approved waiver.

Service Definition (Scope):

- Medication Reminder System (Not Face-To-Face)
Medication Reminder System provides a medication reminder by a third party entity or individual that is not the clinician responsible for prescribing and/or clinically managing the individual, not the entity responsible for the administration of medication, and not the entity responsible for the provision of nursing or personal care, attendant care, or companion care services. Services involve non face-to-face medication reminder techniques (e.g. phone calls, telecommunication devices, medication dispenser devices with electronic alarms which alert the individual and a central response center staffed with qualified individuals, etc.)
- Medication Set-Up
Services of an individual authorized by State law to set-up medications in containers that facilitate safe and effective self-administration when individual dose bubbling packaging by a pharmacy is not available and assistance with self-administration is not covered as an element of another waiver service.

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

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

Provider Specifications

Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
				Medication reminder equipment suppliers, Home health agencies

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

<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
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Provider Qualifications *(provide the following information for each type of provider):*

Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Medication Administration Assistance	UAC R156-31b (medication set-up) Current business license as applicable (reminder devices)		Medicaid provider enrolled to provide medication administration assistance.

Verification of Provider Qualifications

State:	
Effective Date	

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Medication Administration Assistance	Division of Medicaid and Health Financing, Long Term Care Bureau	Upon initial enrollment and routinely scheduled monitoring of waiver providers thereafter.
Service Delivery Method		
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/> Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

Service Title:	Personal Emergency Response System		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input checked="" type="radio"/>	Service is included in approved waiver. There is no change in service specifications.		
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the approved waiver.		
Service Definition (Scope):			
An electronic device that enables an individual to secure help in an emergency through a connection to a signal response center that is staffed by trained professionals on a 24 hour per day, seven days a week basis.			
<ul style="list-style-type: none"> - Personal Emergency Response Systems (PERS) Response Center Service Provides ongoing access to a signal response center that is staffed twenty-four hours per day, seven days a week by trained professionals responsible for securing assistance in the event of an emergency. - Personal Emergency Response System (PERS) Purchase, Rental & Repair Provides an electronic device of a type that allows the individual to summon assistance in an emergency. The device may be any one of a number of such devices but must be connected to a signal response center. - Personal Emergency Response System (PERS) Installation, Testing & Removal Provides installation, testing, and removal of the PERS electronic device by trained personnel. 			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
No Limits			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:
			Personal Emergency Response System supplier; Home Health Agency; Other response centers
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/> Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>

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Emergency Response System Supplier	Current business license, and		Equipment suppliers: FCC registration of equipment placed in the individual's home.
Personal Emergency Response System Installer	Current business license, and		Installers: Demonstrated ability to properly install and test specific equipment being handled.
Personal Emergency Response Center	Current business license, and		Response Centers: 24 hour per day operation, 7 days per week. All providers: Medicaid provider enrolled to provide personal emergency response system services.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Emergency Response System	Division of Medicaid and Health Financing, Long Term Care Bureau	Upon initial enrollment and routinely scheduled monitoring of waiver providers thereafter.

Service Delivery Method

Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
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Service Title:	Specialized Medical Equipment and Supplies
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input checked="" type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service covers items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the	

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State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation. Coverage includes the costs of maintenance and upkeep of equipment, training the participant or caregivers in the operation and/or maintenance of the equipment or the use of a supply, and the performance of assessments to identify the type of equipment needed by the participant.

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:
				Medical equipment and supply suppliers
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):				
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)	
Medical equipment and supply suppliers	Current business license if applicable		Medicaid provider enrolled to provide medical equipment and supplies.	
Verification of Provider Qualifications				
Provider Type:	Entity Responsible for Verification:		Frequency of Verification	
Medical equipment and supply suppliers	Division of Medicaid and Health Financing, Long Term Care Bureau		Upon initial enrollment and routinely scheduled monitoring of waiver providers thereafter.	
Service Delivery Method				
Service Delivery Method (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed

Service Title:	Transportation - Non-Medical
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
<input checked="" type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
Service offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the service plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, and does not	

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Effective Date	

replace them. Transportation services under the waiver are offered in accordance with the participant's service plan. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized.				
Specify applicable (if any) limits on the amount, frequency, or duration of this service:				
Non-Medical transportation is not available for the provision of transportation to medical appointments.				
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:
				Public transit agencies, taxi companies, private transportation companies.
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):				
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)	
Non-Medical Transportation	Licensed public transportation carrier or Individual driver's license		All providers: (a) Registered and insured vehicle: UCA 53-3-202, UCA 41-12s-301 to 412 (b) Medicaid provider enrolled to provide non-medical transportation services.	
Verification of Provider Qualifications				
Provider Type:	Entity Responsible for Verification:		Frequency of Verification	
Non-Medical Transportation Providers	Division of Medicaid and Health Financing, Long Term Care Bureau		Upon initial enrollment and routinely scheduled monitoring of waiver providers thereafter.	
Service Delivery Method				
Service Delivery Method (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed

Service Title:	Personal Budget Assistance
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
<input checked="" type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the approved waiver.

State:	
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Service Definition (Scope):				
Personal budget assistance provides assistance with financial matters, fiscal training, supervision of financial resources, savings, retirement, earnings and funds monitoring, monthly check writing, bank reconciliation, budget management, tax and fiscal record keeping and filing, and fiscal interaction on behalf of the individual.				
The purpose of this service is to offer opportunities for waiver participants to increase their ability to provide for their own basic needs, increase their ability to cope with day to day living, maintain more stability in their lives and maintain the greatest degree of independence possible, by providing timely financial management assistance to waiver participants in the least restrictive setting, for those individuals who have no close family or friends willing to take on the task of assisting them with their finances.				
Specify applicable (if any) limits on the amount, frequency, or duration of this service:				
The Personal Budget Assistance provider must assist the waiver participant in reviewing their finances/budget at least monthly, must maintain documentation of this review and must submit the budget review documentation to the to the Case Management Agency for review on a monthly basis.				
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:
				Personal Budget Assistance Providers
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):				
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)	
Personal Budget Assistance	Current Business License		Medicaid provider enrolled to provide personal budget assistance. Demonstrated ability to perform task.	
Verification of Provider Qualifications				
Provider Type:	Entity Responsible for Verification:		Frequency of Verification	
Personal Budget Assistance	Division of Medicaid and Health Financing, Long Term Care Bureau		Upon initial enrollment and routinely scheduled monitoring of waiver providers thereafter.	
Service Delivery Method				
Service Delivery Method (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed

State:	
Effective Date	

Service Title:		Assistive Technology Devices		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>				
<input checked="" type="radio"/>	Service is included in approved waiver. There is no change in service specifications.			
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.			
<input type="radio"/>	Service is not included in the approved waiver.			
Service Definition (Scope):				
<p>This service under the waiver differs in nature, scope, supervision arrangements, or provider from services in the State plan. Assistive technology device means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. Assistive technology includes--</p> <p>(A) The evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;</p> <p>(B) Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants;</p> <p>(C) Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;</p> <p>(D) Coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan;</p> <p>(E) Training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and</p> <p>(F) Training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.</p>				
Specify applicable (if any) limits on the amount, frequency, or duration of this service:				
<p>Service Limit: The maximum allowable cost per assistive technology device is \$2,000.00. At the point a waiver participant reaches the service limit, the care coordination team will conduct an evaluation to determine how the individual's health and safety can continue to be assured through authorization for additional service beyond the limit or alternative arrangements that meet the individual's needs while remaining in a community setting.</p> <p>Therapies that are not directly related to instructing the participant on the use or selection of an assistive device are not covered under this service.</p>				
Provider Specifications				
Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
				Assistive technology device supplier
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>				
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>	

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Assistive Technology Device Supplier	Current Business License		Medicaid provider enrolled to provide assistive technology device supplier

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Assistive Technology Device Supplier	Division of Medicaid and Health Financing, Long Term Care Bureau	Upon initial enrollment and routinely scheduled monitoring of waiver providers thereafter.

Service Delivery Method				
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed

Service Title: **Specialized Behavioral Health Services**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

This waiver service is designed specifically to address complex needs of waiver enrollees who demonstrate severe, persistent behavior problems related to organic brain diseases, acquired brain injuries, dementia and dementia-related conditions, and other non-psychiatric factors, and who require levels of service that are not otherwise available through the Medicaid State plan or Prepaid Mental Health Program (PMHP). This service is above and beyond the services provided by the State plan and not duplicative in nature.

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

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

These services are available to individuals whose severe, persistent behaviors have been documented during the comprehensive needs assessment process and have been determined to be problems related to organic brain

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diseases, acquired brain injuries, dementia and dementia-related conditions, and other non-psychiatric factors.

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:
			Specialized Behavioral Health Services

Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
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Provider Qualifications (provide the following information for each type of provider):

Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Specialized Behavioral Health Services	UAC Title R156; and R501 as applicable		(a) Board Certified Associate Behavior Analysts (BCABA); or proof of achievement of a post-graduate degree of at least a Masters' in a behaviorally-related field as well as experience of at least one year working in the field of mental retardation or other related conditions; or (b) Completion of a training course in positive behavioral supports approved by the SMA and the successful completion of a learning assessment at the conclusion of the course. And All Providers: (c) Medicaid provider enrolled to provide specialized behavioral health services

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Specialized Behavioral Health Services	Division of Medicaid and Health Financing, Long Term Care Bureau	Upon initial enrollment and routinely scheduled monitoring if waiver providers thereafter.

Service Delivery Method

Service Delivery Method (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed

State:	
Effective Date	

Service Title:	Supportive Maintenance (Home Health Aide) Services			
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>				
<input checked="" type="radio"/>	Service is included in approved waiver. There is no change in service specifications.			
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.			
<input type="radio"/>	Service is not included in the approved waiver.			
Service Definition (Scope):				
Services defined in 42 CFR 440.70 that are provided when home health aide services furnished under the approved State plan limits are exhausted. The scope and nature of these services do not differ from home health aide services furnished under the State plan. Services are defined in the same manner as provided in the approved State plan. The provider qualifications specified in the State plan apply.				
Specify applicable (if any) limits on the amount, frequency, or duration of this service:				
Supportive maintenance services will only be ordered after full utilization of available State Plan home health services by the participant.				
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 Agency
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):				
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)	
Supportive Maintenance Services	Home Health Agency: UAC R432-700	Certified by the LTCB as an authorized provider of services and supports.	Under State contract with LTCB as an authorized provider of services and supports.	
Verification of Provider Qualifications				
Provider Type:	Entity Responsible for Verification:		Frequency of Verification	
Supportive Maintenance Services	Division of Medicaid and Health Financing, Long Term Care Bureau		Upon initial enrollment and routinely scheduled monitoring of waiver providers thereafter.	
Service Delivery Method				
Service Delivery Method (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed

State:	
Effective Date	

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Service Title: **Consumer Preparation Services**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Services that assists the participant (or the participant’s family or representative, as appropriate) in arranging for, directing and managing services. Serving as the agent of the participant or family, the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services. Practical skills training is offered to enable families and participants to independently direct and manage waiver services. Examples of skills training include providing information on recruiting and hiring personal care workers, managing workers and providing information on effective communication and problem-solving. The service/function includes providing information to ensure that participants understand the responsibilities involved with directing their services. The extent of the assistance furnished to the participant or family is specified in the service plan. This service does not duplicate other waiver services, including case management.

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

This service is limited to participants who direct some or all of their waiver services or are considering directing some or all of their waiver services.

Provider Specifications

Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
				Independent Living Centers

Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
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Provider Qualifications *(provide the following information for each type of provider):*

Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Consumer Preparation Services	Have entered into a Medicaid Provider Agreement with the Department of Health. Current Business License	Certified by the LTCB as an authorized provider of services and supports.	1) Under State contract with LTCB as an authorized provider of services and supports. 2) Must complete a training course approved by the Long Term Care Bureau, State Medicaid Agency, and must demonstrate competency in related topical area(s) of: <ul style="list-style-type: none"> a) Self-determination b) Natural supports c) Instruction and/or consultation with families/siblings on:

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			i) Assisting self sufficiency ii) Safety 3) Must be a professional with a bachelor's degree in social or behavioral sciences or a mental health professional with a master's degree in social or behavioral sciences.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Consumer Preparation Services	Division of Medicaid and Health Financing, Long Term Care Bureau	Upon initial enrollment and routinely scheduled monitoring if waiver providers thereafter.

Service Delivery Method

Service Delivery Method (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed

Service Title: **Financial Management Services**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

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

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

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

Service is provided to those utilizing Self Administered Services

Provider Specifications

Provider Individual. List types: Agency. List the types of agencies:

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Category(s) (check one or both):		Licensed Public Accounting Agency

Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
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Provider Qualifications (provide the following information for each type of provider):

Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Financial Management Services	Certified Public Accountant Sec 58-26A, UCA And R 156-26A, UAC	Certified by the LTCB as an authorized provider of services and supports.	<ul style="list-style-type: none"> • Under State contract with LTCB as an authorized provider of services and supports. • Comply with all applicable State and Local licensing, accrediting, and certification requirements. • Understand the laws, rules and conditions that accompany the use of State and local resources and Medicaid resources. • Utilize accounting systems that operate effectively on a large scale as well as track individual budgets. • Utilize a claims processing system acceptable to the Utah State Medicaid Agency. • Establish time lines for payments that meet individual needs within DOL standards. • Generate service management, and statistical information and reports as required by the Medicaid program. • Develop systems that are flexible in meeting the changing circumstances of the Medicaid program. • Provide needed training and technical assistance to clients, their representatives, and others. • Document required Medicaid provider qualifications and enrollment requirements and maintain results in provider/employee file. • Act on behalf of the person receiving supports and services for the purpose of payroll reporting. • Develop and implement an effective payroll system that addresses all related tax obligations.

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			<ul style="list-style-type: none"> • Make related payments as approved in the person’s budget, authorized by the case management agency. • Generate payroll checks in a timely and accurate manner and in compliance with all federal and state regulations pertaining to “domestic service” workers. • Conduct background checks as required and maintain results in employee file. • Process all employment records. • Obtain authorization to represent the individual/person receiving supports. • Prepare and distribute an application package of information that is clear and easy for the individuals hiring their own staff to understand and follow. • Establish and maintain a record for each employee and process employee employment application package and documentation. • Utilize and accounting information system to invoice and receive Medicaid reimbursement funds. • Utilize and accounting and information system to track and report the distribution of Medicaid reimbursement funds. • Generate a detailed Medicaid reimbursement funds distribution report to the individual Medicaid recipient or representative semi-annually. • Withhold, file and deposit FICA, FUTA and SUTA taxes in accordance with federal IRS and DOL, and state rules. • Generate and distribute IRS W-2’s. Wage and Tax Statements and related documentation annually to all support workers who meet the statutory threshold earnings amounts during the tax year by January 31st. • File and deposit federal and state income taxes in accordance with federal IRS and state rules and regulations. • Assure that employees are paid established unit rates in accordance with the federal and state Department of
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			<p>Labor Fair Labor Standards Act (FLSA)</p> <ul style="list-style-type: none"> • Process all judgments, garnishments, tax levies or any related holds on an employee's funds as may be required by local, state or federal laws. • Distribute, collect and process all employee time sheets as summarized on payroll summary sheets completed by the person or his/her representative. • Prepare employee payroll checks, at least monthly, sending them directly to the employees. • Keep abreast of all laws and regulations relevant to the responsibilities it has undertaken with regard to the required federal and state filings and the activities related to being a Fiscal/Employer Agent. • Establish a customer service mechanism in order to respond to calls from individuals or their representative employers and workers regarding issues such as withholding and net payments, lost or late checks, reports and other documentation. • Customer service representatives are able to communicate effectively in English and Spanish by voice and TTY with people who have a variety of disabilities. • Have a Disaster Recovery Plan for restoring software and master files and hardware backup if management information systems are disabled so that payroll and invoice payment systems remain intact. • Regularly file and perform accounting auditing to ensure system accuracy and compliance with general accounting practice.
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Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Financial Management Services	Division of Medicaid and Health Financing, Long Term Care Bureau	Upon initial enrollment and routinely scheduled monitoring if waiver providers thereafter.

State:	
Effective Date	

Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed
	<input type="checkbox"/>		<input type="checkbox"/>

State:	
Effective Date	

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

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

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

<input type="checkbox"/>	Limit(s) on Set(s) of Services. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver. <i>Furnish the information specified above.</i>
<input type="checkbox"/>	Prospective Individual Budget Amount. 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"/>	Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services. <i>Furnish the information specified above.</i>
<input type="checkbox"/>	Other Type of Limit. The State employs another type of limit. <i>Describe the limit and furnish the information specified above.</i>
<input checked="" type="checkbox"/>	Not applicable. The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

State:	
Effective Date	

Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	
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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"/>	Registered nurse, licensed to practice in the State
<input type="checkbox"/>	Licensed practical or vocational nurse, acting within the scope of practice under State law
<input checked="" type="checkbox"/>	Licensed physician (M.D. or D.O)
<input checked="" type="checkbox"/>	Case Manager (qualifications specified in Appendix C-3)
<input type="checkbox"/>	Case Manager (qualifications not specified in Appendix C-3). <i>Specify qualifications:</i>
<input checked="" type="checkbox"/>	Social Worker. <i>Specify qualifications:</i>
<input type="checkbox"/>	Other (<i>specify the individuals and their qualifications</i>):

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

<input type="radio"/>	Entities and/or individuals that have responsibility for service plan development <i>may not provide</i> other direct waiver services to the participant.
<input checked="" type="radio"/>	Entities and/or individuals that have responsibility for service plan development <i>may provide</i> other direct waiver services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. <i>Specify:</i>
	Safeguards to ensure appropriate service plan development will include utilization of a standardized form, developed by the SMA, listing all services covered under the waiver as well as <u>all</u> potential providers of each service category available in the participants’ area of residence. The form will also provide information that participants have the right to select a provider of services different than the entity developing the service plan. Waiver participants will sign the standardized form to acknowledge that they were informed of all services offered and given a choice of waiver providers. Forms will be reviewed as a component of the quality assurance monitoring completed by the SMA. Additionally a sample of participants will be interviewed to determine their satisfaction with the waiver program – offering choice of service providers is one element of data collected in the survey.

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

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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 service plan is developed in consultation with the participant, the participant's legal representative, the participant's case management agency and any other individuals of the waiver participant's choosing.
The waiver participant will have service plan development information made available to them.

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

The service plan is developed based upon the assessed needs of the waiver participant. The participant’s needs are assessed by utilizing a standard comprehensive assessment instrument, the InterRAI MINIMUM DATA SET – HOME CARE. (MDS-HC) The MDS-HC provides a comprehensive assessment to identify the services and supports necessary to assure the health, welfare and safety of waiver participants. The comprehensive assessment is completed by the case management agency on participants’ application to the waiver, at a minimum of annually (within the calendar month of the last level of care evaluation), and at any time a significant change in the participant’s status occurs that necessitates an increase or decrease in services.

The service plan is developed in consultation with the participant, the participant’s legal representative, the participant’s and any other individuals of the waiver participant’s choosing. The participant or legal representative will be advised of any needs identified during the assessment process and given the opportunity to accept or decline services that would address those needs. The participant will be provided with the standardized form listing all waiver services and waiver providers available in their area and given the opportunity to select their service providers.

The service plan will contain, at a minimum, the following information:

1. Service plan effective date;
2. Full name of the waiver participant;
3. Address;
4. Names of Case management agency participants;
5. List of all waiver services to be provided to the individual, regardless of the funding source;
6. The approved amount, frequency and duration for each service;
7. The type and name of qualified provider(s) selected to furnish each service;
8. Expected start date for each service;

Signatures of the waiver participant, the case management agency members, and the individual’s legal representative, when applicable, are required on each of the completed assessments.

The participant selected Case Management agency will be responsible for implementing and coordinating the developed service plan. The service plan must be approved by the Operating Agency prior to implementation. Service plans will be reviewed as a component of the quality assurance monitoring completed by the SMA. Additionally a sampling of participants will be interviewed to survey their satisfaction with the waiver program.

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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.

During the comprehensive needs assessment and service plan development process will complete a risk analysis to identify: Risks posed by the participant’s physical and cognitive conditions and choice of services and supports to best meet the participant’s needs.

In completing the risk analysis, specific emphasis will be placed on identifying risks that would result in a high likelihood of death or actual harm if an interruption in the delivery of services and supports to the waiver participant occurred.

The risk analysis will be reviewed with the waiver enrollee and others of the person’s choosing. The individual service plan will describe services and supports to be rendered to mitigate risks and will identify back-up plans for the provision of essential services.

- 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.

Waiver participants will sign the standardized form, listing all waiver services and providers of those services in their area, to acknowledge that they were given a choice of waiver providers. These forms will be updated and provider information reviewed with the participant during the participants’ annual MDS-HC assessment process and at any time there is a change in services. Forms will be reviewed as a component of the quality assurance monitoring completed by the SMA.

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

The SMA retains final authority for oversight and approval of the service planning process. The oversight function involves at a minimum an annual review of a sample of waiver enrollee’s service plans that is representative of the caseload distribution across the program. If the sample evaluation identifies system-wide service planning problems, an expanded review is initiated by the SMA.

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

<input type="radio"/>	Every three months or more frequently when necessary
<input type="radio"/>	Every six months or more frequently when necessary
<input type="radio"/>	Every twelve months or more frequently when necessary
<input checked="" type="radio"/>	Other schedule (<i>specify</i>):
	The individual’s service plan is screened at the time a substantial change in the individual’s health status occurs to determine whether modifications to the service plan are necessary. A full service plan review is conducted:
	a. Whenever indicated by the results of a health status change screening;
	b. In conjunction with completion of a full comprehensive assessment;
	c. At a minimum of annually (within the calendar month of the last level of care evaluation)

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and within 14 days of annual MDS-HC.
d. All revisions must be reviewed and approved by the Operating Agency prior to implementation

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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"/>	Medicaid agency
<input type="checkbox"/>	Operating agency
<input checked="" type="checkbox"/>	Case manager
<input type="checkbox"/>	Other (<i>specify</i>):

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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 case management agency has “front-line” responsibility for monitoring the health and welfare of waiver participants and to ensure the appropriate implementation of the service plan, including oversight to ensure that services are delivered within the scope, frequency, and duration described in the service plan. The assigned case manager from the case management agency will meet with the participant face to face as assessed necessary to insure the quality of services provided by the waiver service providers. Summarization of the performance of these oversight activities will be documented in the case management notes in the individual waiver participants’ case files.

The Operating Agency is responsible to review and approve all service plans prior to implementation. All service plans are subject to annual and periodic reviews by the SMA. A sample of service plans will be reviewed periodically. Significant findings from those reviews will be addressed with the case management agencies. The case management agencies will be required to develop a plan of correction with specific timeframes for completion to address identified concerns. The SMA will conduct follow-up reviews as necessary to ensure the plan of correction is implemented and sustained.

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

<input type="radio"/>	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare <i>may not provide</i> other direct waiver services to the participant.
<input checked="" type="radio"/>	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare <i>may provide</i> other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. <i>Specify:</i>
	Safeguards to ensure appropriate service plan development will include utilization of a standardized form listing all potential providers of each service category. Waiver participants will sign the standardized form, which will be developed by the SMA, to acknowledge that they were given a choice of waiver providers. The case management agency will be required to maintain these forms in their files. These forms will be reviewed as a component of the quality assurance monitoring completed by the OA and the SMA. Additionally a sampling of participants will be interviewed to verify that they were given a choice of providers and in order to survey their satisfaction with the waiver program – offering choice of service providers is one element of data collected in the survey.

Quality Improvement: Service Plan

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

- a. Methods for Discovery: **Service Plan Assurance/Sub-assurances**

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

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

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

Performance Measure #1:	The number and percentage of care plans in a representative sample which address the needs identified in the full assessment.		
Data Source MDS-HC Care Plan	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input checked="" 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 = 5
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input checked="" type="checkbox"/> Other: Specify: OA: Continuously and Ongoing SMA: At a minimum every 5 years	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	

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	<input checked="" 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 checked="" type="checkbox"/> <i>Other: Specify: OA: Annually SMA: at a minimum every five years.</i>	

<i>Performance Measure #2:</i>	<i>The number and percentage of care plans in a representative sample in which State plan services and other resources, for which the individual is eligible, are exhausted prior to authorizing the same service offered through the waiver.</i>		
<i>Data Source</i> Care Plan	<i>Responsible Party for data collection/generation</i> <i>(check each that applies)</i>	<i>Frequency of data collection/generation:</i> <i>(check each that applies)</i>	<i>Sampling Approach</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>100% Review</i>
	<input checked="" type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input checked="" type="checkbox"/> <i>Less than 100% Review</i>
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	<input checked="" type="checkbox"/> <i>Representative Sample; Confidence Interval = 5</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>Stratified: Describe Groups</i>
		<input checked="" type="checkbox"/> <i>Other: Specify: OA: Continuously and Ongoing SMA: At a minimum every 5 years</i>	
			<input type="checkbox"/> <i>Other: Describe</i>
<i>Data Aggregation and Analysis</i>	<i>Responsible Party for data aggregation and analysis</i> <i>(check each that applies)</i>	<i>Frequency of data aggregation and analysis:</i> <i>(check each that applies)</i>	
	<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	
	<input checked="" 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>	

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		<input type="checkbox"/> Continuously and Ongoing	
		<input checked="" type="checkbox"/> Other: Specify: OA: Annually SMA: at a minimum every five years.	

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

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

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

Performance Measure #1:	The number and percentage of care plans in a representative sample that are updated, at a minimum, within 14 days of the annual MDS-HC		
<u>Data Source</u>	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
Care Plan			
MDS-HC			
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input checked="" 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 = 5
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input checked="" type="checkbox"/> Other: Specify: OA: Continuously and Ongoing SMA: At a minimum every 5 years	
			<input type="checkbox"/> Other: Describe

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Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input checked="" 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 checked="" type="checkbox"/> Other: Specify: OA: Annually SMA: at a minimum every five years.	

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

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

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

Performance Measure #1:	The number and percentage of care plans in a representative sample that are updated, at a minimum, annually (the calendar month of the last level of care evaluation).		
Data Source Care Plan Participant Records	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" 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 = 5

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	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input checked="" type="checkbox"/> Other: Specify: OA: Continuously and Ongoing SMA: At a minimum every 5 years	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input checked="" 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 checked="" type="checkbox"/> Other: Specify: OA: Annually SMA: at a minimum every five years.	

Performance Measure #2:	The number and percentage of care plans in a representative sample that are updated when warranted by changes in the waiver participant's needs.		
Data Source	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
Care Plan			
Participant Records			
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input checked="" 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 = 5
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and	<input type="checkbox"/> Stratified:

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		Ongoing	Describe Groups
		<input checked="" type="checkbox"/> Other: Specify: OA: Continuously and Ongoing SMA: At a minimum every 5 years	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input checked="" 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 checked="" type="checkbox"/> Other: Specify: OA: Annually SMA: at a minimum every five years.	

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

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

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

Performance Measure #1:	The number and percentage of participants in a representative sample whose record contains documentation they were contacted by their Case Managers, monthly, either by phone or in person to monitor the delivery and quality of services provided.		
Data Source Care Plan	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)

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Participant Records	<i>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 checked="" type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input checked="" type="checkbox"/> <i>Less than 100% Review</i>
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	<input checked="" type="checkbox"/> <i>Representative Sample; Confidence Interval = 5</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>Stratified: Describe Groups</i>
		<input checked="" type="checkbox"/> <i>Other: Specify: OA: Continuously and Ongoing SMA: At a minimum every 5 years</i>	
			<input type="checkbox"/> <i>Other: Describe</i>
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis <i>(check each that applies)</i>	Frequency of data aggregation and analysis: <i>(check each that applies)</i>	
	<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	
	<input checked="" 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 checked="" type="checkbox"/> <i>Other: Specify: OA: Annually SMA: at a minimum every five years.</i>	

Performance Measure #2:	The number and percentage of care plans in a representative sample that identify the amount, frequency and duration for each waiver service.		
Data Source	Responsible Party for data collection/generation <i>(check each that applies)</i>	Frequency of data collection/generation: <i>(check each that applies)</i>	Sampling Approach <i>(check each that applies)</i>
Care Plan			
Participant Records			

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	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input checked="" 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 = 5
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input checked="" type="checkbox"/> Other: Specify: OA: Continuously and Ongoing SMA: At a minimum every 5 years	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input checked="" 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 checked="" type="checkbox"/> Other: Specify: OA: Annually SMA: at a minimum every five years.	

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

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

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

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Performance Measure #1:	The number and percentage of participants in a representative sample who were offered the choice between institutional care and home and community based waiver services as documented on the “Freedom of Choice Consent Form”.		
Data Source Freedom of Choice Consent Form	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input checked="" 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 = 5
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input checked="" type="checkbox"/> Other: Specify: OA: Continuously and Ongoing SMA: At a minimum every 5 years	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input checked="" 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 checked="" type="checkbox"/> Other: Specify: OA: Annually SMA: at a minimum every five years.	

Performance Measure #2:	The number and percentage of participants in a representative sample who were offered the choice between waiver providers as documented on
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<i>the “Freedom of Choice of Waiver Providers Form”.</i>			
<u>Data Source</u>	<i>Responsible Party for data collection/generation (check each that applies)</i>	<i>Frequency of data collection/generation: (check each that applies)</i>	<i>Sampling Approach (check each that applies)</i>
Care Plan			
Participant Records			
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input checked="" 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 = 5
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input checked="" type="checkbox"/> Other: Specify: OA: Continuously and Ongoing SMA: At a minimum every 5 years	
			<input type="checkbox"/> Other: Describe
<i>Data Aggregation and Analysis</i>	<i>Responsible Party for data aggregation and analysis (check each that applies)</i>	<i>Frequency of data aggregation and analysis: (check each that applies)</i>	
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input checked="" 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 checked="" type="checkbox"/> Other: Specify: OA: Annually SMA: at a minimum every five years.	

<i>Performance Measure #3:</i>	<i>The number and percentage of participants in a representative sample who received a list of all NCW services as documented on the “Freedom of Choice of Waiver Providers Form”.</i>		
<u>Data Source</u>	<i>Responsible Party for data</i>	<i>Frequency of data collection/generation:</i>	<i>Sampling Approach (check each that</i>

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Care Plan	collection/generation (check each that applies)	(check each that applies)	applies)
Participant Records			
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input checked="" 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 = 5
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input checked="" type="checkbox"/> Other: Specify: OA: Continuously and Ongoing SMA: At a minimum every 5 years	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input checked="" 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 checked="" type="checkbox"/> Other: Specify: OA: Annually SMA: at a minimum every five years.	

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

The SMA conducts an annual review of the New Choices Waiver program for each of the five waiver years. At a minimum, one comprehensive review will be conducted during this five year cycle. The comprehensive review will include participant and provider interviews. The other annual reviews will be focused reviews. The criteria for the focused reviews will be determined from the OA and SMA

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review findings as well as other issues that develop during the review year. The sample size for each review will be sufficient to provide a confidence level equal to 95% and a confidence interval equal to 5.

b. Methods for Remediation/Fixing Individual Problems

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

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

b.ii Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	Responsible Party (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
	<input checked="" 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 checked="" type="checkbox"/> Other: Specify: OA: Annually. SMA: At a minimum every five years.

c. Timelines

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

<input type="radio"/>	Yes (complete remainder of item)
<input checked="" type="radio"/>	No

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

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Appendix E: Participant Direction of Services

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

Applicability (select one):

<input checked="" type="radio"/>	Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
<input type="radio"/>	No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

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

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

Appendix E-1: Overview

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

Participant direction will be limited to participation in decision-making related to employer related activities. The waiver will not involve participation in budget decision making.
 The State authorized waiver services to be provided through two service delivery methods as defined below:

Agency Based Provider Service delivery means the provision of services through a licensed or certified agency or through a contracted vendor. Under this method, participants choose from which provider they wish to receive services. Services are then provided by the chosen agency. It is then the responsibility of the provider agency to perform the functions of supervising, hiring, assuring that provider qualifications are met, scheduling, paying the wages, etc. of the agency’s employees. All waiver service categories are available under the Agency Based Provider Service delivery method.

Self-Administered Services* means service delivery that is provided through a non-agency based provider. Under this method, the individuals and/or their chosen representatives hire individual employees to perform a waiver service/s. The individual and/or their chosen representative are then responsible to perform the functions of supervising, hiring, assuring that employee qualifications are met, scheduling, assuring accuracy of time sheet, etc. of the individual employee/s.

In the case of an individual who cannot direct his or her own services, another person may be appointed as the decision-maker in accordance with applicable State law. The appointed person must perform supervisory activities at a frequency and intensity specified in the service plan. The appointed person may also train the employee to perform assigned activities.

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The Self-Administered Service method requires the individual to use a Financial Management Services provider as an integral component of the waiver service to assist with managing the employer-related financial responsibilities associated with the delivery of self-administered services.

Appendix E-1(g) identifies services that are available under the Self-Administered Services method.

* Individuals authorized to receive services under the Self Administered Services method may also receive services under the Agency Based Provider Service method in order to obtain the array of services that best meet the individual’s needs.

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

<input checked="" type="radio"/>	Participant – Employer Authority. 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"/>	Participant – Budget Authority. 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"/>	Both Authorities. 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 checked="" 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 (<i>specify</i>):

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

<input type="radio"/>	Waiver is designed to support only individuals who want to direct their services.
<input type="radio"/>	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 checked="" type="radio"/>	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. <i>Specify the criteria:</i>
	<ol style="list-style-type: none"> 1. Participants may only choose to direct the covered waiver services listed in E-1(g). 2. Participants must acknowledge the obligation of the State to assure basic health and safety and agree to abide by necessary safeguards negotiated during the risk assessment/service planning process. 3. In the case of an individual who cannot direct his or her own waiver services, another person may be appointed as the decision-maker in accordance with applicable State law.

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.

A two-stage approach will be used to inform each individual about the overall participant-directed approach available through the waiver and about specific details of the process through which an individual can choose to self-direct to the degree desired.

Initially, the SMA Health Program Representative will provide a general orientation to the participant-directed approach, including written materials, to each individual during the waiver eligibility determination and enrollment process. At the time information will be provided regarding the freedom to choose self-directed, the mandatory use of a Financial Management Agent, and the responsibilities of the waiver enrollee and the case management agency related to self-direction. During the comprehensive needs assessment process, the case management agency will identify each individual’s needs that can be addressed through one or more of the available self-administered waiver services. The case management agency will inform the individual of the opportunity to utilize self-direction for the identified services and discuss the option to directly employ the provider or to utilize an agency based provider.

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Upon the decision of the individual to utilize self-direction, the case management agency will assist the individual in selecting a financial management services provider to be used in conjunction with self-direction.

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

<input type="radio"/>	The State does not provide for the direction of waiver services by a representative.
<input checked="" type="radio"/>	The State provides for the direction of waiver services by a representative. 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.
<input checked="" type="checkbox"/>	Waiver services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant: Individual’s possessing decision making capability, but having communication deficits or Limited English Proficiency (LEP) may select a representative to communicate decisions on the individual’s behalf.

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

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Homemaker Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Non-residential Respite Care Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Chore Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Personal Attendant Services	<input checked="" 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*:

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

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

<input checked="" type="radio"/>	FMS are covered as the waiver service entitled Financial Management Services as specified in Appendix C-3. <i>Provide the following information</i> :
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○	FMS are provided as an administrative activity. <i>Provide the following information:</i>								
i.	<p>Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:</p> <p>The State uses private vendors to furnish FMS. Any qualified, willing provider may enroll to offer this service. The procurement method is the same as with all other service.</p>								
ii.	<p>Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:</p> <p>Payment for FMS is a monthly unit that is paid to the providers.</p>								
iii.	<p>Scope of FMS. Specify the scope of the supports that FMS entities provide (<i>check each that applies</i>):</p> <p><i>Supports furnished when the participant is the employer of direct support workers:</i></p> <table border="1"> <tr> <td align="center"><input checked="" type="checkbox"/></td> <td>Assist participant in verifying support worker citizenship status</td> </tr> <tr> <td align="center"><input checked="" type="checkbox"/></td> <td>Collect and process timesheets of support workers</td> </tr> <tr> <td align="center"><input checked="" type="checkbox"/></td> <td>Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance</td> </tr> <tr> <td align="center"><input checked="" type="checkbox"/></td> <td> <p><i>Other (specify):</i></p> <p>In support of self-administration, Financial Management Services will assist individuals in the following activities:</p> <ol style="list-style-type: none"> 1. Verify that the employee completed the following forms <ol style="list-style-type: none"> a. Form I-9, including supporting documentation (i.e. copies of driver's license, social security card, passport). If fines are levied against the person for failure to report INS information, the Fiscal Agent shall be responsible for all such fines. b. Form W-4 2. Obtain a completed and signed Form 2678, Employer Appointment of Agent, from each person receiving services from the Financial Management Services provider, in accordance with IRS Revenue Procedure 70-6. 3. Provide persons with a packet of all required forms when using a Financial Management Services provider, including all tax forms (IRS Forms I-9, W-4 and 2678), payroll schedule, Financial Management Services provider's contact information, and training material for the web-based timesheet. 4. Process and pay approved employee timesheets, including generating and issuing paychecks to employees hired by the person. 5. Assume all fiscal responsibilities for withholding and depositing FICA and SUTA/FUTA payments on behalf of the person. Any federal and/or State penalties assessed for failure to withhold the correct amount and/or timely filing and depositing will be paid by the Financial Management Services provider. 6. Maintain a customer service system for persons and employees who may have billing </td> </tr> </table>	<input checked="" type="checkbox"/>	Assist participant in verifying support worker citizenship status	<input checked="" type="checkbox"/>	Collect and process timesheets of support workers	<input checked="" type="checkbox"/>	Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance	<input checked="" type="checkbox"/>	<p><i>Other (specify):</i></p> <p>In support of self-administration, Financial Management Services will assist individuals in the following activities:</p> <ol style="list-style-type: none"> 1. Verify that the employee completed the following forms <ol style="list-style-type: none"> a. Form I-9, including supporting documentation (i.e. copies of driver's license, social security card, passport). If fines are levied against the person for failure to report INS information, the Fiscal Agent shall be responsible for all such fines. b. Form W-4 2. Obtain a completed and signed Form 2678, Employer Appointment of Agent, from each person receiving services from the Financial Management Services provider, in accordance with IRS Revenue Procedure 70-6. 3. Provide persons with a packet of all required forms when using a Financial Management Services provider, including all tax forms (IRS Forms I-9, W-4 and 2678), payroll schedule, Financial Management Services provider's contact information, and training material for the web-based timesheet. 4. Process and pay approved employee timesheets, including generating and issuing paychecks to employees hired by the person. 5. Assume all fiscal responsibilities for withholding and depositing FICA and SUTA/FUTA payments on behalf of the person. Any federal and/or State penalties assessed for failure to withhold the correct amount and/or timely filing and depositing will be paid by the Financial Management Services provider. 6. Maintain a customer service system for persons and employees who may have billing
<input checked="" type="checkbox"/>	Assist participant in verifying support worker citizenship status								
<input checked="" type="checkbox"/>	Collect and process timesheets of support workers								
<input checked="" type="checkbox"/>	Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance								
<input checked="" type="checkbox"/>	<p><i>Other (specify):</i></p> <p>In support of self-administration, Financial Management Services will assist individuals in the following activities:</p> <ol style="list-style-type: none"> 1. Verify that the employee completed the following forms <ol style="list-style-type: none"> a. Form I-9, including supporting documentation (i.e. copies of driver's license, social security card, passport). If fines are levied against the person for failure to report INS information, the Fiscal Agent shall be responsible for all such fines. b. Form W-4 2. Obtain a completed and signed Form 2678, Employer Appointment of Agent, from each person receiving services from the Financial Management Services provider, in accordance with IRS Revenue Procedure 70-6. 3. Provide persons with a packet of all required forms when using a Financial Management Services provider, including all tax forms (IRS Forms I-9, W-4 and 2678), payroll schedule, Financial Management Services provider's contact information, and training material for the web-based timesheet. 4. Process and pay approved employee timesheets, including generating and issuing paychecks to employees hired by the person. 5. Assume all fiscal responsibilities for withholding and depositing FICA and SUTA/FUTA payments on behalf of the person. Any federal and/or State penalties assessed for failure to withhold the correct amount and/or timely filing and depositing will be paid by the Financial Management Services provider. 6. Maintain a customer service system for persons and employees who may have billing 								

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questions or require assistance in using the web-based timesheet. The Financial Management Services provider will maintain an 800-number for calls received outside the immediate office area. Messages must be returned within 24 hours Monday thru Friday. Messages left between noon on Friday and Sunday evening shall be returned the following Monday.

a. Must have capabilities in providing assistance in English and Spanish. Fiscal Agent must also communicate through TTY, as needed, for persons with a variety of disabilities.

7. File consolidated payroll reports for multiple employers. The Financial Management Services provider must obtain federal designation as Financial Management Services provider under IRS Rule 3504, (Acts to be Performed by Agents). A Financial Management Services provider applicant must make an election with the appropriate IRS Service Center via Form 2678, (Employer Appointment of Agent). The Financial Management Services provider must carefully consider if they want to avail the Employers of the various tax relief provisions related to domestics and family employers. The Financial Management Services provider may forego such benefits to maintain standardization. Treatment on a case-by-case basis is tedious, and would require retroactive applications and amended employment returns. The Financial Management Services provider will, if required, comply with IRS Regulations 3306(a)(3)(c)(2), 3506 and 31.3306(c)(5)-1 and 31.3506 (all parts), together with IRS Publication 926, Household Employer's Tax Guide. In order to be fully operational, the Form 2678 election should be postured to fall under two vintages yet fully relevant Revenue Procedures; Rev. Proc. 70-6 allows the Financial Management Services provider file one employment tax return, regardless of the number of employers they are acting for, provided the Financial Management Services provider has a properly executed Form 2678 from each Employer. Rev. Proc 80-4 amplifies 70-6, and does away with the multiple Form 2678

Supports furnished when the participant exercises budget authority:

- Maintain a separate account for each participant's participant-directed budget
- Track and report participant funds, disbursements and the balance-of participant funds
- Process and pay invoices for goods and services approved in the service plan
- Provide participant with periodic reports of expenditures and the status of the participant-directed budget
- Other services and supports (*specify*):

Additional functions/activities:

- Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
- Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
- Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget
- Other (*specify*):

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iv.		<p>Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.</p> <p>The State Medicaid Agency and the OA will assure that high standards are maintained by utilizing the following: surveys of clients, regular observation and evaluation by case managers, provider quality assurance reviews, and other oversight activities as appropriate.</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 checked="" type="checkbox"/>	<p>Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. <i>Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:</i></p> <p>During the comprehensive needs assessment process, the will identify each individual's needs that can be addressed through one or more of the available self-administered waiver services. The case management agency will inform the individual of the opportunity to utilize self-direction for the identified services and discuss the option to directly employ the provider or to utilize an agency based provider.</p>
<input checked="" type="checkbox"/>	<p>Waiver Service Coverage. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-3 entitled: Consumer Preparation Services</p>
<input type="checkbox"/>	<p>Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity. <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 type="radio"/>	<p>Yes. Independent advocacy is available to participants who direct their services. <i>Describe the nature of this independent advocacy and how participants may access this advocacy:</i></p>
<input checked="" type="radio"/>	<p>No. Arrangements have not been made for independent advocacy.</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:

<p>In the event the individual make a voluntary declaration to terminate self-direction of one or more waiver services, the case management provider will revise the service plan to address access to necessary services through agency based providers. This process will include all aspects of service plan development including participation by the participant and individuals of his or her choosing and offering choice of providers.</p>

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.

<p>In the event it is determined that the individual is unable to adequately perform necessary self-</p>
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administered services activities and has no qualified appointed person to direct the services on behalf of the participant, the service plan will be revised to address access to necessary services through agency based providers. This process will include all aspects of service plan development including participation by the participant and individuals of his or her choosing and offering choice of providers.

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

Table E-1-n		
	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1	30	
Year 2	35	
Year 3	40	
Year 4 (renewal only)	45	
Year 5 (renewal only)	50	

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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. Check each that applies:

<input type="checkbox"/>	Participant/Co-Employer. The participant (or the participant’s representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. <i>Specify the types of agencies (a.k.a., “agencies with choice”) that serve as co-employers of participant-selected staff; the standards and qualifications the State requires of such entities and the safeguards in place to ensure that individuals maintain control and oversight of the employee:</i>
<input checked="" type="checkbox"/>	Participant/Common Law Employer. The participant (or the participant’s representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant’s agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

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

<input checked="" type="checkbox"/>	Recruit staff
<input type="checkbox"/>	Refer staff to agency for hiring (co-employer)
<input type="checkbox"/>	Select staff from worker registry
<input checked="" type="checkbox"/>	Hire staff (common law employer)
<input type="checkbox"/>	Verify staff qualifications
<input type="checkbox"/>	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated:
<input checked="" type="checkbox"/>	Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-3.
<input checked="" type="checkbox"/>	Determine staff duties consistent with the service specifications in Appendix C-3.
<input checked="" type="checkbox"/>	Determine staff wages and benefits subject to applicable State limits
<input checked="" type="checkbox"/>	Schedule staff
<input checked="" type="checkbox"/>	Orient and instruct-staff in duties
<input checked="" type="checkbox"/>	Supervise staff
<input checked="" type="checkbox"/>	Evaluate staff performance
<input checked="" type="checkbox"/>	Verify time worked by staff and approve time sheets
<input checked="" type="checkbox"/>	Discharge staff (common law employer)
<input type="checkbox"/>	Discharge staff from providing services (co-employer)

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<input type="checkbox"/>	Other (<i>specify</i>):

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

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

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

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

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

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

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

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

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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.

1. Upon the individual's choice of home and community based services, the case management agency conducts a comprehensive assessment. The comprehensive assessment identifies; (a) the individual's needs related to assuring health, welfare, and safety in a home or community setting in lieu of institutionalization and (b) the individual's goals related to enhancing community integration and quality of life.
2. The individual is informed of the results of the assessment and the specific needs identified as related to assuring health, welfare, and safety in a home or community setting in lieu of institutionalization.
3. The individual is informed that the SMA provides an opportunity for a fair hearing, under 42 CFR Part 431, Subpart E, to individuals who are not advised of the results of the comprehensive assessment or feel the assessment results do not accurately reflect the individual's needs related to assuring health, welfare, and safety in a home and community setting in lieu of institutionalization.
4. Written documentation of the individual's acknowledgement that the case management agency fully disclosed the results of the comprehensive assessment and the right to a fair hearing is documented.
5. From the comprehensive assessment, a written service plan is developed by the case management agency in accordance with Appendix D-1 to address the individual's identified needs through a specified array of services and supports. The written service plan may also incorporate other optional services and supports that are not primary to preventing institutionalization or protecting health and safety but will contribute in assisting the individual to achieve personal goals for independence and community integration. The service plan will identify these other services and support as optional and will identify funding sources other than Medicaid to cover any associated costs.
6. The individual is informed that the SMA provides an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to individuals who are not advised of the content of the service plan, are not advised of the specific service providers responsible for providing identified services, or who feel the service plan does not accurately reflect the individual's needs related to assuring health, welfare, and safety in a home and community setting in lieu of institutionalization.
7. Written documentation of the individual's acknowledgement that the case management agency fully disclosed the results of the service plan development, afforded free choice of providers, and the right to a fair hearing is documented.

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8. The Division of Medicaid and Health Financing provides an individual applying for or receiving waiver services an opportunity for a hearing upon written request, if the individual is:
 - a) Not given the choice of institutional (NF) care or HCBS waiver services.
 - b) Denied the waiver provider(s) of choice if more than one provider is available to render the service(s).
 - c) Denied access to waiver services identified as necessary to prevent institutionalization.
 - d) Experiences a reduction, suspension, or termination of waiver services identified as necessary to prevent institutionalization.
9. An individual and the individual's legal representative, as applicable, will receive a written Notice of Agency Action from the Single State Medicaid Agency if the individual is denied a choice of institutional or New Choices Waiver program, or found ineligible for the waiver program.
10. An individual and the individual's legal representative, as applicable, will receive a written Notice of Agency Action from the contracted case management agency if the individual is denied access to the provider of choice for a covered waiver service. The Notice of Agency Action delineates the individual's right to appeal the decision.
11. An aggrieved individual may request a formal hearing within 30 calendar days from the date written notice is issued or mailed, whichever is later. The Division of Medicaid and Health Financing may reinstate services for recipients or suspend any adverse action for providers if the aggrieved person requests a formal hearing not more than ten calendar days after the date of action.
- 12.. The individual is encouraged to utilize an informal dispute resolution process to expedite equitable solutions but may forgo or interrupt the available informal resolution process at any time by completing a request for hearing and directing the request be sent to the Department of Health for a formal hearing and determination.
13. An informal dispute resolution process does not alter the requirements of the formal fair hearings process. The individual must still file a request for hearing and a request for continuation of services within the mandatory time frames established by the Division of Medicaid and Health Financing. An informal dispute resolution must occur prior to the deadline for filing the request for continuation of service and/or the request for formal hearing, or be conducted concurrent with the formal hearing process.

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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="radio"/>	Yes. The State operates an additional dispute resolution process (<i>complete Item b</i>)
<input type="radio"/>	No. This Appendix does not apply (<i>do not complete Item b</i>)

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

The participant handbook will describe the participant’s ability to contact the SMA constituent services line to discuss issues or concerns. The SMA constituent services representative will log the issue and will assign the review to the Long Term Care Bureau staff to review and follow-up as necessary. Documentation of the issue and outcome will be retained by the SMA.

Participants are encouraged to utilize the informal dispute resolution process to expedite equitable solutions but may forgo or interrupt the a informal process at any time by completing a request for hearing and directing that the request be sent to the Department of Health for a formal hearing and determination.

Utilizing the informal dispute resolution process does not alter the time requirements for requesting a formal fair hearing. The participant must still file a request for hearing and a request for continuation of services within the mandatory time frames established by the Division of Medicaid and Health Financing.

The informal dispute resolution activities will either be completed within the time limits allowed for filing a request for a fair hearing or the waiver participants will be advised of the need to file a request for a fair hearing within the allowed time limits and continue the informal dispute resolution process during the interim period until the fair hearing is actually scheduled and conducted.

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Appendix F-3: State Grievance/Complaint System

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

<input checked="" type="radio"/>	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 <i>(complete the remaining items)</i> .
<input type="radio"/>	No. This Appendix does not apply <i>(do not complete the remaining items)</i>

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

The SMA is the agency 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 participant handbook will describe the participant’s ability to contact the SMA constituent services line to discuss issues or concerns. The SMA constituent services representative will log the issue and will assign the review to the Long Term Care Bureau staff to review and follow-up as necessary. Documentation of the issue and outcome will be retained by the SMA.</p> <p>The informal dispute resolution activities will either be completed within the time limits allowed for filing a request for a fair hearing or the waiver participants will be advised of the need to file a request for a fair hearing within the allowed time limits and continue the informal dispute resolution process during the interim period until the fair hearing is actually scheduled and conducted.</p>
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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"/>	Yes. The State operates a Critical Event or Incident Reporting and Management Process <i>(complete Items b through e)</i>
<input type="radio"/>	No. This Appendix does not apply <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).

Incidents of abuse, neglect or exploitation must be reported in accordance with Utah State Law 76-5-111 and State Rule R510-302. Waiver services providers must subsequently report such incidences to the SMA through a standardized incident reporting system.

In addition to reporting incidents of abuse, neglect or exploitation waiver services providers must report the following to the SMA:

1. death of a waiver participant
2. events that result in the need to obtain direct intervention by a medical professional (IE: physician office visit, emergency room visit, or hospitalization)
3. events in which the waiver participants injures another waiver participant or staff of a waiver services provider if the injury results in seeking direct intervention by a medical professional (IE: physician office visit, emergency room visit, or hospitalization)
4. substantial loss in value of the personal or real property of an enrollee due to theft, damage, or exploitation.

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.

The participant handbook, which will be given to each participant upon enrollment in the waiver.

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The participant handbook will describe participant’s rights to be free from abuse, neglect and exploitation, the State’s definitions of abuse, neglect and exploitation, the responsibilities of participants, case managers and other waiver services providers, and all other entities covered by State law to report suspected incidents, and the processes to be followed by participants or on behalf of participants in reporting suspected incidents.

In addition, Consumer Preparation Services provides the participant with information/training on the following topics:

1. how to avoid theft/security issues
2. maintaining personal safety when recruiting/interviewing potential employees
3. assertiveness/boundaries/rules with employees
4. maintaining personal safety when firing an employee
5. when and how to report instances of abuse, neglect, exploitation
6. resources on a local level to assist the participant if they are a victim of abuse, neglect or exploitation

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receive 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.

1. Initial reports of suspected abuse, neglect, or exploitation must be reported to the State’s Adult Protective Services Agency or the local law enforcement agency in accordance with R510-302.
2. Persons observing suspected abuse, neglect, or exploitation must comply with reporting guidelines contained R510-302. The SMA will define incident reporting policy that requires reporting to the SMA within 48 hours.
3. The SMA will develop an incident report data collection and management system. At a minimum, annual reports will be generated to identify trends.

- 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.

1. Suspected incidents of abuse, neglect or exploitation – Adult Protective Services Agency, Utah Department of Human Services as per R510-302, UC 62A-3-302.
2. The SMA will be responsible for the oversight of incident reporting. Incident reports will be submitted to the SMA within 48 hours of occurrence. The SMA will review, track and compile information into an electronic data base. At a minimum of annually, reports will be generated to identify trends and potential areas for quality improvement.

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Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

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

<input checked="" type="radio"/>	The State does not permit or prohibits the use of restraints or seclusion. Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:
	The Bureau of Health Facility Licensing, Certification and Resident Assessment (HFLCRA) is responsible for detecting the unauthorized use of restraints or seclusion. This oversight is conducted during annual surveys and any complaint investigations.
<input type="radio"/>	The use of restraints or seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii:

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

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

b. Use of Restrictive Interventions

<input checked="" type="radio"/>	The State does not permit or prohibits the use of restrictive interventions. Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:
	The Bureau of Health Facility Licensing, Certification and Resident Assessment (HFLCRA) is responsible for detecting the unauthorized use of restrictive interventions. This oversight is conducted during annual surveys and any complaint investigations.
<input type="radio"/>	The use of restrictive interventions is permitted during the course of the delivery of waiver services. Complete Items G-2-b-i and G-2-a-ii:

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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.

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- 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:

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

The case management agency has primary responsibility for monitoring participant medication regimens. This is accomplished through ongoing interaction with the participant and provider of residential care services. The case management agency will address concerns with residential care service providers directly and document interaction and outcome. This record will be maintained and reviewed as part of the QA process. The case management agency will notify the OA for additional follow up should issues remain unresolved.

The State does not prescribe a set frequency of monitoring or a set monitoring process of the waiver as a whole. Instead the case management agency is responsible for specifying an individualized monitoring plan for each participant as part of the needs assessment/service planning process.

- 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.

The SMA is responsible for overseeing the performance of case management providers in assisting participants to properly manage medication regimens. Performance of providers in assisting participants to properly manage medication regimes and the performance of the case management agency in proper primary oversight is incorporated in the comprehensive quality monitoring program of the SMA and is a performance measure scrutinized during on-site reviews of the case management agency and during reviews of periodic quality assurance reports provided by the case management agency in summarizing its internal quality assurance activities.

c. Medication Administration by Waiver Providers

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

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

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- 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).

Medication Administration – All waiver providers are required to comply with the State’s administrative rules governing medication administration including the State’s Nurse Practice Act.

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

<input type="radio"/>	Providers that are responsible for medication administration are required to <i>both</i> record and report medication errors to a State agency (or agencies). <i>Complete the following three items:</i>
	(a) Specify State agency (or agencies) to which errors are reported:
	(b) Specify the types of medication errors that providers are required to <i>record</i> :
	(c) Specify the types of medication errors that providers must <i>report</i> to the State:
<input checked="" type="radio"/>	Providers responsible for medication administration are required to <i>record</i> medication errors but make information about medication errors available only when requested by the State. Specify the types of medication errors that providers are required to record:
	As per Administrative Rule - R432-270-19. Medication Administration.

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.

<p>The SMA will be the agency responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants. The SMA will contract with case management services providers. The contract will include the requirement for the case management services providers to monitor the quality of services provided to include oversight of waiver providers responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. Additionally, the SMA will conduct a quality assurance review of a sample of waiver participant cases. Medication administration processes will be monitored during these quality assurance reviews.</p>

Quality Improvement: Health and Welfare

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

- a. Methods for Discovery: **Health and Welfare**
The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

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

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

Performance Measure #1:	The number and percentage of referrals in a representative samples made to Adult Protective Services and/or law enforcement, according to state law, when there was reason to believe that abuse, neglect and/or exploitation had occurred.		
Data Source	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
Incident Reports			
Participant Interviews (PES)			
Participant Records			
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input checked="" 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 = 5
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input checked="" type="checkbox"/> Other: Specify: OA: Continuously and Ongoing SMA: At a minimum every 5 years	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<input checked="" type="checkbox"/> State Medicaid	<input type="checkbox"/> Weekly	

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	<i>Agency</i>		
	<input checked="" 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 checked="" type="checkbox"/> <i>Other: Specify: OA: Annually SMA: at a minimum every five years.</i>	

Performance Measure #2:	The number and percentage of critical incidents and events in a representative sample in which the SMA was notified by the OA per the "Protocol: Critical Incidents and Events Notification to SMA"		
<u>Data Source</u>	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
Incident Reports			
Participant Interviews (PES)			
Participant Records			
	<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input type="checkbox"/> <i>100% Review</i>
	<input checked="" type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input checked="" type="checkbox"/> <i>Less than 100% Review</i>
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	<input checked="" type="checkbox"/> <i>Representative Sample; Confidence Interval = 5</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>Stratified: Describe Groups</i>
		<input checked="" type="checkbox"/> <i>Other: Specify: OA: Annually SMA: At a minimum every 5 years</i>	
			<input type="checkbox"/> <i>Other: Describe</i>
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	

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	<input checked="" 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 checked="" type="checkbox"/> <i>Other: Specify: OA: Annually SMA: at a minimum every five years.</i>	

<i>Performance Measure #3:</i>	<i>The number and percentage of incidents in a representative sample in which the case manager, when warranted, put effective safeguards and interventions in place that address the participant’s health and welfare needs and verifies the effectiveness of interventions.</i>		
<i>Data Source</i>	<i>Responsible Party for data collection/generation (check each that applies)</i>	<i>Frequency of data collection/generation: (check each that applies)</i>	<i>Sampling Approach (check each that applies)</i>
<i>Incident Reports</i>			
<i>Participant Interviews (PES)</i>			
<i>Participant Records</i>			
	<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input type="checkbox"/> <i>100% Review</i>
	<input checked="" type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input checked="" type="checkbox"/> <i>Less than 100% Review</i>
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	<input checked="" type="checkbox"/> <i>Representative Sample; Confidence Interval = 5</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>Stratified: Describe Groups</i>
		<input checked="" type="checkbox"/> <i>Other: Specify: OA: Annually SMA: At a minimum every 5 years</i>	
			<input type="checkbox"/> <i>Other: Describe</i>
<i>Data Aggregation and Analysis</i>	<i>Responsible Party for data aggregation and analysis (check each that applies)</i>	<i>Frequency of data aggregation and analysis: (check each that applies)</i>	
	<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	

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	<input checked="" 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 checked="" type="checkbox"/> <i>Other: Specify: OA: Annually SMA: at a minimum every five years.</i>	

<i>Performance Measure #4:</i>	<i>The number and percentage of participants using the self-directed model for service delivery in a representative sample for which the Emergency Back-up Plan Form was completed and current.</i>		
<u>Data Source</u>	<i>Responsible Party for data collection/generation (check each that applies)</i>	<i>Frequency of data collection/generation: (check each that applies)</i>	<i>Sampling Approach (check each that applies)</i>
Incident Reports			
Participant Interviews (PES)			
Participant Records			
	<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input type="checkbox"/> <i>100% Review</i>
	<input checked="" type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input checked="" type="checkbox"/> <i>Less than 100% Review</i>
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	<input checked="" type="checkbox"/> <i>Representative Sample; Confidence Interval = 5</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>Stratified: Describe Groups</i>
		<input checked="" type="checkbox"/> <i>Other: Specify: OA: Continuously and Ongoing SMA: At a minimum every 5 years</i>	
			<input type="checkbox"/> <i>Other: Describe</i>
<i>Data Aggregation and Analysis</i>	<i>Responsible Party for data aggregation and analysis (check each that applies)</i>	<i>Frequency of data aggregation and analysis: (check each that applies)</i>	
	<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	

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	<input checked="" 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 checked="" type="checkbox"/> <i>Other: Specify: OA: Annually SMA: at a minimum every five years.</i>	

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

Referrals are made to Adult Protective Services (APS) and/or law enforcement according to state law. Prevention strategies are developed and implemented, when warranted, when abuse, neglect and/or exploitation are reported. Case managers work closely with local APS workers to resolve issues. When a case manager reports or becomes aware of a referral made to APS about a New Choices Waiver participant, the case manager informs the OA as soon as possible and documents the notification in the participant’s record. The OA reviews this information and provides the information to the SMA.

The SMA and the OA follow the SMA Critical Incidents and Events Protocol to: 1) assure that appropriate actions have taken place when a critical incident or event occurs; and/or 2) in cases where appropriate safeguards were not in place, that an analysis is conducted and appropriate strategies have been implemented to safeguard participants. Within 24 hours or on the first business day after a critical incident or event has occurred to or by a participant, a representative from the Waiver Operating Agency will notify the SMA Quality Assurance representative via email, telephone or in person. After reviewing the information provided describing the critical incident/event, the SMA determines on a case-by-case basis if the incident or event requires an investigation. In cases where further investigation is required the operating agency completes the form “Critical Incident/Event Findings Operating Agency Report to SMA”. The SMA reviews the information provided by the Operating Agency and determines if any additional information or action is required. A final report is developed which contains: 1) a summary describing the incident/event based on all evidence reviewed, including evidence provided by the Medicaid Fraud Control Unit, Licensing, log notes etc. 2) Remediation Activities, describing the remediation activities that were developed and implemented to address the incident/event, including changes to care plans and systemic changes implemented by the operating agency and/or provider. 3) SMA Findings and Recommendations including an assessment of the operating agency’s response to the incident/event and the identification of any issues related to reporting protocols. The SMA notifies the Operating Agency representative when the critical incident/event has been resolved.

The SMA conducts an annual review of the New Choice Waiver program for each of the five waiver years. At a minimum, one comprehensive review will be conducted during this five year cycle. The comprehensive review will include participant and provider interviews. The other annual reviews will be focused reviews. The criteria for the focused reviews will be determined from the OA and SMA review findings as well as other issues that develop during the review year. The sample size for each review will be sufficient to provide a confidence level equal to 95% and a confidence interval equal to 5.

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b. Methods for Remediation/Fixing Individual Problems

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

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

b.ii Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	Responsible Party (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
	<input checked="" 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 checked="" type="checkbox"/> Other: Specify: OA: Annually. SMA: At a minimum every five years.

c. Timelines

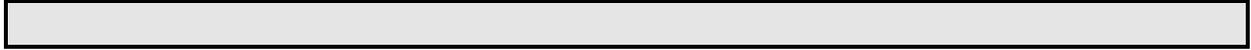
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

<input type="radio"/>	Yes (complete remainder of item)
<input checked="" type="radio"/>	No

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

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Appendix H: Systems Improvement

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

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

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

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

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

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

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

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

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

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H.1 Systems Improvement

H.1.a.i Describe the process(es) for trending, prioritizing and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

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

H.1.a.ii

System Improvement Activities	Responsible Party (check each that applies)	Frequency of monitoring and analysis (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
	<input checked="" type="checkbox"/> Quality Improvement Committee	<input type="checkbox"/> Annually
	<input type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Other: Specify: Third year of waiver operation

H.1.b.i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes, and how the results of the changes and the assessment are communicated (and with what frequency) to stakeholders, including participants, families, providers, agencies and other interested parties. If applicable, include the State's targeted standards for systems improvement.

The SMA will establish a Quality Improvement Committee consisting of the SMA Quality Assurance Team, the OA, and others. The team will meet to assess the results of the systems design changes. The success of the systems changes will be based on criteria that must be met to determine that the change has been accomplished and also criteria that will determine that the systems change has been sustained or will be sustained. The Quality Improvement Committee will determine the sustainability criteria. Results of system design changes will be communicated to participants and families, providers, agencies and others through the Medicaid Information Bulletin and the New Choices Waiver website.

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

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

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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).

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.

The State conducts a single audit in conformance with the Single Audit Act of 1984, Public Law 98-502.

Post-payment reviews are conducted by the SMA reviewing a sample of individual written support plans and Medicaid claims histories to ensure: (1) all of the services required by the individual are identified in the support plan, (2) that the individual is receiving the services identified in the support plan, and (3) that Medicaid reimbursement is not claimed for waiver services which were not included in the support plan.

Quality Improvement: Financial Accountability

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

- a. Methods for Discovery: **Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.
- a.i *For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

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

Performance Measure #1:	The number and percentage of claims, in a representative sample paid for services identified on a participant's Comprehensive Care Plan.		
Data Source	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
Care Plans			
Claims Data			
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input checked="" 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 = 5
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input checked="" type="checkbox"/> Other: Specify: OA: Continuously and Ongoing SMA: At a minimum every 5 years	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input checked="" 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 checked="" type="checkbox"/> Other: Specify: OA: Annually SMA: at a minimum every five years.	

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Performance Measure #2:	The number and percentage of claims, in a representative sample paid for services that do not exceed the amount, frequency and duration identified on the participant's Comprehensive Care Plan.		
Data Source Care Plans Claims Data	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input checked="" 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 = 5
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input checked="" type="checkbox"/> Other: Specify: OA: Continuously and Ongoing SMA: At a minimum every 5 years	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input checked="" 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 checked="" type="checkbox"/> Other: Specify: OA: Annually SMA: at a minimum every five years.	

Performance Measure #3:	Number and percentage of participant claims in a representative sample that paid for services using approved waiver codes and rates.
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<u>Data Source</u>	<i>Responsible Party for data collection/generation (check each that applies)</i>	<i>Frequency of data collection/generation: (check each that applies)</i>	<i>Sampling Approach (check each that applies)</i>
Care Plans			
Claims Data			
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input checked="" 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 = 5
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input checked="" type="checkbox"/> Other: Specify: OA: Continuously and Ongoing SMA: At a minimum every 5 years	
			<input type="checkbox"/> Other: Describe
<i>Data Aggregation and Analysis</i>	<i>Responsible Party for data aggregation and analysis (check each that applies)</i>	<i>Frequency of data aggregation and analysis: (check each that applies)</i>	
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input checked="" 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 checked="" type="checkbox"/> Other: Specify: OA: Annually SMA: at a minimum every five years.	

<i>Performance Measure #4:</i>	Number of recoupment in a representative sample that are returned to the federal government within 60 days of discovery.		
<u>Data Source</u>	<i>Responsible Party for data collection/generation (check each that applies)</i>	<i>Frequency of data collection/generation: (check each that applies)</i>	<i>Sampling Approach (check each that applies)</i>
Care Plans			

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Claims Data	<i>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>
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	<input checked="" type="checkbox"/> <i>Representative Sample; Confidence Interval = 5</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>Stratified: Describe Groups</i>
		<input checked="" type="checkbox"/> <i>Other: Specify: SMA: At a minimum every 5 years</i>	
			<input type="checkbox"/> <i>Other: Describe</i>
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis <i>(check each that applies)</i>	Frequency of data aggregation and analysis: <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 checked="" type="checkbox"/> <i>Other: Specify: SMA: at a minimum every five years.</i>	

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

The SMA conducts an annual review of the New Choices Waiver program for each of the five waiver years. At a minimum, one comprehensive review will be conducted during this five year cycle. The comprehensive review will include participant and provider interviews. The other annual reviews will be focused reviews. The criteria for the focused reviews will be determined from the OA and SMA review findings as well as other issues that develop during the review year. The sample size for each review will be sufficient to provide a confidence level equal to 95% and a confidence interval equal to 5.

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b. Methods for Remediation/Fixing Individual Problems

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

Recoupment of Funds:

- When payments are made for a service not identified on the Comprehensive Care Plan: a recoupment 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 Comprehensive Care Plan: a recoupment 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 the OA discovers that unauthorized claims have been paid, the OA works with Medicaid Operation and Medicaid Operations reprocess the MMIS claims to reflect the recoupment. The OA will then notify the SMA of the recoupment.

When the SMA discovers that unauthorized claims have been paid, the recoupment of funds will proceed as follows:

1. The State Medicaid Agency will complete a Recoupment of Funds Form that indicates the amount of the recoupment and send it to the Operating Agency.
2. The Operating Agency will review the Recoupment of funds form and return the signed form to the State Medicaid Agency.
3. Upon receipt of the Recoupment of Funds Form, the State Medicaid Agency will submit the Recoupment of Funds Form to Medicaid Operations.
4. Medicaid Operations will reprocess the MMIS claims to reflect the recoupment.
5. Overpayments are returned to the federal government within 60 days of discovery.

b.ii Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	Responsible Party (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
	<input checked="" 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 checked="" type="checkbox"/> Other: Specify: OA: Annually. SMA: At a minimum

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		<i>every five years.</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 Level of Care that are currently non-operational.

<input type="radio"/>	Yes <i>(complete remainder of item)</i>
<input checked="" type="radio"/>	No

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

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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).

Waiver rates are established by the State Medicaid Agency. Opportunity for public comment of the rates is available during the application renewal process and annually as the rates are adjusted. Information about payment rates will be communicated using provider bulletins and letters, annual public notices, annual waiver training, and the New Choices Waiver website.

Adult Day Care, Adult Residential, Attendant Care, Caregiver Training, Case Management, Chore, Consumer Preparation, Financial Management, Habilitation, Home Delivered Meals, Homemaker, Medication Assistance, Personal Budget Assistance, Personal Emergency Response System, Respite Care, Specialized Behavioral Health, Supportive Maintenance, and Transportation Services are reimbursed on a fee-for-service basis. Payment is based on a statewide fee schedule.

The rates for Assistive Technology Services, Community Transition Services, Specialized Medical Equipment and Supplies, and Environmental Accessibility Adaptations are negotiated by the case management agency on behalf of the Single State Agency. Allowable expenditures are based on the individual client need and are not to exceed the service limits.

Below is a list of the services and the rate information:

The following services were based on a 2009 market study:

Adult Residential Services

The following services were rebased in 2005 and have received COLA adjustments:

Adult Day Care

Habilitation Services

Home Delivered Meals

Case Management Service

Specialized Behavioral Health Services

Chore Services

Attendant Care Services

Financial Management Services

Personal Budget Assistance

Respite Care

Medication Assistance Services

Caregiver Training

The following services are based on the State Plan rate:

Supportive Maintenance

The following services were based on a 1997 cost study and have received COLA adjustments:

Homemaker

Consumer Preparation Services

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The following services are paid using the actual cost of the service:
 Assistive Technology Services
 Environmental Accessibility Adaptations
 Community Transition Services
 Specialized Medical Equipment and Supplies

The following services are paid using a Competitive Contract written in 2005 with slight increase in an amendment in 2007:
 Personal Emergency Response System

The following services are paid using the Utah Transportation Authority rate:
 Transportation - Non Medical (Per One-Way Trip)
 Transportation - Non Medical (Public Transit Pass)

The following service is paid using the State of Utah Employee mileage reimbursement:
 Transportation - Non Medical (Per Mile)

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

Waiver services providers submit claims directly to the SMA, the SMA then pays the waiver service provider directly.

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

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

<input type="radio"/>	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 (<i>check each that applies</i>):
<input type="checkbox"/>	Certified Public Expenditures (CPE) of State Public Agencies. Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (<i>Indicate source of revenue for CPEs in Item I-4-a.</i>)
<input type="checkbox"/>	Certified Public Expenditures (CPE) of Local Government Agencies. Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (<i>Indicate source of revenue for CPEs in Item I-4-b.</i>)

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No. State or local government agencies do not certify expenditures for waiver services.

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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:

DESCRIPTION OF BILLING PROCESS AND RECORDS RETENTION

1. A participant's Medicaid eligibility is determined by the Office of Health and Eligibility within the Department of Workforce Services or the Bureau of Eligibility Services within the Department of Health. The information is entered into the Public Assistance Case Management Information System (PACMIS). PACMIS is an on-line, menu-driven system which automates Medicaid eligibility decisions, benefits amounts, participants' notices and administrative reports. PACMIS 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 PACMIS: 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 PACMIS to ensure the participant is Medicaid eligible before payment of claims is made.

2. Post-payment reviews are conducted by the SMA reviewing a sample of individual written support plans and Medicaid claims histories to ensure: (1) all of the services required by the individual are identified in the support plan, (2) that the individual is receiving the services identified in the support plan, and (3) that Medicaid reimbursement is not claimed for waiver services which were not included in the support plan.

3. Prior to the order and delivery of Medicaid reimbursed approved specialized medical equipment, medical supplies, or assistive technology, the support coordinator must obtain prior approval based on a determination of medical necessity and a determination that the item is not available as a Medicaid State Plan service.

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

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

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

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

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

<input type="radio"/>	Yes. State or local government providers receive payment for waiver services. Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish. <i>Complete item I-3-e.</i>
<input checked="" type="radio"/>	No. State or local government providers do not receive payment for waiver services. <i>Do not complete Item I-3-e.</i>

- 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 type="radio"/>	The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.
<input type="radio"/>	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.
<input type="radio"/>	The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report. Describe the recoupment process:

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

g. Additional Payment Arrangements

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

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

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

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

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

<input type="radio"/>	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 <i>voluntarily</i> elect to receive <i>waiver</i> and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.
<input type="radio"/>	This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain <i>waiver</i> 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.
<input checked="" type="radio"/>	The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

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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. *Check each that applies:*

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

- b. **Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Check each that applies:*

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

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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="checkbox"/>	None of the specified sources of funds contribute to the non-federal share of computable waiver costs.
<input type="checkbox"/>	The following source (s) are used. <i>Check each that applies.</i>
<input type="checkbox"/>	Health care-related taxes or fees
<input type="checkbox"/>	Provider-related donations
<input type="checkbox"/>	Federal funds
	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 type="radio"/>	No services under this waiver are furnished in residential settings other than the private residence of the individual. <i>(Do not complete Item I-5-b).</i>
<input type="radio"/>	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual. <i>(Complete Item I-5-b)</i>

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:

Since the daily Medicaid reimbursement excludes all room and board costs, the individual waiver participants are responsible to pay room and board directly to their landlord/facility. Each participant has a rental agreement with the facility where they reside. This agreement breaks out the room and board portion that the client is responsible to pay to the facility.

To assure that the Medicaid rate was appropriately set and did not include room and board costs, Facility Cost Reports were obtained from each provider of Adult Residential Services. The reporting period was from May 1, 2007 through December 31, 2008.

The results of the facility cost report show that the total average daily base rate charged to a private pay client was \$94.10. The total average daily cost for a New Choices Waiver client was \$90.00. The average daily Medicaid service rate was \$71.40 and the average daily room and board amount paid by the client was \$18.60 or \$558. Monthly room and board costs for a small one bedroom living arrangement totaling approximately \$560 per month is consistent with the prevailing rental property rates in the state.

In comparing the prevailing market price for base rate assisted living services (\$94.10) against the Medicaid rate (\$71.40) paid for the basic services plus services that would result in additional add-ons to the private pay rate, the facility cost report findings demonstrate the Medicaid rate is reasonable.

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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 type="radio"/>	<p>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. <i>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:</i></p> <div style="border: 1px solid black; height: 50px; width: 100%; background-color: #f0f0f0;"></div>
<input checked="" type="radio"/>	<p>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.</p>

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 checked="" type="radio"/>	No. The State does not impose a co-payment or similar charge upon participants for waiver services. <i>(Do not complete the remaining items; proceed to Item I-7-b).</i>
<input type="radio"/>	Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services. <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"/>	Nominal deductible
<input type="checkbox"/>	Coinsurance
<input type="checkbox"/>	Co-Payment
<input type="checkbox"/>	Other charge <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.** In the following table, list the waiver services for which a charge is made, the amount of the charge, and the basis for determining the charge.

Waiver Service	Amount of Charge	Basis of the Charge

State:	
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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"/>	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.
<input type="radio"/>	There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. Specify the cumulative maximum and the time period to which the maximum applies:

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

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

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

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Appendix J: Cost Neutrality Demonstration

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

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

Level(s) of Care (<i>specify</i>):							
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	\$22,655	\$4,850	\$27,505	\$34,555	\$10,536	\$45,091	\$17,586
2	\$23,108	\$4,947	\$28,055	\$35,246	\$10,746	\$45,992	\$17,937
3	\$23,570	\$5,046	\$28,616	\$35,951	\$10,961	\$46,912	\$18,296
4	\$24,040	\$5,147	\$29,187	\$36,670	\$11,180	\$47,850	\$18,663
5	\$24,521	\$5,250	\$29,771	\$37,403	\$11,404	\$48,807	\$19,036

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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:

Table J-2-a: Unduplicated Participants			
Waiver Year	Total Unduplicated Number of Participants (From Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
Year 1	1200		
Year 2	1200		
Year 3	1200		
Year 4 (renewal only)	1200		
Year 5 (renewal only)	1200		

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

The average length of stay estimate is based on preliminary numbers for the LOS during the New Choices Waiver year two.

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:

- These calculations are based off the actual preliminary numbers for New Choices waiver year two

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:

- These calculations are based off the actual preliminary numbers for New Choices waiver year two
 - Average cost per enrollee was increased by 4% for the first year to account for WY03 increases. Each subsequent year was increased 2%

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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 fiscal year 2007 and multiplied by actual NW waiver LOS to get fiscal year 2007 base estimate and the increased by 2% each subsequent year.

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

- Used actual average nursing home cost per day for fiscal year 2007 and multiplied by actual NW waiver LOS to get fiscal year 2007 base estimate and the increased by 2% each subsequent year.

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

<input checked="" 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

Waiver Year: Year 1					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Adult Day Care	Day	5	50	\$38.41	\$9,603
Adult Residential Services (Adult Host Homes)	Day	2	273	\$81.35	\$44,417
Adult Residential Services (Assisted Living Facilities)	Day	950	273	\$71.15	\$18,452,753
Adult Residential Services (Certified Community Residential Care)	Day	140	273	\$84.25	\$3,220,035
Adult Residential Services (Licensed Community Residential Care)	Day	30	273	\$105.32	\$862,571
Assistive Technology Services	Per Item	6	1	\$2,040.00	\$12,240
Attendant Care Services	15 Minute	120	600	\$3.09	\$222,480
Caregiver Training	15 Minute	7	54	\$4.98	\$1,882
Case Management Service	15 Minute	1200	144	\$20.40	\$3,525,120
Chore Services	15 Minute	8	340	\$4.87	\$13,246
Consumer Preparation Services	Hour	25	4	\$56.63	\$5,663
Environmental Accessibility Adaptations (Home Modifications)	Per service	5	1	\$663.00	\$3,315
Environmental Accessibility Adaptations (Vehicle modification)	Per service	5	1	\$1,511.64	\$7,558
Financial Management Services	Month	25	12	\$48.96	\$14,688
Habilitation Services	Hour	25	35	\$23.10	\$20,213
Home Delivered Meals	Per Meal	25	35	\$5.99	\$5,241
Homemaker Service	Hour	37	116	\$20.25	\$86,913
Community Transition Services	Per service	200	1	\$742.56	\$148,512
Medication Assistance Services (Medication Reminder System)	Month	15	12	\$49.98	\$8,996
Medication Assistance Services(Medication Set-up)	15 Minute	63	26	\$20.16	\$33,022

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Waiver Year: Year 1					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Personal Budget Assistance	15 Minute	400	48	\$4.81	\$92,352
Personal Emergency Response System (Installation, Testing & Removal)	Per Service	10	1	\$43.53	\$435
Personal Emergency Response System (Purchase, Rental, Repair)	Per Item	10	1	\$207.04	\$2,070
Personal Emergency Response System (Response Center Service Fee)	Month	50	9	\$32.66	\$14,697
Respite Care (Client's Home)	Day	10	14	\$57.85	\$8,099
Respite Care (Room and Board Included)	Day	10	14	\$141.27	\$19,778
Respite Care (Routine)	Hour	10	96	\$21.21	\$20,362
Specialized Behavioral Health Services (Level I)	Hour	15	160	\$5.18	\$12,432
Specialized Behavioral Health Services (Level II)	Hour	10	160	\$9.02	\$14,432
Specialized Behavioral Health Services (Level III)	Hour	5	160	\$16.46	\$13,168
Specialized Medical Equipment and Supplies	Per Item	300	4	\$71.40	\$85,680
Supportive Maintenance	Hour	10	50	\$21.89	\$10,945
Transportation - Non Medical (Per Mile)	Per Mile	10	1000	\$0.37	\$3,700
Transportation - Non Medical (Per One-Way Trip)	Per Trip	190	48	\$15.24	\$138,989
Transportation - Non Medical (Public Transit Pass)	Month	65	9	\$85.68	\$50,123
GRAND TOTAL:					\$27,185,730
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					1200
FACTOR D (Divide grand total by number of participants)					\$22,655
AVERAGE LENGTH OF STAY ON THE WAIVER					273

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Waiver Year: Year 2					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Adult Day Care	Day	5	50	\$39.18	\$9,795
Adult Residential Services (Adult Host Homes)	Day	2	273	\$82.98	\$45,307
Adult Residential Services (Assisted Living Facilities)	Day	950	273	\$72.57	\$18,821,030
Adult Residential Services (Certified Community Residential Care)	Day	140	273	\$85.94	\$3,284,627
Adult Residential Services (Licensed Community Residential Care)	Day	30	273	\$107.43	\$879,852
Assistive Technology Services	Per Item	6	1	\$2,080.80	\$12,485
Attendant Care Services	15 Minute	120	600	\$3.15	\$226,800
Caregiver Training	15 Minute	7	54	\$5.08	\$1,920
Case Management Service	15 Minute	1200	144	\$20.81	\$3,595,968
Chore Services	15 Minute	8	340	\$4.97	\$13,518
Consumer Preparation Services	Hour	25	4	\$57.76	\$5,776
Environmental Accessibility Adaptations (Home Modifications)	Per service	5	1	\$676.26	\$3,381
Environmental Accessibility Adaptations (Vehicle modification)	Per service	5	1	\$1,541.87	\$7,709
Financial Management Services	Month	25	12	\$49.94	\$14,982
Habilitation Services	Hour	25	35	\$23.56	\$20,615
Home Delivered Meals	Per Meal	25	35	\$6.11	\$5,346
Homemaker Service	Hour	37	116	\$20.66	\$88,673
Community Transition Services	Per service	200	1	\$757.41	\$151,482
Medication Assistance Services (Medication Reminder System)	Month	15	12	\$50.98	\$9,176
Medication Assistance Services (Medication Set-up)	15 Minute	63	26	\$20.56	\$33,677
Personal Budget Assistance	15 Minute	400	48	\$4.91	\$94,272
Personal Emergency Response System (Installation, Testing & Removal)	Per Service	10	1	\$44.40	\$444
Personal Emergency Response	Per Item	10	1	\$211.18	\$2,112

State:	
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Waiver Year: Year 2					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
System (Purchase, Rental, Repair)					
Personal Emergency Response System (Response Center Service Fee)	Month	50	9	\$33.31	\$14,990
Respite Care (Client's Home)	Day	10	14	\$59.01	\$8,261
Respite Care (Room and Board Included)	Day	10	14	\$144.10	\$20,174
Respite Care (Routine)	Hour	10	96	\$21.63	\$20,765
Specialized Behavioral Health Services (Level I)	Hour	15	160	\$5.28	\$12,672
Specialized Behavioral Health Services (Level II)	Hour	10	160	\$9.20	\$14,720
Specialized Behavioral Health Services (Level III)	Hour	5	160	\$16.79	\$13,432
Specialized Medical Equipment and Supplies	Per Item	300	4	\$72.83	\$87,396
Supportive Maintenance	Hour	10	50	\$22.33	\$11,165
Transportation - Non Medical (Per Mile)	Per Mile	10	1000	\$0.38	\$3,800
Transportation - Non Medical (Per One-Way Trip)	Per Trip	190	48	\$15.54	\$141,725
Transportation - Non Medical (Public Transit Pass)	Month	65	9	\$87.39	\$51,123
GRAND TOTAL:					\$27,729,170
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					1,200
FACTOR D (Divide grand total by number of participants)					\$23,108
AVERAGE LENGTH OF STAY ON THE WAIVER					273

State:	
Effective Date	

Waiver Year: Year 3					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Adult Day Care	Day	5	50	\$39.96	\$9,990
Adult Residential Services (Adult Host Homes)	Day	2	273	\$84.64	\$46,213
Adult Residential Services (Assisted Living Facilities)	Day	950	273	\$74.02	\$19,197,087
Adult Residential Services (Certified Community Residential Care)	Day	140	273	\$87.66	\$3,350,365
Adult Residential Services (Licensed Community Residential Care)	Day	30	273	\$109.58	\$897,460
Assistive Technology Services	Per Item	6	1	\$2,122.42	\$12,735
Attendant Care Services	15 Minute	120	600	\$3.21	\$231,120
Caregiver Training	15 Minute	7	54	\$5.18	\$1,958
Case Management Service	15 Minute	1200	144	\$21.23	\$3,668,544
Chore Services	15 Minute	8	340	\$5.07	\$13,790
Consumer Preparation Services	Hour	25	4	\$58.92	\$5,892
Environmental Accessibility Adaptations (Home Modifications)	Per service	5	1	\$689.79	\$3,449
Environmental Accessibility Adaptations (Vehicle modification)	Per service	5	1	\$1,572.71	\$7,864
Financial Management Services	Month	25	12	\$50.94	\$15,282
Habilitation Services	Hour	25	35	\$24.03	\$21,026
Home Delivered Meals	Per Meal	25	35	\$6.23	\$5,451
Homemaker Service	Hour	37	116	\$21.07	\$90,432
Community Transition Services	Per service	200	1	\$772.56	\$154,512
Medication Assistance Services (Medication Reminder System)	Month	15	12	\$52.00	\$9,360
Medication Assistance Services(Medication Set-up)	15 Minute	63	26	\$20.97	\$34,349
Personal Budget Assistance	15 Minute	400	48	\$5.01	\$96,192
Personal Emergency Response System (Installation, Testing & Removal)	Per Service	10	1	\$45.29	\$453
Personal Emergency Response	Per Item	10	1	\$215.40	\$2,154

State:	
Effective Date	

Waiver Year: Year 3					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
System (Purchase, Rental, Repair)					
Personal Emergency Response System (Response Center Service Fee)	Month	50	9	\$33.98	\$15,291
Respite Care (Client's Home)	Day	10	14	\$60.19	\$8,427
Respite Care (Room and Board Included)	Day	10	14	\$146.98	\$20,577
Respite Care (Routine)	Hour	10	96	\$22.06	\$21,178
Specialized Behavioral Health Services (Level I)	Hour	15	160	\$5.39	\$12,936
Specialized Behavioral Health Services (Level II)	Hour	10	160	\$9.38	\$15,008
Specialized Behavioral Health Services (Level III)	Hour	5	160	\$17.13	\$13,704
Specialized Medical Equipment and Supplies	Per Item	300	4	\$74.29	\$89,148
Supportive Maintenance	Hour	10	50	\$22.78	\$11,390
Transportation - Non Medical (Per Mile)	Per Mile	10	1000	\$0.39	\$3,900
Transportation - Non Medical (Per One-Way Trip)	Per Trip	190	48	\$15.85	\$144,552
Transportation - Non Medical (Public Transit Pass)	Month	65	9	\$89.14	\$52,147
GRAND TOTAL:					\$28,283,936
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					1200
FACTOR D (Divide grand total by number of participants)					\$23,570
AVERAGE LENGTH OF STAY ON THE WAIVER					273

State:	
Effective Date	

Waiver Year: Year 4 (renewal only)					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Adult Day Care	Day	5	50	\$40.76	\$10,190
Adult Residential Services (Adult Host Homes)	Day	2	273	\$86.33	\$47,136
Adult Residential Services (Assisted Living Facilities)	Day	950	273	\$75.50	\$19,580,925
Adult Residential Services (Certified Community Residential Care)	Day	140	273	\$89.41	\$3,417,250
Adult Residential Services (Licensed Community Residential Care)	Day	30	273	\$111.77	\$915,396
Assistive Technology Services	Per Item	6	1	\$2,164.87	\$12,989
Attendant Care Services	15 Minute	120	600	\$3.27	\$235,440
Caregiver Training	15 Minute	7	54	\$5.28	\$1,996
Case Management Service	15 Minute	1200	144	\$21.65	\$3,741,120
Chore Services	15 Minute	8	340	\$5.17	\$14,062
Consumer Preparation Services	Hour	25	4	\$60.10	\$6,010
Environmental Accessibility Adaptations (Home Modifications)	Per service	5	1	\$703.59	\$3,518
Environmental Accessibility Adaptations (Vehicle modification)	Per service	5	1	\$1,604.16	\$8,021
Financial Management Services	Month	25	12	\$51.96	\$15,588
Habilitation Services	Hour	25	35	\$24.51	\$21,446
Home Delivered Meals	Per Meal	25	35	\$6.35	\$5,556
Homemaker Service	Hour	37	116	\$21.49	\$92,235
Community Transition Services	Per service	200	1	\$788.01	\$157,602
Medication Assistance Services (Medication Reminder System)	Month	15	12	\$53.04	\$9,547
Medication Assistance Services (Medication Set-up)	15 Minute	63	26	\$21.39	\$35,037
Personal Budget Assistance	15 Minute	400	48	\$5.11	\$98,112
Personal Emergency Response System (Installation, Testing & Removal)	Per Service	10	1	\$46.20	\$462
Personal Emergency Response	Per Item	10	1	\$219.71	\$2,197

State:	
Effective Date	

Waiver Year: Year 4 (renewal only)					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
System (Purchase, Rental, Repair)					
Personal Emergency Response System (Response Center Service Fee)	Month	50	9	\$34.66	\$15,597
Respite Care (Client's Home)	Day	10	14	\$61.39	\$8,595
Respite Care (Room and Board Included)	Day	10	14	\$149.92	\$20,989
Respite Care (Routine)	Hour	10	96	\$22.50	\$21,600
Specialized Behavioral Health Services (Level I)	Hour	15	160	\$5.50	\$13,200
Specialized Behavioral Health Services (Level II)	Hour	10	160	\$9.57	\$15,312
Specialized Behavioral Health Services (Level III)	Hour	5	160	\$17.47	\$13,976
Specialized Medical Equipment and Supplies	Per Item	300	4	\$75.78	\$90,936
Supportive Maintenance	Hour	10	50	\$23.24	\$11,620
Transportation - Non Medical (Per Mile)	Per Mile	10	1000	\$0.40	\$4,000
Transportation - Non Medical (Per One-Way Trip)	Per Trip	190	48	\$16.17	\$147,470
Transportation - Non Medical (Public Transit Pass)	Month	65	9	\$90.92	\$53,188
GRAND TOTAL:					\$28,848,318
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					1200
FACTOR D (Divide grand total by number of participants)					\$24,040
AVERAGE LENGTH OF STAY ON THE WAIVER					273

State:	
Effective Date	

Waiver Year: Year 5 (renewal only)					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Adult Day Care	Day	5	50	\$41.58	\$10,395
Adult Residential Services (Adult Host Homes)	Day	2	273	\$88.06	\$48,081
Adult Residential Services (Assisted Living Facilities)	Day	950	273	\$77.01	\$19,972,544
Adult Residential Services (Certified Community Residential Care)	Day	140	273	\$91.20	\$3,485,664
Adult Residential Services (Licensed Community Residential Care)	Day	30	273	\$114.01	\$933,742
Assistive Technology Services	Per Item	6	1	\$2,208.17	\$13,249
Attendant Care Services	15 Minute	120	600	\$3.34	\$240,480
Caregiver Training	15 Minute	7	54	\$5.39	\$2,037
Case Management Service	15 Minute	1200	144	\$22.08	\$3,815,424
Chore Services	15 Minute	8	340	\$5.27	\$14,334
Consumer Preparation Services	Hour	25	4	\$61.30	\$6,130
Environmental Accessibility Adaptations (Home Modifications)	Per service	5	1	\$717.66	\$3,588
Environmental Accessibility Adaptations (Vehicle modification)	Per service	5	1	\$1,636.24	\$8,181
Financial Management Services	Month	25	12	\$53.00	\$15,900
Habilitation Services	Hour	25	35	\$25.00	\$21,875
Home Delivered Meals	Per Meal	25	35	\$6.48	\$5,670
Homemaker Service	Hour	37	116	\$21.92	\$94,081
Community Transition Services	Per service	200	1	\$803.77	\$160,754
Medication Assistance Services (Medication Reminder System)	Month	15	12	\$54.10	\$9,738
Medication Assistance Services (Medication Set-up)	15 Minute	63	26	\$21.82	\$35,741
Personal Budget Assistance	15 Minute	400	48	\$5.21	\$100,032
Personal Emergency Response System (Installation, Testing & Removal)	Per Service	10	1	\$47.12	\$471
Personal Emergency Response	Per Item	10	1	\$224.10	\$2,241

State:	
Effective Date	

Waiver Year: Year 5 (renewal only)					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
System (Purchase, Rental, Repair)					
Personal Emergency Response System (Response Center Service Fee)	Month	50	9	\$35.35	\$15,908
Respite Care (Client's Home)	Day	10	14	\$62.62	\$8,767
Respite Care (Room and Board Included)	Day	10	14	\$152.92	\$21,409
Respite Care (Routine)	Hour	10	96	\$22.95	\$22,032
Specialized Behavioral Health Services (Level I)	Hour	15	160	\$5.61	\$13,464
Specialized Behavioral Health Services (Level II)	Hour	10	160	\$9.76	\$15,616
Specialized Behavioral Health Services (Level III)	Hour	5	160	\$17.82	\$14,256
Specialized Medical Equipment and Supplies	Per Item	300	4	\$77.30	\$92,760
Supportive Maintenance	Hour	10	50	\$23.70	\$11,850
Transportation - Non Medical (Per Mile)	Per Mile	10	1000	\$0.41	\$4,100
Transportation - Non Medical (Per One-Way Trip)	Per Trip	190	48	\$16.49	\$150,389
Transportation - Non Medical (Public Transit Pass)	Month	65	9	\$92.74	\$54,253
GRAND TOTAL:					\$29,425,156
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					1200
FACTOR D (Divide grand total by number of participants)					\$24,521
AVERAGE LENGTH OF STAY ON THE WAIVER					273

State:	
Effective Date	