



# Utah Long-Term Services and Supports (LTSS) Project

Final Recommendations Report

March 2026

# Utah Long-Term Services and Supports (LTSS) Project Final Recommendations Report | March 2026

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## *About Human Services Research Institute*

Human Services Research Institute (HSRI) is a nonprofit, mission-driven organization that works with government agencies and others to improve health and human services and systems, enhance the quality of data to guide policy, and engage stakeholders to effect meaningful systems change.

## *About Utah State University Institute for Disability Research, Policy & Practice*

The Institute for Disability Research, Policy, & Practice (IDRPP) at Utah State University is Utah's federally designated University Center for Excellence in Developmental Disabilities (UCEDD).

## *Acknowledgements*

We are incredibly grateful to our Steering Committee members who provided deep insight and expertise regarding our recommendations, which were instrumental in shaping this final report. We also thank the hundreds of people receiving services as well as the caregivers, advocates, service providers, support coordinators, state staff, and representatives of other states and programs who so freely gave their time and shared their experience to support Utah's DHHS to move forward. We could not have completed this project without their feedback. We acknowledge that many of you have competing priorities and yet you made time to help improve Utah's support system.

**Disclaimer:** This study is sponsored by Utah DHHS. All opinions expressed herein are solely those of the authors and do not reflect the position or policy of DHHS.



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# Executive Summary

The Utah Department of Health and Human Services (DHHS) strives to ensure all Utahns have fair and equitable opportunities to live safe and healthy lives. Through its Division of Integrated Healthcare (DIH), Division of Aging and Adult Services (DAAS), and Division of Services for People with Disabilities (DSPD), DHHS has established a comprehensive long-term service and support (LTSS) system. The state delivers LTSS through nine 1915(c) Medicaid home and community-based services (HCBS) waivers and through intermediate care facilities for individuals with intellectual disabilities (ICF-IIDs), state plan services, aging programs, and other state-funded programs. DHHS has engaged in numerous initiatives to improve these services over recent years, and it commissioned a study to make further progress. DHHS engaged [Human Services Research Institute \(HSRI\)](#) for a two-year, cross-disability research study aimed at building on current initiatives and providing actionable recommendations. The study sought input from individuals receiving LTSS, those on waiting lists, family members, providers, support coordinators, advocates, and others to understand what is working well and where improvements are needed. HSRI worked with a Steering Committee to prioritize and advance this work.

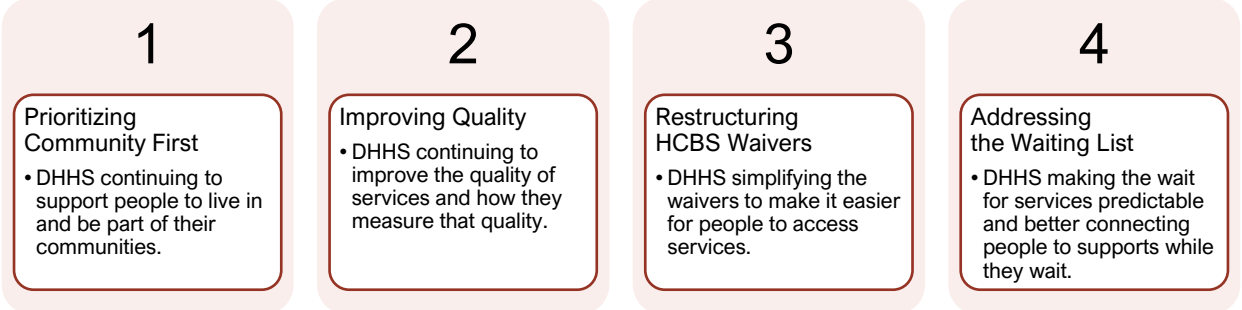
DHHS and the Steering Committee requested that HSRI prioritize recommendations that support:

- **Inclusion** – Supporting and honoring people’s choices for where they live and who they live with. Giving people options for receiving community services and participating in competitive integrated employment.
- **Person-Centered Support** – Empowering people to maintain control over their own life and services (self-direction) by offering holistic support.
- **Service Quality** – Ensuring that people in Utah equitably receive the services they need. Promoting high-quality services and highly qualified providers.
- **Effective Service System** – Improving coordination between agencies, funding, and reimbursement of services to help more people.

## Recommendations

To meet these aims, we developed recommendations in four primary areas:

Figure 1. Topical Areas for Recommendations



In each of these areas we provide detailed recommendations to help DHHS develop implementation plans to make progress.

## Prioritizing Community First

We recommend that DHHS **plan for the community**. This work would start with developing a Community First plan; this plan would structure DHHS's approach to each of the recommendations in this report. We recommend a unified planning process that bridges the promising planning practices in place in each of DHHS's divisions. To ensure the planning process results in meaningful outcomes for participants, HSRI also recommends that DHHS provide robust training and increase informed choice.

Next, we recommend that DHHS **transition and divert people from institutional and segregated settings**. First, HSRI recommends that DHHS continue to build on its years of supporting people to transition from the Utah State Developmental Center (USDC) and ICF-IIDs and that DHHS help ICF-IIDs transition their programs to more closely resemble community settings. We recommend that DHHS offer supports and services to help divert people from nursing facilities. DHHS should also build on its progress in supporting people to work in the community, reduce its use of segregated work settings, and offer new employment services. Since some people seek institutional supports due to their complex needs, we recommend that DHHS address gaps in services to support people with complex needs—including gaps in nursing, integrated health management, and behavior services. Finally, HSRI recommends that DHHS improve its supports to people and families by strengthening and expanding its peer and family support services.

## Improving Quality

First, HSRI recommends that DHHS **improve its quality systems and measurement**. DHHS must meet the provisions outlined in the new Medicaid Access Rule. These rules, intended to promote quality by creating uniform measures, are required by the federal government for all states. We recommend that DHHS conform to all these rules and that DHHS use tools to track its progress. HSRI recommends that DHHS pay increased attention to improving its grievance system and implementing a vigorous process for tracking and addressing grievances. We also recommend that DHHS improve its quality measurement system, consolidate and align its performance measures across its different waivers, and include people and their families in the process. This will not only facilitate other efforts to simplify the HCBS waivers but will also allow DHHS to compare measures across waivers. DHHS participates in the National Core Indicators; HSRI suggests that DHHS better stratify its National Core Indicators sample to better understand discrepancies in quality by different populations.

Beyond measuring quality, we recommend that DHHS build on all of these recommendations by engaging in **continuous quality improvement**. DHHS can do this by using the data that it collects to share information with community members, working with a core group of people to set meaningful



targets for improving quality, developing strategies to improve quality, reporting its progress, and adjusting as necessary.

## Restructuring HCBS Waivers

To simplify its waiver system and increase equitability, HSRI recommends that DHHS restructure its HCBS waivers in two phases. During **Phase 1**, we recommend that DHHS align its existing waivers where feasible and make essential improvements. These improvements include updating the existing service arrays to provide services that address critical needs. In this phase DHHS would also update its quality performance measures and data collection. DHHS would also begin work to set a foundation for a resource allocation model to equitably distribute service funding by selecting an assessment instrument and aligning service rates.

During **Phase 2**, we recommend that DHHS restructure its HCBS waivers by division so that each division has two waivers. In the early stage of this phase, DHHS can develop its equitable resource allocation model by collecting data and determining how to fund the model. Then, DHHS would implement the model in the new waiver structure.

Once both phases are complete, HSRI recommends that DHHS evaluate the restructured HCBS waiver program by evaluating eligibility, access, and service changes, and evaluating the resource allocation model.

## Addressing the DSPD Waiting List

Regarding the DSPD waiting list, we recommend **continuing to project future service needs and transparently sharing information** with the community so that people have information about the wait for services.

Next, HSRI recommends **exploring and monitoring the efficacy of initiatives to support people while they wait** such as the supported work independence (SWI) program, Resource Navigation, and Community Care Hub.

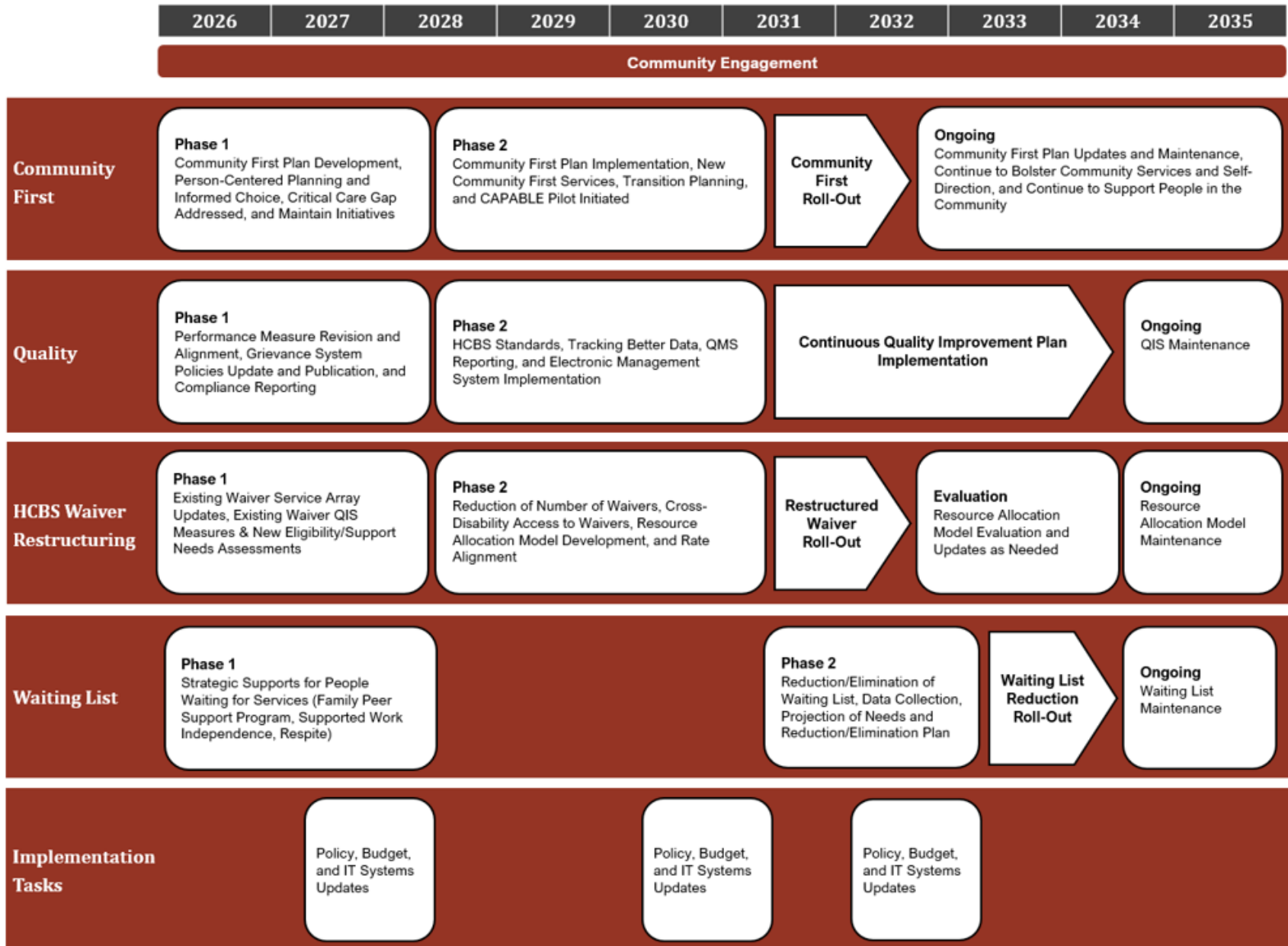
We also recommend **balancing the funding between the limited supports waiver and the community supports waiver** to make sure that people with a range of needs can get on the waivers. Additionally, DHHS should **update state plan eligibility and provide more services** to people waiting for them by coordinating better with other agencies.

## Timeline

We recommend that DHHS adopt a phased approach to implementing these activities, so that each of the recommended activities build on one another.



Figure 2. High-Level Timeline



## Meeting Priorities

These recommendations address the identified priorities in the following ways.

**Inclusion** – Promoting Community First through planning and modifying services supports people to be included in their communities. Including input from people and families in the Comprehensive Quality Improvement Strategy will ensure people with lived experience help shape the service system. Modifying the service arrays will give people more options for receiving community services, getting support for complex needs, and participating in competitive integrated employment. Providing people with timely access to services can prevent them from seeking institutional services.

**Person-Centered Support** – Strengthening person-centered planning and informed choice, along with supporting people to live in and receive services in their homes and communities as long as possible, supports individual choice. Compliance with the Access Rule and creating a state-level grievance system will help ensure that DHHS focuses on person-centered outcomes and that issues are addressed. Establishing cross-disability waivers will empower people to maintain control over their own life and services by offering holistic support. Providing services before someone is in crisis can help the person ease into services and prevent the negative impacts of waiting too long.

**Service Quality** – Robust training, along with the development of new services and provider incentives, can improve the quality of services and supports people receive. Continuous quality improvement will make sure everyone in Utah gets high-quality services offered by well-trained providers and support staff. Aligning performance measures across waivers will enhance the state's ability to analyze trends across the entire HCBS population to make system-wide improvements. Providing services before people reach crisis levels can prevent overwhelming the system's capacity and the resulting negative impacts to service quality.

**Effective Service System** – Coordinating planning across departments and piloting new programs, as well as reducing unnecessary institutional placement, can lead to a more effective service system. Using consistent performance measures will make reporting easier, reduce paperwork, and improve how service quality is tracked across DHHS. Reducing the number of HCBS waivers operated by DHHS will make HCBS programs easier for people and families to navigate and simplify operational burdens for DHHS staff. Coordinating between state agencies and community partners can help people get connected to additional support.



# Introduction

The Utah Department of Health and Human Services (DHHS) strives to ensure all Utahns have fair and equitable opportunities to live safe and healthy lives. Through its Division of Integrated Healthcare (DIH), Division of Aging and Adult Services (DAAS), and Division of Services for People with Disabilities (DSPD), DHHS has established a comprehensive long-term service and support (LTSS) system. The state delivers LTSS through nine 1915(c) Medicaid home and community-based services (HCBS) waivers and through intermediate care facilities for individuals with intellectual disabilities (ICF-IIDs), state plan services, aging programs, and other state-funded programs. In recent years, DHHS and its divisions have developed initiatives to transition people from its state institution, the USDC, and from ICF-IIDs to community supports, to reduce the number of individuals waiting for waiver services, to enhance supports to older adults, and to improve caregiver compensation. DHHS staff have participated in state and national workgroups established to promote person-centered thinking, to promote competitive integrated employment (CIE), and to address staffing shortages. Building on this momentum, DHHS sanctioned a study to determine what changes are needed to improve its support system for people with LTSS needs.

## Project Overview

DHHS engaged [Human Services Research Institute](#) (HSRI) for a two-year, cross-disability research study aimed at building on current initiatives and providing actionable recommendations. The study sought input from individuals receiving LTSS, those on waiting lists, family members, providers, support coordinators, advocates, and others to understand what is working well and where improvements are needed.

Using this feedback, HSRI developed recommendations to help DHHS:

- Meet people's wants and needs in a more person-centered way and expand individual choice
- Promote quality in the service system
- Better structure services
- Create greater capacity to serve more people

DHHS and a project steering committee requested that HSRI prioritize recommendations that support:

- **Inclusion** – Supporting and honoring people's choices for where they live and who they live with. Giving people options for receiving community services and participating in competitive integrated employment.
- **Person-Centered Support** – Empowering people to maintain control over their own life and services (self-direction) by offering holistic support.
- **Service Quality** – Ensuring that people in Utah equitably receive the services they need. Promoting high-quality services and highly qualified providers.



- **Effective Service System** – Improving coordination between agencies, funding, and reimbursement of services to help more people.

HSRI reviewed Utah policies, program documents, DHHS websites, and available data. We conducted focus groups and interviews with individuals receiving services, families, providers, advocacy organizations, experts, and DHHS staff. We analyzed Utah’s waivers, examined HCBS programs in other states, and consulted relevant literature. Regular meetings with the project steering committee provided insights and feedback throughout the process.

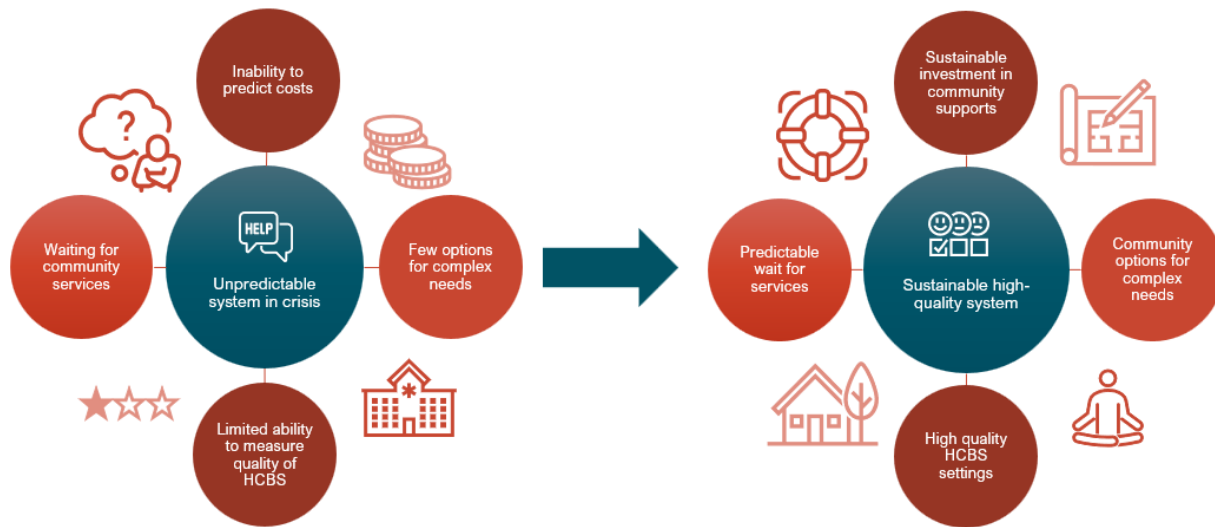
Despite considerable progress in recent years improving the service system, significant barriers remain. For example, people receiving services and their families expressed several barriers to accessing quality services. People receiving services cited a lack of resources and information from support coordinators about what services are available to them. Overwhelmingly, we heard from community members that waiting for services has been a long process, and that while on the waiting list their needs go unacknowledged, which taxes the support that families are able to provide. We have heard from different types of interested parties that there are limited services available to people with complex medical and behavioral support needs, and that the limitations in services sometimes lead people to choose noncommunity options, such as institutional or segregated services, or emergency services. Interested parties also reported that the support system is confusing and difficult to navigate, with some individuals sharing that limitations in specific waivers made it difficult for people who could benefit from the services to access them. Families reported forgoing opportunities to earn income to provide support due to a lack of services and providers. Providers shared that services are not adequately funded to enable them to provide quality support. Advocates shared concerns about the quality of services and limited options for support in the community. Based on what we learned about Utah’s support system, our recommendations focus on building a sustainable system that meets the priorities outlined by DHHS and the project steering committee and sets DHHS on a sustainable trajectory into the future.

A full description of the research background, HSRI’s approach, research activities and project limitations can be found in [Appendix A](#).

## A Sustainable Path Forward

Addressing the concerns brought forth by the community are of primary concern; however, the recommendations in this report are also intended to support DHHS in a move to a more sustainable future that meets the needs of people receiving services and their families in a person-centered way. Our recommendations focus on serving everyone—including people with complex medical and behavioral support needs—in the community and expanding the community service array. The recommendations address gaps in quality and help DHHS meet required forthcoming changes. We recommend focusing on making the service system simpler and easier to navigate, as well as having more predictable costs, by restructuring the HCBS waivers. Finally, we recommend developing ways to make the wait for services more predictable and offering means to help DHHS better forecast the cost of serving people in the future.

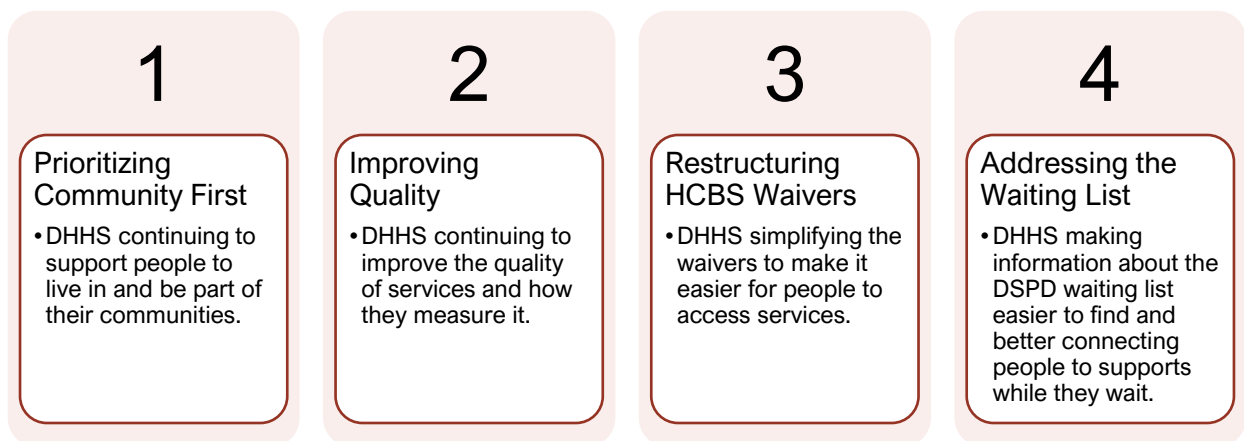
Figure 3. Sustainable Path Forward



In this report, HSRI provides context about DHHS, including information about how the service system is structured and data related to the programs under the purview of DHHS. We include recommendations in this report to:

- **Prioritize a Community First** approach to services
- Focus on **improving the quality** of services
- **Restructure the HCBS waivers**, and
- **Address the DSPD waiting list**

Figure 4. Topical Areas for Recommendations



For each recommendation area, we present the research underpinning the recommendation together with community feedback. We also provide specific steps for each recommendation, outline details, and provide examples. We provide phased recommendations to help DHHS take successive actions to achieve large-scale changes. We outline a timeline for how to pursue each change, along with important considerations for DHHS. We provide fiscal estimates, where appropriate, to help

DHHS understand the costs associated with these changes. We conclude by revisiting the priorities outlined above to describe how our recommendations align with DHHS's and the steering committee's priorities. Finally, we include appendices related to different aspects of the recommendations to offer more information and detailed examples that may support DHHS efforts to create sustainable change.



# Utah LTSS Landscape

Older adults and people with disabilities in Utah benefit from a variety of supports and services, both formal and informal. The following provides an overview of the Utah LTSS system to provide context for the analysis and recommendations that follow.

## Utah LTSS System

Like many state systems across the country, Utah’s LTSS for people with disabilities and older adults are funded through multiple mechanisms and delivered through a variety of state and regionally administered programs.

DHHS provides LTSS through Medicaid state plan and waiver authorities, other federal authorities, and state-funded programs.

Under its Medicaid state plan authority, Utah DHHS provides the following LTSS:

***Mandatory Services***

- Nursing facility services
- Home health services
- Early periodic screening, diagnostic, and treatment
- Transportation for Medicaid-covered services

***Selected Optional Services***

- Services provided in an ICF/IID
- Personal care
- Physical and occupational therapy
- Medical supplies

These state plan services may be provided to individuals through one of four managed care health plans or a fee-for-service network of providers. While the managed care health plans are available to all Utahns, only individuals living in specific, more rural counties may choose to have services provided through the fee-for-service network.<sup>1</sup> Additionally, individuals who are eligible for Medicaid as a result of the adult expansion provisions who live in select counties may choose to receive services from an integrated managed care health plan, which covers physical and behavioral health services.<sup>2</sup>

HCBS waivers are administered by three distinct state divisions DIH, DAAS, and DSPD. Together these divisions operate a total of nine different 1915(c) HCBS waivers, described briefly in the table that follows. As we note in detail in [Background for Restructuring HCBS Waivers](#), these waivers vary in eligibility, access, and the type and amounts of services and supports provided.



Table 1. DHHS HCBS Waivers

Waiver Name	Acronym	Description	DHHS Operating Division
<b>Community Supports Waiver</b>	CSW	Provides services to 6,200* people with intellectual disabilities and related conditions.	DSPD
<b>Community Transitions Waiver</b>	CTW	Provides services to 476* people who have transitioned from an intermediate care facility into home and community-based settings.	DSPD
<b>Limited Supports Waiver</b>	LSW	Provides limited services to 99* people with intellectual disabilities, related conditions, and acquired brain injuries. This waiver includes an individual cost limit of \$19,605* annually.	DSPD
<b>Physical Disabilities Waiver</b>	PDW	Provides limited self-directed personal assistance services to more than 84* people with physical disabilities over their lifespan.	DSPD
<b>Acquired Brain Injury Waiver</b>	ABI	Provides services to 161* people who are 18 or older with an acquired brain injury.	DSPD
<b>New Choices Waiver</b>	NCW	Serves 2,425* individuals who are residing in select long-term care facilities and wish to transition to a home and community-based setting.	DIH
<b>Medically Complex Children’s Waiver</b>	MCCW	Serves 509* children who have three or more specialty physicians and three or more organ systems involved in their disability.	DIH
<b>Waiver for Technology Dependent, Medically Fragile Individuals</b>	TDW	Serves 144* individuals who are under age 21 at the time of enrollment and with a disability that requires dependence on mechanical ventilation, tracheostomy, C-PAP or Bi-PAP, or intravenous administration of nutritional substance/medication.	DIH
<b>Waiver for Individuals Age 65 or Older</b>	AGW	Serves 397* seniors who qualify for both Medicaid and nursing home placement to remain at home and have services delivered in their residences.	DAAS

\*Numbers reported reflect fiscal year 2024.



In addition to the services available through the HCBS waivers, older adults and people with a range of disabilities can access services and other supports that meet their needs through:

- **Area Agencies on Aging (AAAs)** – The front line for older adults’ access to services. There are 12 AAAs responsible for providing a comprehensive array of community-based services to older adults across the state<sup>3</sup> including home-delivered meals and rides to medical appointments.
- **Utah Caregiver Support Program** – Managed by the AAAs, this short-term program provides respite care for caregivers of older adults with health, mobility, neurological, or functional limitations. Funded by the Older Americans Act, this short-term program has no low-income requirement; its goal is to enable caregivers to care for their loved ones as long as possible to delay nursing facility placement.<sup>4, 5</sup>
- **The Home and Community Based Alternatives Program** – Designed to meet the needs of low-income older adults who do not qualify for Medicaid but who could benefit from services that help them remain in their own homes and maintain their independence. The program offers a variety of in-home services to adults based on an assessment of their needs.<sup>6</sup> The Alternatives program serves more than 700 older adults.
- **State-funded, limited services for individuals waiting for DSPD waiver services** – Includes the supported work independence (SWI) program, which offers limited employment supports; caregiver compensation program, which pays caregivers for the support they provide; and respite services to give caregivers a break.<sup>7</sup>
- **Medicaid and/or Medicare-certified nursing facilities** – These nursing facilities are available to serve people 24 hours a day 7 days a week with skilled nursing and rehabilitative services. Utah has approximately 8,400 beds and an average occupancy rate of 66%. Much like the national landscape, nursing facilities are the main institutional option for older adults in Utah.
- **Utah State Developmental Center** – The state-run institution serving people with intellectual and developmental disabilities (IDD). There are 183 people receiving services at USDC as of September 2024. USDC also offers sheltered work for people who want to develop employment skills or earn income.
- **Intermediate Care Facilities for Individuals with Intellectual and Developmental Disabilities** – Privately owned facilities licensed for a specific number of beds to accommodate people with intellectual disabilities. Currently there are seven ICF-IIDs remaining in Utah providing these services.

People with LTSS needs in Utah also benefit from DHHS’s collaboration with other statewide programs. These include [Vocational Rehabilitation](#) services in the Utah Department of Workforce Services, which provides employment support to people with disabilities, and the [Utah’s State Board of Education](#), which administers educational and transition programs as well as certain therapies. Finally, Utah’s DHHS also administers the federally funded [Early and Periodic Screening, Diagnostic & Treatment](#) (EPSDT) program which provides early detection of health issues in children and funds

necessary services, such as physical exams, immunizations, vision and hearing screenings, and dental care.

There are also many organizations that help older adults and people with disabilities to navigate the support system or connect with informal or alternative supports. For example, the [Utah Parent Center](#) helps people who are waiting for DSPD services to connect to other public and generic supports. The Utah Commission on Aging manages [utahaging.org](http://utahaging.org) which helps older adults find needed resources and offers free education for caregivers. Additionally the Church of Jesus Christ of Latter-day Saints provides welfare supports throughout the state of Utah that aid many people with disabilities and older adults connected to the church.

While our recommendations address several components of this system, the primary focus is on the HCBS waiver program, under the purview of DSPD, DIH, and DAAS where most long-term supports are concentrated, as well as other programs operated, licensed, or monitored by these divisions.

## Utah Service Use and Spending Summary

The research and recommendations in this report are largely focused on the nine HCBS waivers listed in Table 1. To provide context on waiver recipients, the services they receive, and associated costs, we analyzed and provide an overview of utilization and cost data.

The utilization and cost data include Medicaid claims data for all services offered on each of the nine waivers included in our analysis. The paid claims, including service codes and modifiers, are from fiscal years 2021 through 2024. HSRI acquired the data after claims were collected for the most recent months of fiscal year 2024; data represent the most comprehensive utilization and spending for each fiscal year included in the data analysis. In addition to utilization and cost data, HSRI requested administrative data—including living situation type and date of birth—for people receiving services. While some demographics are included in this analysis, we note as relevant when data are missing for some segment of the population analyzed.

### People Receiving Services

Table 2 displays the number of people who used any service in one of the waivers in fiscal year 2024. The table shows the type of waiver followed by the number of people who received services funded by that waiver.

*Table 2. Number of people by waiver receiving services in fiscal year 2024*

DHHS Division	Waiver	Number of People
DSPD	CSW	6,200
	CTW	476
	LSW	99
	PDW	84
	ABI	161

	<b>DSPD Total</b>	<b>7,020</b>
<b>DIH</b>	NCW	2,425
	MCCW	509
	TDW	144
	<b>DIH Total</b>	<b>3,078</b>
<b>DAAS</b>	AGW	397
	<b>DAAS Total</b>	<b>397</b>
<b>DHHS Total</b>		<b>10,334</b>

## Services by Waiver

Table 3 displays the services offered across waivers. An “X” indicates the service is offered. Note that the list of services combines some like services to allow for comparison across waivers when the services are similar (e.g., pre-employment and pre-vocational services). Self-Administered Service (SAS) is available for some services shown below, and it can be administered by a provider or SAS only. Additionally, the overarching service groupings are not predefined by waivers but are a way of organizing services for the purpose of this report. This analysis is based on claims data provided by DHHS and may reflect inconsistencies within the claims data (e.g., services incongruent with listed waiver services).

Table 3. Services offered by waiver

	CSW	CTW	LSW	PDW	ABI	NCW	MCCW	TDW	AGW
<b>Supports Planning</b>									
Case Management/Support Coordination	X	X	X†	X†	X	X	X†	X†	X
Consumer Preparation Services					X	X			
Plan of Care Development						X			
<b>Residential Supports</b>									
Adult Residential Services						X			
Host Home Supports	X	X			X				
Residential Habilitation	X	X			X	X			
Supported Living	X*	X*			X*				
<b>Personal Supports</b>									
Adult Companion Services	X*	X			X*				X

Extended Living Supports	X	X			X				
Home Health Aide								X	X*
Personal Attendant Care/Assistance	X*	X	X*	X*		X*	X	X*	X*
<b>Home Supports</b>									
Chore Services	X	X			X	X			X
Environmental Adaptations	X	X	X		X	X			X
Home-Delivered/Supplemental Meals						X			X
Homemaker	X	X			X	X			X
In-home Feeding Therapy								X	
<b>Community Supports</b>									
Community Transition/Living Services	X	X			X				X
Integrated Community Learning			X						
Transportation Services	X	X	X	X	X	X			X
<b>Employment/Day Supports</b>									
Day Habilitation/Day Care Supports	X	X			X	X			X
Pre-Employment/Vocational Services	X	X	X		X				
Supported Employment	X	X	X		X				
<b>Financial Supports</b>									
Financial Management Services	X	X	X	X	X	X	X	X	X
Personal Budget Assistance	X	X			X	X			X
<b>Behavior Supports</b>									
Behavior Consultation I, II, III	X	X			X				
Behavior Analysis Therapy			X						
Behavior Services			X						
<b>Medical Supports</b>									
Supportive Maintenance Services						X			
Medication Monitoring	X	X			X	X		X	
Medication Admin/Reminder Assistance						X			X
Medical Supplies/Equipment	X	X	X	X	X	X			X



Nursing		X						X	
Massage Therapy	X	X			X				
<b>Technology Supports</b>									
Assistive Tech Devices						X			
Personal Emergency Response System (PERS)	X	X		X	X	X			X
Remote Supports Monitoring			X						
<b>Family/Caregiver Supports</b>									
Professional Parent Supports	X	X							
Family/Caregiver & Individual Training	X	X				X		X	
Individual/Family Peer Support			X						
Respite	X*	X*	X		X	X	X*	X*	X
<b>Other</b>									
Individual Goods and Services			X						

†Case management is offered as an administrative activity of the state.

\*Service used through combined provider and Self-Administered Service (SAS), provider only, or SAS only.

## Overall Services and Spending Across Waivers

Below we provide the overall combined federal and state spending and the number of people receiving any service, as well as the spending and number of only those with a full year of expenditures. Table 4 includes information on overall spending by DSPD waiver. We show both total spending and full year spending to demonstrate how much the services cost for people who rely on them throughout the year. As CSW makes up the majority of service recipients at DSPD, it is unsurprising that the spending on CSW accounts for most of the spending across the division (89%). The LSW, being fairly new and supporting few people at lower costs, has the lowest spending of DSPD waivers.

Table 4. Overall spend by DSPD waiver in fiscal year 2024

Waiver	Number of People Using Services	Spend Total	Number of People Using Service for Full Year	Full Year Spend Total
CSW	6,200	\$460,608,322.71	5,597	\$439,491,850.51
CTW	476	\$43,262,706.24	279	\$31,972,949.83
LSW	99	\$1,135,216.61	29	\$458,387.34



<b>PDW</b>	84	\$2,553,230.19	59	\$2,176,710.04
<b>ABI</b>	161	\$12,652,056.20	140	\$11,468,791.81
<b>Total</b>	7,020	\$520,211,532.00	6,104	\$485,568,690.00

Table 5 displays the overall spending by DIH waivers. NCW accounts for the majority of the people using services through DIH as well as the majority of waiver spending through DIH at 95% of the overall DIH spending. MCCW, with low service use, has the lowest spending, even though it does not serve the lowest number of service recipients.

*Table 5. Overall spend by DIH waivers in fiscal year 2024*

<b>Waiver</b>	<b>Number of People Using Services</b>	<b>Spend Total</b>	<b>Number of People Using Service for Full Year</b>	<b>Full Year Spend Total</b>
<b>NCW</b>	2,425	\$59,280,410.35	1,343	\$43,157,609.74
<b>MCCW</b>	509	\$1,168,942.81	145	\$477,999.28
<b>TDW</b>	144	\$2,055,444.26	95	\$1,763,174.28
<b>Total</b>	3,078	\$62,504,797.42	1,583	\$45,398,783.30

Lastly, Table 6 displays overall spending by the Aging waiver.

*Table 6. Overall spend by DAAS waiver in fiscal year 2024*

<b>Waiver</b>	<b>Number of People Using Services</b>	<b>Spend Total</b>	<b>Number of People Using Service for Full Year</b>	<b>Full Year Spend Total</b>
<b>AGW</b>	397	\$4,715,797.10	271	\$3,919,887.47
<b>Total</b>	397	\$4,715,797.10	271	\$3,919,887.47

## Use of Services Across Waivers

This section includes comparisons of services that are shared across more than one waiver and may be of interest due to widespread use of the services, interest in expanding services, and/or interest in comparing use of services between waivers. Despite their frequent use, we do not display findings on case management or support coordination due to the standardization and requirements for this service as well as differences in how support coordination is managed.

## Residential Supports

Across waivers, residential supports include adult residential services, residential habilitation, host home supports, and supported living (agency or SAS). The waivers that offer residential supports are CSW, CTW, ABI, and NCW.

First, we explore the number of people using residential supports and the total cost across waivers. NCW offers adult residential services and residential habilitation. The other residential services are offered across CSW, CTW, and ABI. Host home supports are a type of residential habilitation offered on the CSW, CTW, and ABI waivers.

Table 7. Overall spend on residential supports by waiver in fiscal year 2024

Residential Supports	Waiver	Number of People Served in Waiver	Number and Percent of People Using Service	Service Spend Total
<b>Adult Residential</b>	NCW	2,425	70 (3%)	\$903,760.00
<b>Residential Habilitation</b>	CSW	6,200	2224 (36%)	\$194,073,248.59
	CTW	476	397 (83%)	\$25,338,973.90
	ABI	161	56 (35%)	\$5,028,640.96
	NCW	2,425	339 (14%)	\$5,857,357.60
<b>Host Home Supports</b>	CSW	6,200	692 (11%)	\$47,980,254.96
	CTW	476	79 (17%)	\$4,939,174.08
	ABI	161	29 (18%)	\$1,960,623.11
<b>Supported Living (All)</b>	CSW	6,200	2739 (44%)	\$72,715,889.37
	CTW	476	20 (4%)	\$762,602.28
	ABI	161	76 (47%)	\$2,552,562.17
<b>Supported Living (Agency)</b>	CSW	6,200	1381 (22%)	\$28,495,020.13
	CTW	476	17 (4%)	\$651,883.84
	ABI	161	55 (34%)	\$1,585,439.31
<b>Supported Living (SAS)</b>	CSW	6,200	1643 (27%)	\$44,220,869.24
	CTW	476	3 (1%)	\$110,718.44
	ABI	161	27 (17%)	\$967,122.86

Next, we present the spending and service use for people using a full year of services in residential supports. That is, people were included in the count above if they had any spending paid at any point across fiscal year 2024. Below, we include only people with a full year of spending—or spending in each month of the year. This may provide a more accurate picture of costs for people who rely on these residential services.

*Table 8. Overall spend on residential supports by waiver, people with full year (FY 2024) of services only*

Residential Supports	Waiver	Number of People Served for Full Year	Number and Percent of People Using Service	Average Units Per Person	Unit Type	Average Spend Per Person
<b>Adult Residential</b>	NCW	1,343	62 (5%)	337.50	Day	\$13,492.26
<b>Residential Habilitation</b>	CSW	5,597	2044 (37%)	329.82	Day	\$90,743.82
	CTW	279	211 (76%)	325.85	Day	\$82,951.42
	ABI	140	46 (33%)	345.72	Day	\$95,647.07
	NCW	1,343	165 (12%)	239.51	Day/Hour*	\$21,602.04
<b>Host Home Supports</b>	CSW	5,597	655 (12%)	312.96	Day	\$70,736.98
	CTW	279	68 (24%)	304.24	Day	\$67,921.85
	ABI	140	46 (33%)	345.72	Day	\$95,647.07
<b>Supported Living (All)</b>	CSW	5,597	2497 (45%)	4,031.87	15 Minute	\$27,446.28
	CTW	279	17 (6%)	5,351.88	15 Minute	\$42,492.28
	ABI	140	67 (48%)	4,592.06	15 Minute	\$34,325.52
<b>Supported Living (Agency)</b>	CSW	5,597	1249 (22%)	2,498.44	15 Minute	\$21,147.74
	CTW	279	14 (5%)	5,228.14	15 Minute	\$43,689.31
	ABI	140	46 (33%)	3,351.11	15 Minute	\$29,647.81
<b>Supported Living (SAS)</b>	CSW	5,597	1505 (27%)	4,615.97	15 Minute	\$27,986.60
	CTW	279	3 (1%)	5,929.33	15 Minute	\$36,906.15
	ABI	140	26 (19%)	5,904.50	15 Minute	\$36,000.39

\*Residential habilitation paid as day or hour; only three people had service billed as hourly.

The types of residential supports and costs vary by waiver. As expected, residential habilitation is the highest cost residential service, with host home being costly on the ABI waiver. The average costs of residential habilitation are highest on the CSW and ABI waivers. The lowest average residential cost service is adult residential, provided only on the NCW.

### **Personal Supports**

Across waivers, personal supports as defined for this report include adult companion services, extended living supports, home health aide, and personal attendant care/assistance. These services



span all of the waivers analyzed in this report—at least one of the personal supports services is offered on each waiver. Here we focus on the most used services across waivers: companion services and personal attendant services.

First, we explore the number of people using personal supports and the total cost across waivers.

*Table 9. Overall spend on personal supports by waiver in fiscal year 2024*

Personal Supports	Waiver	Number of People Served in Waiver	Number and Percent of People Using Service	Service Spend Total
<b>Adult Companion Services (All)</b>	CSW	6,200	41 (1%)	\$614,299.11
	ABI	161	2 (1%)	\$28,212.84
	AGW	397	133 (34%)	\$268,459.11
<b>Adult Companion Services (Agency)</b>	CSW	6,200	1 (<1%)	\$45,463.04
<b>Adult Companion Services (SAS)</b>	CSW	6,200	40 (1%)	\$568,836.07
	ABI	161	2 (1%)	\$28,212.84
	CSW	6,200	88 (1%)	\$1,154,108.59
	LSW	99	92 (93%)	\$1,001,747.90
	PDW	84	84 (100%)	\$2,463,216.19
	NCW	2,425	982 (40%)	\$3,716,872.39
	MCCW	404	111 (27%)	\$219,565.62
	TDW	144	78 (54%)	\$594,366.97
	AGW	397	145 (37%)	\$1,865,286.34
<b>Personal Attendant Care (Agency)</b>	CSW	6,200	88 (1%)	\$1,154,108.59
	LSW	99	41 (41%)	\$324,986.53
	NCW	2,425	942 (39%)	\$2,517,620.52
	AGW	397	3 (1%)	\$817.74
<b>Personal Attendant Care (SAS)</b>	CSW	6,200	88 (1%)	\$1,154,028.37
	LSW	99	64 (65%)	\$ 676,761.37
	PDW	84	84 (100%)	\$2,463,216.19
	NCW	2,425	53 (2%)	\$1,199,251.87
	TDW	144	78 (54%)	\$594,366.97
	AGW	397	142 (36%)	\$1,864,468.60

Next, we present full-year spending and service use for people using personal supports. That is, people were included in the count above if they had any spending paid at any point across fiscal year 2024. Below, we include only people with a full year of spending—or spending in each month of the

year. This may provide a more accurate picture of costs for people who more frequently rely on these personal supports.

*Table 10: Overall spending on personal supports by waiver, people with full year (FY 2024) of services only*

Personal Supports	Waiver	Number and		Average Units Per Person	Unit Type	Average Spend Per Person
		Number of People Served for Full Year	Percent of People Using Service			
<b>Adult Companion Services (All)</b>	CSW	5,597	38 (1%)	--	--	\$15,241.41
	ABI	140	2 (1%)	2,718.00	15 Minute	\$14,106.42
	AGW	271	96 (35%)	594.83	15 Minute	\$2,357.57
<b>Adult Companion Services (Agency)</b>	CSW	5,597	1 (<1%)	301.00	Day	\$45,463.04
<b>Adult Companion Services (SAS)</b>	CSW	5,597	37 (1%)	2,830.57	15 Minute	\$14,424.61
	ABI	140	2 (1%)	2,718.00	15 Minute	\$14,106.42
<b>Personal Attendant Care (All)</b>	CSW	5597	85 (2%)	2,878.04	15 Minute	\$13,304.58
	LSW	29	27 (93%)	2,226.89	15 Minute	\$14,664.80
	PDW	59	59 (100%)	7,601.54	15 Minute	\$35,641.03
	NCW	1343	708 (53%)	791.59	15 Minute	\$4,684.54
	MCCW	145	111 (77%)	505.00	15 Minute	\$1,978.07
	TDW	95	55 (58%)	2,249.76	15 Minute	\$8,880.23
	AGW	271	107 (39%)	3,468.64	15 Minute	\$14,941.90
<b>Personal Attendant Care (Agency)</b>	CSW	5597	1 (<1%)	14.00	15 Minute	\$ 80.22
	LSW	29	11 (38%)	958.73	15 Minute	\$8,974.23
	NCW	1343	674 (50%)	460.84	15 Minute	\$3,196.01
	AGW	271	2 (1%)	74.00	15 Minute	\$341.88
<b>Personal Attendant Care (SAS)</b>	CSW	5597	85 (2%)	2,877.87	15 Minute	\$13,303.64
	LSW	29	22 (76%)	2,253.64	15 Minute	\$13,510.59
	PDW	59	59 (100%)	7,601.54	15 Minute	\$35,641.03
	NCW	1343	46 (3%)	5,431.37	15 Minute	\$25,272.78
	TDW	95	55 (58%)	2,249.76	15 Minute	\$8,880.23
	AGW	271	105 (39%)	3,533.30	15 Minute	\$15,220.00

Personal supports provided to people using the PDW has the highest average cost, which is consistent with higher use by service recipients on the PDW. NCW also has a high use of SAS personal attendant service. The CSW and ABI have very low use of personal supports. Service



recipients are most likely to use SAS personal supports over non-SAS supports on the LSW and TDW; a high percentage of the AGW population is also using the SAS option. SAS is required on the PDW.

### **Employment/Day Supports**

Across waivers, employment/day supports includes day/day care supports, pre-employment, pre-vocational services, and supported employment. These services are offered on CSW, CTW, LSW, ABI, NCW, and AGW, with at least one of the services being offered on each.

First, we explore the number of people using employment/day supports and the total cost across waivers.

*Table 11. Overall spend on employment/day supports by waiver in fiscal year 2024*

<b>Employment/Day Support Service</b>	<b>Waiver</b>	<b>Number of People Served in Waiver</b>	<b>Number and Percent of People Using Service</b>	<b>Service Spend Total</b>
<b>Day Care Services</b>	NCW	2425	1 (<1%)	\$677.88
	AGW	397	10 (3%)	\$38,656.56
<b>Day Habilitation (All)</b>	CSW	6,200	3749 (60%)	\$75,699,421.38
	CTW	476	425 (89%)	\$8,038,437.93
	ABI	161	80 (50%)	\$1,887,187.59
<b>Day Habilitation (Day Rate)</b>	CSW	6,200	3355 (54%)	\$64,963,685.61
	CTW	476	396 (83%)	\$7,274,926.12
	ABI	161	45 (28%)	\$ 924,420.96
<b>Day Habilitation (15 Minute Rate)</b>	CSW	6,200	561 (9%)	\$10,735,735.77
	CTW	476	44 (9%)	\$763,511.81
	ABI	161	40 (25%)	\$962,766.63
<b>Pre-Employment</b>	LSW	99	1 (1%)	\$743.08
<b>Supported Employment (All)</b>	CSW	6200	670 (11%)	\$5,781,329.50
	CTW	476	27 (6%)	\$158,887.32
	LSW	99	6 (6%)	\$14,684.58
	ABI	161	19 (12%)	\$130,339.62
<b>Supported Employment (Day Rate)</b>	CSW	6200	105 (2%)	\$1,039,748.59
	CTW	476	6 (1%)	\$32,232.93
<b>Supported Employment (15 Minute Rate)</b>	CSW	6200	571 (9%)	\$4,741,580.91
	CTW	476	21 (4%)	\$126,654.39
	LSW	99	6 (6%)	\$14,684.58
	ABI	161	19 (12%)	\$130,339.62



Next, we present the spending and service use for people using employment/day supports for people with a full year of service use. That is, people were included in the count above if they had any spending paid at any point across fiscal year 2024. Below, we include only people with a full year of spending—or spending in each month of the year. This may provide a more accurate picture of costs for people who participate regularly in day and employment services.

*Table 12. Overall spending on employment/day supports by waiver, people with full year (FY 2024) of services only*

Employment/Day Support Service	Waiver	Number of People Served for Full Year	Number and Percent of People Using Service	Average Units Per Person	Unit Type	Average Spend Per Person
<b>Day Care Services</b>	CSW	5597	3449 (62%)	--	--	\$21,094.64
<b>Day Habilitation (All)</b>	CTW	279	254 (91%)	--	--	\$22,685.55
	ABI	140	70 (50%)	--	--	\$25,165.23
	NCW	1343	1 (%)	--	--	\$677.88
	AGW	271	5 (2%)	123.60	15 Minute	\$5,344.46
<b>Day Habilitation (Day Rate)</b>	CSW	5597	3096 (55%)	179.62	Day	\$20,229.92
	CTW	279	235 (84%)	192.34	Day	\$21,928.51
	ABI	140	37 (26%)	190.70	Day	\$22,046.29
<b>Day Habilitation (15 Minute Rate)</b>	CSW	5597	507 (9%)	2,622.89	15 Minute	\$19,967.61
	CTW	279	32 (11%)	2,459.09	15 Minute	\$19,029.09
	ABI	140	37 (26%)	3,374.59	15 Minute	\$25,563.60
<b>Pre-Employment</b>	LSW	29	1 (3%)	--	--	\$743.08
<b>Supported Employment (All)</b>	CSW	5597	653 (12%)	--	--	\$8,655.10
	CTW	279	25 (9%)	--	--	\$6,023.03
	LSW	29	2 (7%)	87.50	15 Minute	\$1,144.45
	ABI	140	18 (13%)	592.00	15 Minute	\$6,954.71
<b>Supported Employment (Day Rate)</b>	CSW	5597	100 (2%)	178.42	Day	\$9,932.64
	CTW	279	5 (2%)	104.80	Day	\$5,834.22
<b>Supported Employment (15 Minute Rate)</b>	CSW	5597	559 (10%)	758.81	15 Minute	\$8,333.66
	CTW	279	20 (7%)	462.50	15 Minute	\$6,070.24
	LSW	29	2 (7%)	87.50	15 Minute	\$1,144.45
	ABI	140	18 (13%)	592.00	15 Minute	\$6,954.71

Very few people use day, or employment supports on the NCW, LSW, or the AGW. Day services are commonly used by people on the CSW, CTW, and ABI. No option of employment services is used by more than 13% of the population, showing that overall, a small number of people access these services.

### Transportation Services

Transportation is a service in community supports that is widely used across waivers. Other community supports (community living services, community transition, and integrated community learning) are used across fewer waivers and/or by a low proportion of service recipients on each waiver so are excluded from this report. First, we explore the number of people using transportation services and the total cost across waivers.

Table 13. Overall spend on transportation services by waiver in fiscal year 2024

Transportation Service	Waiver	Number of People Served in Waiver	Number and Percent of People Using Service	Service Spend Total
<b>Transportation (Per Trip)</b>	CSW	6,200	91 (1%)	\$23,857.85
	CTW	476	10 (2%)	\$1,945.33
	LSW	99	1 (1%)	\$63.96
	ABI	161	54 (34%)	\$193,433.62
	NCW	2425	919 (38%)	\$1,427,528.68
	AGW	397	104 (26%)	\$125,343.90
<b>Transportation (Per Day)</b>	CSW	6,200	3349 (54%)	\$11,999,459.40
	CTW	476	385 (81%)	\$1,241,836.84
	LSW	99	1 (1%)	\$5,699.97
	ABI	161	30 (19%)	\$41,306.46
<b>Transportation (Per Month)</b>	CSW	6,200	454 (7%)	\$553,345.83
	CTW	476	69 (14%)	\$72,857.04
	LSW	99	8 (8%)	\$10,202.85
	ABI	161	5 (3%)	\$639.60
<b>Transportation (Per Mile)</b>	CSW	6,200	22 (<1%)	\$32,787.80

Next, we present the spending and service use for people using transportation services for people with a full year of service use. That is, people were included in the count above if they had any spending paid at any point across fiscal year 2024. Below, we include only people with a full year of spending – or spending in each month of the year. This may provide a more accurate picture of costs for people who frequently use transportation services. The most use of transportation and the highest average cost is on the LSW.

Table 14. Overall spending on transportation services by waiver, people with full FY 2024 year of services only

Transportation services	Waiver	Number of People Served for Full Year	Number and Percent of People Using Service	Average Units Per Person	Average Spend Per Person
<b>Transportation (Per Trip)</b>	CSW	5597	88 (2%)	60.64	\$267.90
	CTW	279	9 (3%)	43.00	\$214.96
	LSW	29	1 (3%)	12.00	\$63.96
	ABI	140	5 (4%)	24.00	\$127.92
	NCW	1343	651 (48%)	119.21	\$1,821.10
	AGW	271	74 (27%)	95.16	\$1,343.86
<b>Transportation (Per Day)</b>	CSW	5597	3116 (56%)	174.84	\$3,727.69
	CTW	279	234 (84%)	184.50	\$3,954.59
	LSW	29	1 (3%)	227.00	\$5,699.97
	ABI	140	5 (4%)	178.00	\$3,781.04
<b>Transportation (Per Month)</b>	CSW	5597	433 (8%)	9.86	\$1,240.40
	CTW	279	62 (22%)	8.97	\$1,124.87
	LSW	29	6 (21%)	11.83	\$1,487.17
	ABI	140	27 (19%)	11.44	\$1,439.54
<b>Transportation (Per Mile)</b>	CSW	5597	22 (%)	3,518.91	\$1,490.35

### Financial Management Services

Financial management services are for people who choose self-direction through the SAS options. Financial management services oversee payroll for support staff, manage tax withholdings, track service recipients funding, and help service recipients comply with rules and regulations. Financial management services may be used across all waivers. Here we compare spending and service use across waivers.

Table 15. Overall spending on financial management services by waiver in Fiscal Year 2024

Financial Management Service	Waiver	Number of People Served in Waiver	Number and Percent of People Using Service	Service Spend Total
<b>Financial Management Services (15 Minute Rate)</b>	NCW	2425	118 (5%)	\$26,413.56
	MCCW	509	436 (86%)	\$193,665.06
	TDW	144	81 (56%)	\$36,912.00
	AGW	397	142 (36%)	\$126,377.48

<b>Financial Management Services (Monthly Rate)</b>	CSW	6200	1976 (32%)	\$2,084,100.00
	CTW	476	4 (1%)	\$4,300.00
	LSW	99	65 (66%)	\$50,600.00
	PDW	84	84 (100%)	\$85,900.00
	ABI	161	28 (17%)	\$31,400.00

Next, we present the spending and service use for people using financial management services for people with a full year of service use. That is, people were included in the count above if they had any spending paid at any point across fiscal year 2024. Below, we include only people with a full year of spending—or spending in each month of the year. This may provide a more accurate picture of costs for people who routinely direct their services.

*Table 16. Overall spending on financial management services by waiver, people with full FY 2024 year of services only*

Financial Management Service	Waiver	Number and Percent of People		Average Units Per Person	Unit Type	Average Spend Per Person
		Number of People Served for Full Year	Percent of People Using Service			
<b>Financial Management Services (15 Minute Rate)</b>	NCW	1343	91 (7%)	7.08	15 Minute	\$278.83
	MCCW	145	122 (84%)	12.45	15 Minute	\$613.70
	TDW	95	58 (61%)	11.28	15 Minute	\$541.24
	AGW	271	105 (39%)	10.67	15 Minute	\$1,015.86
<b>Financial Management Services (Monthly Rate)</b>	CSW	5597	1833 (33%)	10.91	Month	\$1,090.73
	CTW	279	4 (1%)	10.75	Month	\$1,075.00
	LSW	29	22 (76%)	10.59	Month	\$1,059.09
	PDW	59	59 (100%)	11.98	Month	\$1,198.31
	ABI	140	27 (19%)	11.41	Month	\$1,140.74

The highest percentage of people using financial management services is on the PDW, as is expected, since all people self-direct on the PDW. The next highest use is MCCW, LSW and TDW, respectively. The lowest use is on the CTW and NCW respectively.

### **Behavior Supports**

Across waivers, behavior supports include behavior services and behavior consultation, including behavior consultation I through III. These services are offered on CSW, CTW, LSW, and Aging Waiver, with at least one of the services being offered on each.



The table below displays the number of people using behavior supports and the total cost across waivers.

*Table 17. Overall spend on behavior supports by waiver in Fiscal Year 2024*

Behavior Support	Waiver	Number of People Served in Waiver	Number and Percent of People Using Service	Service Spend Total
<b>Behavior Consultation I</b>	CSW	6200	150 (2%)	\$187,635.79
	CTW	476	5 (1%)	\$8,964.78
	ABI	161	3 (2%)	\$4,135.59
<b>Behavior Consultation II</b>	CSW	6200	1735 (28%)	\$4,143,212.09
	CTW	476	310 (65%)	\$697,164.94
	ABI	161	46 (29%)	\$120,360.28
<b>Behavior Consultation III</b>	CSW	6200	745 (12%)	\$3,661,175.59
	CTW	476	37 (8%)	\$172,798.92
	ABI	161	25 (16%)	\$108,930.85
<b>Behavior Services</b>	LSW	99	1 (1%)	\$8,759.51

Next, we present the spending and service use for people using behavior supports for people with a full year of service use. That is, people were included in the count above if they had any spending paid at any point across fiscal year 2024. Below, we include only people with a full year of spending – or spending in each month of the year. This may provide a more accurate picture of costs for people who frequently need behavioral support.

Table 18. Overall spend on behavior supports by waiver, people with full FY 2024 year of services only

Behavior Support	Waiver	Number of People Served for Full Year	Number and Percent of People Using Service	Average Units Per Person	Average Spend Per Person
<b>Behavior Consultation I</b>	CSW	5597	142 (3%)	145.46	\$1,261.12
	CTW	279	3 (1%)	303.00	\$2,627.01
	ABI	140	3 (2%)	159.00	\$1,378.53
<b>Behavior Consultation II</b>	CSW	5597	1621 (29%)	166.19	\$2,464.27
	CTW	279	176 (63%)	183.13	\$2,710.76
	ABI	140	40 (29%)	181.73	\$2,694.98
<b>Behavior Consultation III</b>	CSW	5597	677 (12%)	224.62	\$5,089.05
	CTW	279	27 (10%)	217.52	\$4,933.32
	ABI	140	23 (16%)	199.70	\$4,525.10
<b>Behavior Services</b>	LSW	29	1 (3%)	544.00	\$8,759.51

The highest percentage of people use behavioral services on the CTW. CSW and ABI have similar numbers of people using behavioral services.

### **Respite services**

Respite services may be used across all waivers except PDW. Here we compare spending and service use across waivers.

Table 19. Overall spend on respite services by waiver in Fiscal Year 2024

Respite Service	Waiver	Number of People Served in Waiver	Number and Percent of People Using Service	Service Spend Total
<b>Respite - Hourly (All)</b>	CSW	6200	873 (14%)	\$8,505,352.90
	CTW	476	4 (1%)	\$17,651.13
	LSW	99	13 (13%)	\$24,681.04
	ABI	161	3 (2%)	\$13,620.92
	NCW	2425	20 (1%)	\$99,167.02
	MCCW	509	147 (29%)	\$342,069.67
	TDW	144	101 (70%)	\$1,329,297.86
	AGW	397	44 (11%)	\$308,942.72
<b>Respite – Hourly (Agency)</b>	CSW	6200	113 (2%)	\$443,056.22
	CTW	476	3 (1%)	\$9,686.70
	ABI	161	3 (2%)	\$13,620.92
	NCW	2425	10 (<1%)	\$35,512.46
	MCCW	509	30 (6%)	\$79,037.41
	TDW	144	61 (42%)	\$711,610.85
	AGW	397	44 (11%)	\$308,942.72
<b>Respite – Hourly (SAS)</b>	CSW	6200	778 (13%)	\$8,062,296.68
	CTW	476	1 (<1%)	\$7,964.43
	LSW	99	13 (13%)	\$24,681.04
	NCW	2425	10 (<1%)	\$63,654.56
	MCCW	509	117 (23%)	\$263,032.26
	TDW	144	45 (31%)	\$617,687.01
<b>Respite - Daily</b>	CSW	6200	138 (2%)	\$387,263.84
	CTW	476	2 (<1%)	\$725.86
	ABI	161	1 (1%)	\$1,239.40
	NCW	2425	1 (<1%)	\$39.00
	AGW	397	7 (2%)	\$28,016.76
<b>Respite - Camp</b>	CSW	6200	311 (5%)	\$822,721.61
	CTW	476	2 (<1%)	\$3,769.95

Next, we present the spend and use for people using respite services for people with a full year of service use. That is, people were included in the count above if they had any spending paid at any point across fiscal year 2024. Below, we include only people with a full year of spending – or spending in each month of the year.

Table 20. Overall spend on respite services by waiver, people with full FY 2024 year of services only

Respite services	Waiver	Number of People Served for Full Year	Number and Percent of People Using Service	Average Units Per Person	Unit Type	Average Spend Per Person
<b>Respite – Hourly (All)</b>	CSW	5597	825 (15%)	2,481.35	15 Minute	\$10,081.32
	CTW	279	3 (1%)	1,257.67	15 Minute	\$5,657.76
	LSW	29	5 (17%)	482.60	15 Minute	\$2,174.81
	ABI	140	3 (2%)	991.33	15 Minute	\$4,540.31
	NCW	1343	18 (1%)	788.78	15 Minute	\$4,872.29
	MCCW	145	52 (36%)	388.63	15 Minute	\$3,530.04
	TDW	95	68 (72%)	1,230.66	15 Minute	\$16,924.64
	AGW	271	30 (11%)	1,567.10	15 Minute	\$8,822.48
<b>Respite – Hourly (Agency)</b>	CSW	5597	102 (2%)	848.01	15 Minute	\$4,075.40
	CTW	279	2 (1%)	983.50	15 Minute	\$4,504.43
	ABI	140	3 (2%)	991.33	15 Minute	\$4,540.31
	NCW	1343	9 (1%)	395.89	15 Minute	\$2,680.43
	MCCW	145	9 (6%)	366.33	15 Minute	\$4,375.52
	TDW	95	40 (42%)	1,050.05	15 Minute	\$15,318.45
	AGW	271	30 (11%)	1,567.10	15 Minute	\$8,822.48
	<b>Respite – Hourly (SAS)</b>	CSW	5597	740 (13%)	2,649.48	15 Minute
CTW		279	1 (<1%)	1,806.00	15 Minute	\$7,964.43
LSW		29	5 (17%)	482.60	15 Minute	\$2,174.81
NCW		1343	9 (1%)	1,181.67	15 Minute	\$7,064.15
MCCW		145	43 (30%)	393.30	15 Minute	\$3,353.08
TDW		95	31 (33%)	1,344.61	15 Minute	\$17,359.28
<b>Respite - Daily</b>		CSW	5597	124 (2%)	22.45	Day
	CTW	279	2 (1%)	2.50	Day	\$362.93
	ABI	140	1 (1%)	10.00	Day	\$1,239.40
	NCW	1343	1 (%)	1.00	Day	\$39.00
	AGW	271	5 (2%)	20.60	Day	\$4,182.21
<b>Respite - Camp</b>	CSW	5597	287 (5%)	16.90	Session	\$2,746.45
	CTW	279	2 (1%)	7.50	Session	\$1,884.98

TDW has higher use of respite than other waivers. TDW also has the highest average costs. CTW, ABI, and NCW have very low use of respite services.



## Summary of Service Use and Spending

Overall, the service use and spending analysis shows that services and use vary considerably by waiver. While this analysis may reflect potential service need, it is likely more reflective of the narrowed eligibility criteria for each waiver, enabling a very specific segment of the LTSS population to access the services. For example, very few people use financial management services on the NCW or the CTW, likely reflecting the fact that many people on these waivers are served in assisted living facilities or have recently transitioned from an institutional setting and may not yet have the supports in place needed to manage a self-directed service. Other aspects of service use and spending may reflect components of the waiver, or the way that services are likely to be used. For instance, everyone in PDW uses financial management services since self-direction is required on that waiver. Respite is highest on the TDW since the respite is provided by skilled nurses offering a means to get nursing support on the TDW.

Other analyses reflect the number of people served on the waiver. For example, costs are highest on the CSW, showing that of all the waivers, the CSW served the most people, while costs are lowest on the LSW, reflecting the limited funds available to participants and the limited number of people served. Despite these differences, there are many similarities between waivers. Waivers share exact or similar services. Accounting for usage, averages are often similar for different service types. Finally, a range of self-directed options are available on all waivers.

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# Prioritizing Community First

HSRI spoke with people in the community and people being served in institutional settings about the barriers to gaining access to community services. Access barriers sometimes lead families to choose institutional services for their loved ones. The important role that HCBS<sup>8</sup> plays is evidenced in this statement from a caregiver: “[We need] more options for mental health care in complex cases. It seems like these individuals are either in hospital, homeless, or living with family. [It is] difficult to get LTSS for this population.”

Recognizing that lack of availability of HCBS may lead people to choose institutional settings to meet critical support needs, we have recommended that DHHS structures its funding, policy, and practices to prioritize offering participants community options first.

## Background for Prioritizing Community First

Community First represents an effort to prioritize LTSS in the community over those in segregated or institutional settings. Bolstered by federal law and legal action, states have been shifting their support systems to favor community supports over segregated services, build robust services that help people to be included in their communities, and remove options that isolate people and lead to poor outcomes. This recommendation builds on what HSRI has heard from the community and aligns with national trends in service delivery. We recommend shifting Utah’s system of supports to one that enables people with disabilities and older adults to receive services in their own homes and communities rather than in isolated institutional or segregated settings. In this section, we provide an overview of issues and trends that form the context for our recommendations to improve the Utah LTSS system, including adopting explicit Community First policies, practices, and services.

## Engagement with the Community

As part of our research, we interviewed key informants familiar with Utah’s state institutions, ICF-IIDs, nursing facilities, and a grant program that helps transition individuals into community settings. We also spoke with people receiving services in the community and key informants in other states with promising programs that might be beneficial for Utah to explore.

ICF-IID staff told us their facilities are uniquely situated to support people with complex needs. They reported that community-based providers do not receive comparable training that would enable them to meet the needs of these participants. We spoke with people familiar with DSPD’s incentive program for providers to transition their ICF-IID licensed beds to HCBS. We heard that though the intent is to support ICF-IID providers to discontinue delivery of ICF-IID services and transition to delivering HCBS, some ICF-IID providers received the incentive but did not use it to transition their service delivery to HCBS or to help the people they serve transition to HCBS. Instead, in some cases, they transitioned people from the ICF-IID that had closed its beds to another ICF-IID. ICF-IID providers who made the transition to delivering HCBS in lieu of ICF-IID services noted that the transition would not have been possible without the grant program, which kept them financially afloat.

They also noted that the delivery of HCBS led to reduced revenue compared to delivering ICF-IID services, and that housing shortages proved problematic for people looking to transition to homes in the community. On the positive side, they were able to divert their nursing services to others served in the community who were previously unable to procure nursing services.

We spoke with people receiving services, their family members, and professionals through interviews and community listening sessions. Providers noted that the USDC and ICF-IIDs are often the only options for some people with complex needs and/or mental health needs because needed services are not available in the community (e.g., skilled nursing, behavioral consultation), especially for those residing in rural or frontier communities. Similarly, crisis support is not widely available. As a result, many people with behavior challenges enter an ICF-IID when a crisis occurs to access needed support. Support coordinators expressed interest in people retaining the choice to move to ICF-IIDs and USDC and stated that for some families USDC is their only respite from providing care. However, they also noted that these facilities may suffer from staffing shortages and quality-of-care concerns. To encourage alternatives to institutional settings, providers shared that it would be important to address DSPD's waiting list and the general shortage of direct support professionals; to focus on complex care services; and to provide ample services in people's homes and communities.

People with disabilities and their families shared that a lack of funding, staffing shortages, and limited community services are driving institutional placements. One professional said, "I think there's a historical lean toward more congregate or group home options versus more individualized settings." They suggested that smaller, more homelike settings are important, and that institutionalization can be prevented if people and their families are able to access adequate support in the community earlier.

Notably, we spoke with a variety of people receiving services in ICF-IIDs, assisted living facilities, and at USDC. People served at USDC with whom we spoke were largely younger adults with involvement with the court system. People served at ICF-IIDs ranged in age and support needs, from people who were quite independent and had community jobs to people with complex medical needs that required frequent nursing interventions. We heard the following themes across settings:

### ***Utah State Developmental Center***

HSRI interviewed people residing in USDC, as well as people working at USDC, in November 2024 and again in May 2025. We share details of [sheltered workshops](#) under that heading. Those residing in USDC reported mixed experiences; however, the consensus of the people we interviewed was a desire for more independent living and dissatisfaction with their current living arrangement. Most residents reported being placed in the facility involuntarily rather than choosing to enter on their own. Staff interactions were generally viewed positively, though a few residents expressed concern about staff using phones while on the floor. Many residents shared a desire to work, though only some had jobs within the facility. One resident noted restrictions around medication and food intake (due to a medical condition), highlighting the overall restrictive nature of the environment. Residents can earn tokens as a reward system to go out, but most expressed a desire to leave and live independently. Only one resident reported liking being there., highlighting the overall restrictive nature of the

environment. Residents can earn tokens as a reward system to go out, but most expressed a desire to leave and live independently. Only one resident reported liking being there.

### **ICF-IIDs**

In November 2024, HSRI conducted onsite interviews at five ICFs in Utah. HSRI pulled themes from the interviews. One theme was that most people came to an institutional setting because they either did not have the support needed in their home (e.g., family could no longer provide that support and/or Medicare/Medicaid were not sufficient) or there was a serious emergent issue that arose (physical or mental health condition). People generally entered because they needed a day program, though only full-stay options were available. Feedback about staff and nurses was overwhelmingly positive. Several people appreciated having help with roommate changes and expressed satisfaction with the schedule and activities. While most enjoyed the environment, one person wanted more flexibility in bedtime routines. People participate in work and volunteer activities and appear to have support for community access, though it's unclear if they desire more opportunities. Some people discussed moving out, but they said family members and caregivers preferred them to remain. Other people expressed a desire to eventually move and live with family, though it was unclear as to whether such plans were in place. At one ICF-IID, people living there expressed appreciation of outdoor activities. People living in ICF-IIDs shared the types of help they receive. One person described how getting help led to a decrease in ability. They said, "I get more help than I need. I used to be able to get undressed, but now I get help with that too."

One family member of a person living in an ICF-IID described her feelings about how the community had failed her sibling and why she selected an ICF-IID for her other sibling. This family member said:

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*Independent Living facilities promised [respondent's brother] that he was going to get a job and be independent, but in less than a year he was fired... It took 2 months for the state to get him into a day program. He was alone in his apartment during that time... In the last year, they have had five different managers at the place where he lives. I have had to retrain each new manager of how to treat my brother and it's led to staff dropping things like medical care... Staff dropped the ball medically, and he had E. coli. He had it for 8 months before staff did anything. Staff weren't monitoring what he was eating and that was what made him sick in the first place. Staff didn't do basic things like program numbers on his phone, and I would try to get someone to help but wouldn't be able to reach anyone and would have to go myself to help him.*

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### **Assisted Living Facilities**

We interviewed people living in one assisted living facility in November 2024. People reported entering this facility due to a lack of adequate in-home supports, often tied to Medicaid or Medicare limitations, and typically following a serious health crisis. Despite needing care, they shared that they paid significant out-of-pocket costs for the care that they receive in the facility. Staffing shortages were reported as a major concern, contributing to inconsistent care and poor scheduling, particularly

around recreational or structured activities. While some staff and nurses were described as friendly and helpful, many residents reported feeling disrespected or dismissed when raising concerns. They indicated a strong sense of mistrust, with staff often reacting negatively or defensively when people advocate for themselves, leading some to regret not escalating issues externally.

People also expressed frustration with limited autonomy and choice. Opportunities to leave the facility were reportedly scarce unless outside support was available, and interest in going out varies. A nearly universal complaint was dissatisfaction with the food. Overall, most people shared they would prefer to live independently or with family, though one person bleakly stated they expect to “probably die” in the facility – highlighting a deep sense of resignation and lack of hope among some people.

### ***Sheltered Workshops***

In May 2025, HSRI interviewed people receiving sheltered work service at USDC and one other sheltered work setting. The feedback from those working in sheltered workshops was mixed, with some people greatly appreciating the work and others feeling constrained. These interviews highlighted several recurring themes. Most participants reported having little to no control over their wages or job assignments, which contributed to dissatisfaction among some workers. One person said “My job [at the sheltered workshop] feels demeaning. I have done a lot of higher paying jobs. I want a challenge... The pay is not worth how much I am doing.” Another said “I want to work in the community. My mom thinks it’s better here.” Many expressed frustrations with the lack of flexibility in tasks, while those working “on the hill” at USDC appreciated the sense of community but desired greater autonomy, particularly in how they could spend their earnings. Overall, a common sentiment across interviews was the desire for higher pay and more freedom in their work environment.

### ***Summary of Key Themes Across Settings***

Throughout the interviews most people reported entering institutional settings because they lacked adequate support at home—either due to family limitations, insufficient Medicare/Medicaid coverage, or emergent health crises. At USDC, placements were largely involuntary, and people reported experiencing the most restrictive environment. While many expressed a desire to leave, their views of staff were generally neutral to positive.

Across settings, opinions on moving varied; however, those who wanted to relocate typically hoped to live with, or closer to, family. Family respondents tended to give very positive feedback, and people with regular family contact or community access reported more satisfaction overall. A consistent theme was positive perceptions of staff and overall experience. Many people expressed interest in working and having more independence and freedom. Finally, food choices emerged as a notable concern and in some settings limited options were frequently mentioned.

## **Overview of Institutional and Segregated Support Settings**

Institutional services vary considerably depending on the population. For the purposes of this section, institutions include state hospitals, ICF-IIDs, and nursing facilities. These types of services are also referred to as congregate care where residents with disabilities or older adults live in large,

segregated settings. People who reside in institutions are liable to be isolated from family and cut off from their communities.

Historically, long-term care in the U.S. was provided in institutions such as nursing homes, state hospitals, psychiatric hospitals, and intermediate care facilities.<sup>9</sup> Before the 1930s, care was usually informal, most often provided by families or in public almshouses. However, the Social Security Act (SSA) of 1935 and subsequent amendments in the 1950s and 1960s led to the expansion of institutional care funded by federal and state programs. The creation of Medicaid in 1965 further entrenched institutions as the default option for long-term support.<sup>10</sup> However, the availability of Medicaid also meant that some low-income families could secure needed health support in their communities, obviating the need for institutionalization of family members.

In the institutional framework, not only were people with disabilities expected to live in congregate settings because of a belief that they were unable to live in their own homes, but they were also expected to work for free in institutions (referred to as peonage). Many people worked in sheltered work, where they lacked autonomous choices about their work and received less than minimum wage pay. These programs claimed to provide people with disabilities training to develop work skills. This labor was officially authorized with the passage of Section 14(c) of the Fair Labor Standards Act (FLSA)<sup>11</sup> in 1938, which exempts people with disabilities from minimum wage requirements. Employers who wish to pay less than minimum wage must acquire a certificate from the U.S. Department of Labor. At that time, these were often the only paid employment options for people with disabilities.

Nursing homes grew out of almshouses, much like institutions. With the passage of the SSA, older adults began receiving payments. The SSA banned federal aid to people living in poorhouses, which prompted a shift to private institutions, while amendments to the SSA in 1950 allowed payments to public, licensed institutions, laying the groundwork for the current nursing home system.<sup>12</sup> As people were slowly moving to private institutions, the Medical Facilities Survey and Construction Act of 1954 brought together public and private institutions. The passage of Medicare and Medicaid in 1965 solidified the modern nursing home. The number of nursing homes expanded significantly in the following years, and by 1979, nearly 80% of older adults who received institutional services received them in commercial nursing homes.<sup>13</sup>

Utah's LTSS system has followed a similar trajectory to other states. In 1921, the Utah State Legislature established the Utah State Training School, now referred to as the Utah State Developmental Center (USDC), and the school officially opened its doors in 1931.<sup>14</sup> The number of individuals served at USDC has fluctuated over the years. At one point, there were more than 1,000 people receiving services there. In addition to USDC, private ICF-IIDs began opening throughout the state in the 1970s as providers took advantage of the 1971 Amendments to Title XIX of the Social Security Act.<sup>15</sup> Another aspect of the LTSS system in Utah is the presence of sheltered workshops. Sheltered workshops exist both at USDC and with community providers who have established sheltered workshops throughout Utah.

## ***Shifting from Institutions to Community Care***

States began to shift their services to the community as conditions in institutions worsened and legal challenges grew, as described below. In 1981 HCBS prompted a shift in the community system that would alter support systems in the decades that followed.

### **Institutional and Nursing Facility Conditions**

By the 1960s, institutions for people with disabilities had become derelict backwaters plagued by overcrowding, inadequate staffing, abuse, and appalling neglect. By 1967, the number of people in institutions for people with IDD ballooned to almost 195,000 people. In 1972, Geraldo Rivera released a documentary showcasing deplorable conditions in the Willowbrook institution in New York.<sup>16</sup> In 1967, Frederick Wiseman released the film *Titicut Follies* that showed life behind the walls of an institution for the criminally insane in Massachusetts. In 1974 Burton Blatt published a photo essay called *Christmas in Purgatory*<sup>17</sup> that showed the deplorable conditions in Seaside state hospital in Connecticut. More exposés would follow.

In addition to exposés, several other factors helped to turn the tide against institutionalization nationwide. In 1970, Wolf Wolfensberger provided a powerful rationale for deinstitutionalization when he introduced the idea of normalization. The concept asserted that segregation of people with disabilities—or any marginalized or disadvantaged group—enhanced stigma and that people should be supported in communities where the rest of us live and work. The decline of institutions was further hastened by federal legislation that asserted the rights of people with disabilities to have agency in their lives (Developmental Disabilities Assistance and Bill of Rights Act of 1963), to be included in public education (Education for All Handicapped Children Act of 1975), and to access the resources and health care necessary to remain in their homes and communities (Medicare and Medicaid in 1965 and Supplemental Security in 1974), along with the aforementioned laws protecting basic rights.

The quality of care provided in nursing facilities has been a long-standing issue. In response to publicly reported concerns on abuse and neglect of people living in nursing homes, as well as a lack of strong oversight, Congress passed the Nursing Home Reform Act of the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987).<sup>18</sup> This act included numerous regulations aimed at improving care quality.<sup>19</sup> The Centers for Medicare and Medicaid Services (CMS) has been publishing [nursing facility quality data](#) since 2003. Despite the increased oversight and regulations stemming from OBRA 1987, quality concerns about nursing facilities persist nationally, especially following the high death rates experienced during the COVID-19 pandemic. These include low nursing facility staffing levels that prompted a 2024 CMS regulation specifying minimum nurse staffing ratios.<sup>20</sup> This rule was subsequently vacated by a federal court.

### **Lawsuits**

Another pillar of the deinstitutionalization movement was the use of class action lawsuits that forced states to upgrade institutional conditions and ultimately, in the case of *Pennhurst State School and Hospital v. Halderman*, to close the institution because it was incapable of providing adequate

habilitation. More recently, the *Olmstead v. L.C.* decision by the U.S. Supreme Court in 1999 was pivotal as well, requiring services to be provided in the most integrated setting possible and noting that failing to do so could violate the Americans with Disabilities Act. The following outlines several of the pivotal lawsuits affecting institutional services.

- **1971 *Wyatt v. Stickney***<sup>21</sup> – A class action lawsuit asserting that several Alabama institutions were committing people to institutional care with no criminal proceedings and providing support that offered no opportunity for personal improvement. Findings affirmed that people who were committed were entitled to rehabilitation and mandated minimum constitutional standards for adequate treatment, such as freedom from restraint, isolation, experimental research, or unwanted procedures, guaranteed specific rights (e.g., exercise, religious worship, compensated labor), required sufficient staffing and individualized planning. It also required people to be served in the least restrictive conditions necessary for habilitation.
- **1972 *NY State Association for Retarded Children v. Carey (Willowbrook)***<sup>22</sup> – A class action lawsuit challenging that the institutional services violated residents' constitutional rights to treatment, due process rights, and equal protection under the law. The lawsuit found that people in institutions were entitled to minimal living conditions and protection from harm. It required changes at Willowbrook including reducing restraint and seclusion, increasing staff, and other changes to improve the conditions for residents.
- **1972 *Welsch v. Likins***<sup>23</sup> – Class action lawsuit asserting that several Minnesota state institutions violated the constitutional rights of residents. A consent decree required state hospitals to reduce their numbers, improve staffing ratios, have procedures for tranquilizers and behavior management practices, and engage in discharge planning and evaluation.
- **1974 *Haldeman v. Pennhurst State School & Hospital***<sup>24</sup> – A class action lawsuit asserting that the Pennhurst State School & Hospital violated several constitutional rights. The ruling in the case found that people had a right to minimally adequate habilitation, free from physical harm, and that they had a right to nondiscriminatory treatment.
- **1982 *Youngberg v. Romero***<sup>25</sup> – A class action lawsuit that held that individuals involuntarily committed to state institutions have a constitutional right to certain basic protections. The Court held that these individuals have a right to safe conditions, freedom from bodily restraint, and "minimally adequate" habilitation or treatment, rights that are protected by the Due Process Clause of the Fourteenth Amendment.
- **1984 *Estate of Michael Patrick Smith v. Heckler***<sup>26</sup> – A class action lawsuit against the US Department of Health and Human Services challenging that Medicaid recipients residing in Colorado nursing homes did not receive quality care because quality enforcement was focused on the physical facility rather than the patient. This court case required the U.S. to monitor the quality of care that nursing home residents receive.
- **1985 *Cleburne v. Cleburne Living Center***<sup>27</sup> – A Supreme Court ruling that a city ordinance requiring a special-use permit for a group home for people with intellectual disabilities was unconstitutional. It found that the city's denial of the permit was based on irrational prejudice and therefore violated the Equal Protection Clause under the more lenient rational-basis test.
- **1999 *Olmstead v. L.C.***<sup>28</sup> - The landmark case that asserted that the unjustified segregation of people with disabilities is a form of discrimination. It affirmed that people with disabilities

have a right to receive public services in the "most integrated setting appropriate," meaning they should be offered community-based services rather than institutional services, provided these services are appropriate, not opposed by the person, and can be reasonably accommodated.

- **2011 Jensen v. MN Dept. of Human Services**<sup>29</sup> – A class action lawsuit asserting that several people served in a Minnesota institution were denied their constitutional rights. Findings required Minnesota to treat people in the most integrated settings, conduct person-centered planning, and develop an Olmstead plan.
- **2023 Murphy v. Harpstead**<sup>30</sup> – A class-action lawsuit filed against the Commissioner of the Minnesota Department of Human Services (DHS) on behalf of Minnesotans with disabilities. The lawsuit challenged the state's overreliance on institutional and group home settings for people with disabilities. The settlement required Minnesota DHS to train and educate people in their options, provide additional services, and measure outcomes.
- **2025 Brown v. District of Columbia**<sup>31</sup> – A class action lawsuit filed against the District of Columbia challenging that people receiving Medicaid in nursing facilities were not notified that they could transition to and receive services in the community, and that they were not assisted to transition to the community. Following the lawsuit, DC was required to assist people to transition out of nursing facilities.

## Advent of HCBS

The advent of funding for home and community-based supports also spurred the downsizing and closure of institutions. In 1981, Congress included Section 1915(c) in the Omnibus Budget Reconciliation Act that eliminated the institutional bias in Medicaid and gave state the ability to cover HCBS for people at risk of institutionalization, including services for people with a range of disabilities. HCBS waivers fund case management, therapies, residential care, personal care, employment and other services. In 1981, President Ronald Reagan created the Katie Beckett Waiver, also known as a TEFRA waiver, which allowed children with significant disabilities to receive Medicaid-funded home and community-based care, even if their family's income would normally disqualify them. It enabled children who qualify with an institutional level of care to live at home with their families.

Public sentiment has also helped to spur these changes for older adults. Most Americans want to age in their own homes and communities for as long as possible as they grow older.<sup>32 33 34 35</sup> This is also called "aging in place." Research shows that older adults prefer to receive care in their homes and communities rather than in institutions such as nursing facilities. One of these studies found that a significant majority of older adults (75% to 88% of Americans) prefer to remain in their homes with their families. Aging in place allows older adults to maintain more independence and autonomy and to keep their social ties and community connections.<sup>36</sup>

Regarding sheltered work, with the passage of Section 504 of the Rehabilitation Act in 1973,<sup>37</sup> discrimination based on disability was outlawed for programs receiving federal funding. Following this, the Americans with Disabilities Act (ADA),<sup>38</sup> passed in 1990, prohibited employment discrimination against qualified individuals with disabilities, significantly expanding access to jobs in

the community. More recently, advocates for people with disabilities have argued that sheltered workshops are discriminatory because they segregate workers with disabilities. Many states have responded to this advocacy by eliminating and/or downsizing these facilities. Vermont was the first state to ban subminimum wages and sheltered workshops in 2002. Since then, six others have enacted legislation banning subminimum wages: Alaska, Maine, Maryland, Nevada, New Hampshire, and Oregon. Of those, four no longer have sheltered workshops. The total number of 14(c) employers and sheltered workshops across the country has decreased from 1,162 in August 2022 to 751 as of 2024.

## Overview of Home and Community-Based Services

The infusion of waiver funding since 1981 facilitated the rapid growth of community alternative services and support. Between 1967 and 2012, the U.S. experienced an 85.5% reduction in the number of people with intellectual disabilities living in institutions.<sup>39</sup> Likewise, spending on services for people with disabilities in the community increased—eventually outpacing spending on institutional care.<sup>40</sup>

In recent years, the number of certified nursing facilities has declined, down from more than 19,000 in 1985<sup>41</sup> to fewer than 15,000 in 2024.<sup>42</sup> Occupancy rates have also fallen, and a number of factors—including the availability of assisted living facilities and community-based services, “rebalancing” efforts, and the growing provision of post-acute rehabilitative services in nursing facilities—have contributed to higher acuity in the nursing facility population.<sup>43</sup>

The [Money Follows the Person](#) (MFP) initiative, the Americans with Disabilities Act, the *Omstead v. LC* decision (described above), and the HCBS Final Settings Rule released by CMS in 2014 have all reinforced the principle that people with disabilities need to live and thrive in communities of their choice, free from the isolation and dehumanization of institutionalization and segregated services.

Over time, Utah has made considerable progress in moving toward a more community-oriented system. Utah launched its first HCBS waiver in 1986. Since that time, Utah’s HCBS program has grown significantly, serving 10,334 people in fiscal year 2024, and the state has introduced programs that help people remain in their homes and transition back to their communities when they have moved into institutional settings (see [Utah LTSS System](#) for more information).

Despite the implementation of HCBS in 1986, many Utahns with disabilities continue to receive services in institutional or segregated settings. In 1989, a class action lawsuit known as the Lisa P. lawsuit<sup>44</sup> was filed against the state by the Disability Law Center (DLC) and the Arc of Utah on behalf of all people residing at USDC due to the practices and treatment of individuals in USDC services. In October 1993, a settlement agreement required the evaluation of each resident to determine the appropriateness of their placement in an institution and HCBS services that would be necessary for them to live in the community. The terms of the settlement agreement resulted in a decline in the population of USDC from about 450 residents to 250. DHHS continues this work as evidenced by working with HSRI and other vendors to better understand USDC capacity and how to serve people in the community.

In January 2018, DLC filed another class action lawsuit—*Christensen v. L.C.*<sup>45</sup>—against the state of Utah, asserting that individuals with disabilities in Utah were being unnecessarily institutionalized and did not have access to supports and services in the most integrated setting, as outlined in Title II of the Americans with Disabilities Act and upheld in the 1999 United States Supreme Court Hearing *Olmstead v. L.C.* The DLC’s lawsuit alleged that Utah was not making meaningful progress toward integrating people with disabilities and instead was increasing the number of people served in institutional settings. DLC and DHHS reached an agreement in the case, and consequently Utah has taken steps toward decreasing the reliance on placement in ICF-IIDs.

Following this lawsuit DHHS established the Intermediate Care Facility Transition Program, which educates current ICF-IID residents and their loved ones about the availability of HCBS in Utah and supports individuals who wish to make a transition to community services and support. According to an interview with a key informant, 500 people have transitioned from ICF-IIDs, USDC, and nursing facilities into HCBS through the Community Transitions Waiver—the waiver developed specifically to support people wanting to transition to community settings. Additionally, DHHS has developed an incentive program for ICF providers to transition their licensed ICF-IID placements to HCBS, giving ICF-IID providers \$50,000 per person if the person transitions to HCBS from an ICF-IID and stays in HCBS for one year. It is important to note that the provider was not paid if someone transitioned from an ICF-IID to another ICF-IID. Further DHHS only fills ICF-IID spots lost to attrition, while all new funding is directed at waiver services. Ending ICF-IID placements is intended to serve more people in HCBS living settings. To date, three ICF-IIDs in Utah have taken advantage of the transition program, transitioning ICF-IID placements to HCBS. Grants for ICF-IID transition and other efforts have led to a 70% reduction in ICF-IIDs placements overall, shrinking the number of facilities from 18 to seven. The remaining ICF-IIDs now operate a total of 198 licensed placements.

Notably, DHHS has invested in educating people in ICF-IIDs regarding transition to the community. One of the innovative efforts is the peer navigator program in which individuals who previously lived in institutional settings educate those interested in transitioning to HCBS. According to key informants, USDC administrators have created stricter guidelines for who can be admitted to ICF-IIDs, citing a need for a clear path to support the person to transition back to their homes and communities. Currently, many people who choose to remain living in an ICF-IID can choose to transition to HCBS and will receive support from DHHS to do so. As a result of these efforts DHHS has successfully supported more than 500 people to move from private ICF-IIDs into the community, purchased licenses from the ICF-IID system to reduce the overall number of people who can be served, and has seen a reduction in the total number of ICF-IIDs in the state.

USDC supports a small number of older adults with complex medical needs, though most people served at USDC are reported to have significant behavioral needs. Key informants report that USDC is moving toward an approach where people with these needs can transition back to their communities to receive HCBS services once stabilized, while honoring their choices. People receiving services at USDC also receive education about HCBS, including education from peer advocates, who help them better understand the transition and what it will mean for them.



In 2024, following a complaint by Utah’s DLC, the Department of Justice (DOJ) concluded that Utah unnecessarily segregates people with disabilities from meaningful employment and day service opportunities.<sup>46</sup> Among the findings, the DOJ noted that DHHS segregates people in sheltered work settings, has limited capacity to support people to find and keep meaningful employment, offers day programming that rewards providers for supporting people in segregated settings, and that Utahns with disabilities are entitled to integrated settings. As of 2024, Utah had eight sheltered workshops serving 365 people with disabilities.<sup>47</sup> That was down from 14 sheltered workshop providers in 2019.<sup>48</sup>

Nursing facilities are the main institutional option for older adults in Utah. There are 98 nursing facilities in Utah that are Medicaid- and/or Medicare-certified, down from 102 in 2018. Approximately 68% of their 8,513 certified beds were occupied in July 2025, which was lower than the national average of 79% and slightly higher than the February 2018 rate of around 64%. Approximately three-fourths of these Utah nursing facilities are for-profit; the remainder are nonprofits or government operated.<sup>49</sup> The latest data from CMS’s provider data catalog shows Utah nursing facilities average quality ratings at or above national averages for overall quality, health inspections, quality measures, and staffing levels.<sup>50</sup> In fiscal year 2020, nearly 80% of Medicaid spending for LTSS for older adults and people with disabilities in Utah went to institutional services, including nursing facilities, making Utah among the lowest performing states on rebalancing investment to HCBS.<sup>51</sup>

While institution populations have declined, other community programs were not always realizing the value of community inclusion. In 2014, in recognition that the aspirations of HCBS were not uniformly met, CMS issued the HCBS Final Settings Rule (known informally as the “Final Settings Rule”) “to ensure that every person receiving Medicaid-funded HCBS has full access to the benefits of community living.”<sup>52</sup> The intent of the HCBS Final Settings Rule is to formalize people’s right to make choices and control their own lives and be treated with respect and dignity.<sup>53</sup>

Among the provisions included in the HCBS Final Settings Rule are that people:

- Engage in a person-centered planning process and direct their supports and services
- Are served in integrated settings that provide access to the community
- Have choices over where they live and receive support
- Have privacy
- Are free from coercion and restraint
- Can choose their services and who provides them

It also stipulates that people living in provider-controlled settings:

- Have legally enforceable agreements for their homes and can choose how to decorate their home, their schedule, and when they have visitors
- Have accessible homes and a choice in their roommates
- Are able to access food
- Have means to have privacy in their homes

All states were required to comply with the HCBS Final Settings Rule as of March 17, 2023. The HCBS Final Settings Rule is meant to represent minimum standards for compliance, but many states have made changes to go beyond just compliance to fully integrate the intent of the Final Settings Rule.

## Important Community Firsts

Along with the Final Settings Rule, several national initiatives have catalyzed a movement toward strengthening community services for people with disabilities and older adults, supporting people with disabilities and their families to develop and plan for a vision for a good life, to find and keep employment, to expand technologies that can enable people to become or remain independent in their homes, and to promote greater authority of services and supports by allowing people to self-direct their services. Utah has already incorporated many aspects of these important initiatives.

### *People First and Family First*

As people with disabilities continue to live and thrive in their communities, recognition has grown that the person's needs should drive their services and supports and that families are a critical part of the continuum of care. Person-centered planning and self-direction put people in charge of their supports and services, making best use of their existing support network, building the capacity of the person and family, and enabling the planning team to develop a culturally appropriate plan.

### Person-Centered Planning

Person-centered planning was formalized through the Final Settings Rule, which requires each person receiving HCBS to have a person-centered plan developed with the person and people chosen by the person. Person-centered plans shift the conversation around what services are needed to support the person's goals rather than what the system can offer. "Person-centered service plans help create a sustainable system where older adults and people with disabilities live their lives by making informed choices, having full control, and accessing a broad array of quality services."<sup>54</sup> Person-centered plans also accommodate changing needs to better support each person's independence, are responsive to the person's needs, and can help bolster existing relationships and community connections.<sup>55</sup>

Person-centered planning is defined as "a dynamic way to learn about the choices and interests that make up a person's idea of a good life – and to identify the services and supports needed to achieve that life. The person directs the person-centered planning with support from a support coordinator as needed and desired."<sup>56</sup> Person-centered plans are associated with lower future costs, better health outcomes, higher likelihood of receiving preventative care, and have numerous other reported positive benefits.<sup>57</sup>

In 2019, DSPD began working with the National Center for Advancing Person-Centered Practices and Systems (NCAPPS), administered by HSRI, to revise the person-centered planning process for Medicaid waivers administered through DSPD to comply with the Final Settings Rule. As part of this work, DSPD incorporated tools and ideas from [Charting the LifeCourse](#) (CtLC), a framework that guides person-centered planning and practices, into its person-centered planning processes for

people with disabilities and their families and support coordinators. This new planning process includes activities such as incorporating the life trajectory planning and life domains (advocacy and engagement, community living, daily life and employment, healthy living, safety and security, and social and spiritual), and including the life trajectory into the planning process, ensuring the person-centered support team considers each domain. This initiative also promotes the use of new tools for support coordinators, including those from CtLC.

Notably, DSPD's work revamping the planning process was highlighted as a promising practice in national presentations such as [Person-Centered Systems Change: Reflections from the First NCAPPS Technical Assistance Cohort](#), [Opening the Door: Importance of Great Person-Centered Conversations on Employment](#), and [Person-Centered Service Planning in HCBS: Individual Rights and Modifications of the Settings Requirements for Provider-Owned or Controlled Residential Settings](#).

### Supporting Families

The Final Settings Rule makes it clear that HCBS for older adults and people with disabilities should ensure that service recipients live lives that mirror lives that are enjoyed by the general public. To be valued members of their communities, people with disabilities and older adults need family members, friends, neighbors, peers and co-workers to play important roles in their lives. While paid supports are important, natural supports also enrich people's quality of life. Studies show that social networks in the lives of older adults and people with disabilities can: act as a protective factor to prevent abuse and exploitation,<sup>58</sup> reduce poor outcomes associated with loneliness and isolation,<sup>59</sup> and help people with disabilities find jobs.<sup>60</sup> Despite these benefits, older adults and people with disabilities living with their families in their communities can receive direct support through HCBS, but family members cannot.

Family caregivers have significant responsibilities to provide support to their family members who have long-term support needs. This is in part due to an aging American population and multigenerational caregiving duties. According to the report *Caregiving in the United States*, one in five Americans (21.3%) are providing caregiving to an adult or child with support needs.<sup>61</sup> Very often these individuals live in their own homes or with family members and have specialized needs, as do their family caregivers.<sup>62</sup> According to the *Wingspread* report, a seminal report on supporting family caregivers, the goal of supporting families "...with all of their complexity and diversity, is to maximize their capacity, strengths, and unique abilities so they can best support, nurture, love and facilitate opportunities for the achievement of self-determination, interdependence, productivity, integration, and inclusion in all facets of community life for their family members."<sup>63</sup>

Given the pivotal role played by family caregivers, there have been recent initiatives to aid families to connect with community support. For example, the CtLC<sup>64</sup> planning tools help families to explore community assets and resources. One component of the framework includes the following three areas in which people and their families require support:

- **Discovery and Navigation.** People need information and tools to seek out the necessary support.

- **Connecting and Networking.** People need to make connections with a range of support networks in their communities and elsewhere.
- **Goods and Services.** People need access to day-to-day tangible items and/or services (publicly funded or not) that are essential.

These domains highlight the importance of blending a variety of supports so that people and their families can be engaged in planning for services and plan for effective supports. These supports and resources enable people and their families to outline a vision for a good life, plot a course to get there, and determine where there are gaps to be filled.

The mission of HCBS systems should be to use innovative solutions and resources to support people in their homes and communities. To do so, the service system needs to respect the choices and expertise of older adults and people with disabilities. Systems also need to provide bridges between participants and the civic life of their communities—helping them build their own networks and friendships.

Utah has advanced many of these aims in recent years through its HCBS system. For example, Utah has individual and family peer supports available on the Limited Supports Waiver. In addition to peer supports, DHHS offers family support services on TDW to help families learn skills to better support their family members who are aging or have disabilities. DHHS also offers individual and family training services on the CSW and the CTW. Additionally, people in Utah benefit from numerous initiatives to advance CtLC, such as embedding CtLC life domains into DSPD’s person-centered planning processes and promoting CtLC tools to support coordinators. Finally, Utah has a robust network of non-Medicaid support available through the Church of Jesus Christ of Latter-Day Saints. Church-sponsored initiatives vary in intensity and service offerings from ward to ward but may include disabilities specialists, health care and mobility supports, and other resources that are free to the community.

### **Self-Direction**

Self-direction is an option that allows people receiving services to have more control over their support services and lives. In recognition that people with disabilities can maximize their autonomy by having a higher degree of authority over the supports they receive, several states began self-direction options in state programs in the 1980s. In the 1990s, the Cash and Counseling project was funded by the U.S. Assistant Secretary for Planning and Evaluation and the Robert Wood Johnson Foundation. In the years since, self-direction has grown dramatically, expanding significantly during the COVID-19 pandemic as people were unable to use traditional providers and services for a host of reasons. Self-direction is recognized as a person-centered approach to service delivery, since people with disabilities are in the driver’s seat, choosing how to use their available funds and, in many cases, choosing who provides their services—including hiring family members and friends.

Self-direction incorporates at least one of two fundamental direct services. These include:

- **Participant Employer Authority** – This self-direction opportunity allows people to recruit, hire, and supervise the people who provide their support. The person receiving services acts as either the employer or co-employer of the people who provide their support.
- **Participant Budget Authority** – This self-direction opportunity allows people to exert authority in managing a participant-directed budget.<sup>65</sup>

Most states offer one or both opportunities within HCBS. States have latitude in how they establish their self-directed programs, can specify which HCBS services can be self-directed, and target which populations can be offered self-direction opportunities. States can also determine whether legally responsible people can be paid to deliver self-directed services. Due to differences in how states and programs collect data and monitor programs, measuring the quality of self-direction can be challenging.<sup>66</sup>

Self-direction has many avid supporters who routinely advocate for improvements in self-direction and who work to expand self-direction so that more people can benefit from having greater opportunity to express their autonomy. With the help of advocates, some states develop robust training and information to accompany their self-direction programs and to help people self-direct to the greatest extent possible. Self-direction can meet the cultural and linguistic needs of people with disabilities and older adults since people can choose staff from their communities who speak their language. Because many of these individuals are not part of the usual pool of workers, self-direction can help to mitigate the care workforce crisis.

Like many states that saw growth of self-direction during the pandemic, Utah expanded its self-direction programs, allowing payments to be made to legally responsible people. Utah offers an expansive array of self-direction options through SAS services. Services that can be self-directed include:

- Supported living
- Respite
- Transportation
- Homemaker
- Attendant care
- Family support services

Many of these services can also be provided by legally responsible people, allowing people to hire people who are deeply familiar with their support needs to deliver their services.

### **Employment First**

In the 2000s, the national Employment First movement spurred a shift toward competitive integrated employment (CIE) and encouraged states to expand employment services that help people with disabilities to find and maintain integrated jobs. Employment First is a national initiative that promotes CIE as an alternative to sheltered work for people with disabilities, including those with the most extensive support needs.<sup>67</sup> Disability rights advocates have continued to push for the elimination of segregated workshops and subminimum wages in favor of regular jobs in the community.

Employment First is a movement that seeks to ensure that all people with disabilities have the supports needed to be competitively employed in an integrated setting, no matter their needs.

Most states across the United States have either formally or informally adopted Employment First initiatives through legislation, executive orders, or agency policies. Utah initially passed Employment First policy in 2012 under [House Bill 296](#). However, Utah lawmakers updated this legislation in 2022 ([House Joint Resolution 15](#)) to include “respecting where an individual chooses to seek work” after family members advocated for the initiative to include language that would recognize sheltered work under Utah’s Employment First policy. DSPD currently has an active 2024-2025 Employment First Strategic Plan.<sup>68</sup> The plan includes objectives with corresponding tactics across four primary domains: 1) education, 2) financing and contracting methods, 3) services and service innovation, and 4) performance measurement. The plan focuses on working with DSPD contractors, support teams, and new partners. Below is a summary of the objectives and tactics under each primary domain.

**TACTIC 1: Education.** DSPD will develop outreach and training materials on CIE and will provide education to support teams on CIE and informed choice activities, including developing plain language materials, developing a training series for support teams on a variety of topics that support CIE, ensuring all working-age individuals in DSPD services have had a conversation through the Employment Pathway Tool, and creating “Supporting a Vision for Employment” as part of the Support Coordinator Core Training series. This [online training series](#) for the Employment Pathway Tool is now required in the planning process. Support coordinators must walk through the Tool at least once a year.

**TACTIC 2: Financing and Contracting Methods.** DSPD will identify and seek to resolve barriers that impact individuals’ abilities to receive CIE and analyze employment data to better understand service gaps. This approach will include updating the language in contracts, services, and waivers to better promote CIE, analyzing current employment data to understand the status of CIE, and using technical assistance to review financing and contracting methods that may promote CIE.

**TACTIC 3: Services and Service Innovation.** DSPD will work with contractors and new partners to support individuals with disabilities to obtain CIE, explore work interests, gain skills that generalize across life domains, and make informed choices. This includes training partners on person-centered practices and tools and participating in new partnerships that (a) include self-advocate and family voice and (b) support users who are typically underserved in employment. Below is a list of current outcomes as a result of this domain (not including outcomes still pending):

- Implementation of a grant that provides Assistive Technology to individuals both in DSPD services and on the waitlist who need AT in order to obtain or maintain CIE. Items include AT such as electric bikes, iPads, and calendar software.
- Creation of an informed choice/consent document concerning rights restrictions.
- Creation of a guide to better understand Supported Decision-Making.
- Gathering data from waiver service users on their PCSP experience.
- Discussions on self-directed employment services, creating a more fluid service structure for employment, and funding structures that incentivize CIE.

**TACTIC 4: Performance Measurement.** DSPD will establish accurate ways to measure, collect, and share employment data for individuals in DSPD services and on the waiting list and will identify and remove processes that are redundant in employment data collection. This will include identifying (a) measures and indicators that assess the progress toward priorities and (b) best use of the Employment Pathway Tool data, gathering employment success stories each quarter, and updating and aligning the data reporting processes.

Using this Employment First Strategic Plan, Utah aims to dramatically alter its approach to employment to make sure that people with disabilities have access to employment services that meet their needs and that it can improve employment outcomes across the system. This plan has already led to many concrete changes that are enabling people to make new choices regarding their employment, such as through the Employment Pathway Tool. The Employment First Strategic Plan will help DHHS move from the issues outlined in the DOJ findings toward greater community inclusion and greater numbers of employed community members. DHHS recently contracted with Alvarez & Marsal with a major focus on strengthening employment processes; this work is ongoing and involves collaboration with an advisory committee.

### ***Technology First***

As assistive and smart technologies have improved, people with disabilities have benefited greatly. Technology has opened options to get needed supports and to connect with others. Technology can be leveraged to enable older adults and people with disabilities to live more independently. For example, medication dispensers make it easier for older adults to take medication; tablets and phones enable people to communicate and connect with others and to set reminders and schedules for important tasks.

Technology First is a transformative framework that was developed through research led by the Kansas University Life Span Institute. Technology First emphasizes the prioritization of technology in person-centered planning. Rather than being an afterthought, technology is considered a primary support option to enhance autonomy, social inclusion, self-determination, and overall quality of life for individuals and families.

The framework supports three core goals: 1) promoting independence and community engagement, 2) addressing workforce shortages in direct care, and 3) driving cost-effective, efficient practices. As of 2020, 22 states had adopted Technology First initiatives or legislation.<sup>69</sup> The Technology First model for systemic change<sup>70</sup> includes key elements such as statewide policy development, resource allocation, collaborative partnerships, and data-driven decision-making. These components work together to ensure sustainable implementation, fidelity to core values, and measurable outcomes for individuals and practitioners alike.

Specifically, technological supports like smart home technologies and remote supports offer ways to augment direct support staffing while continuing to meet the needs of participants. Since these supports are adaptable and can be customized, they may also benefit people with complex needs. Consistent with the philosophy of person-centered practice, the use of technologies can contribute

to increased independence, self-direction, privacy, and personal sense of security and safety for people with complex needs. Increasingly, people with disabilities are indicating the benefits of these types of support.<sup>71</sup>

Utah offers remote supports on the LSW. For some, these supports can offer greater independence and privacy while reducing in-home staffing needs. The service allows a provider to support someone in their home through technology that enables live two-way communication. Assistance may be provided by either an individual staff member or a computer system. The service is integrated into the person's overall support plan. This service is fairly new and has not seen any take up to date given the substantial start up for providers and the very small population (being served on the LSW) that can access it; however, it offers potential to meet people's needs in a way that maximizes their autonomy and independence. See [Appendix B](#) for examples of remote supports.

## **Recommendations for Prioritizing Community First**

Below we outline the recommendations for prioritizing Community First, including systematically planning for community, transitioning to community, and offering community services.

### **Planning for Community**

DHHS has an opportunity to improve the responsiveness of the LTSS system by intentionally prioritizing community alternatives and using person-centered planning to facilitate the ability of participants to select community services.

### ***Take Steps Toward the Development of a Community First Plan***

DHHS has made considerable progress over the past years to shift its system toward Community First. Some of these recent initiatives include:

- Implementing the LSW to reduce the wait time for services and to target support to people living in the community.
- Implementing the NCW to support people to move from nursing facilities into HCBS.
- Creating and monitoring goals to reduce the number of people residing in ICF-IIDs, providing education about HCBS to people entering or residing in ICF-IIDs to help them choose the most integrated services, and diverting youth from ICF-IIDs with specialized funding.
- Supporting people in ICF-IIDs to meet with peer mentors who can help them understand what HCBS are and the experience of transition.
- Focusing on the Wealth, Independence, Security, Engagement (WISE) initiative to help people age well so they do not need to rely on nursing homes.
- Continuing to advocate for funding for community services and investing considerably in its community system.

As a result of these efforts, over the past ten years, the number of people living in the state-run ICF has decreased by approximately 25% and DHHS has successfully supported more than 500 people to move from private ICFs into the community, purchased licenses from the ICF-IID system to reduce

the overall number of people who can be served, and has seen a reduction in the total number of ICF-IIDs in the state.

Given the feedback from community members and the research HSRI undertook to look at the programs of other states, our overarching recommendation is to prioritize Community First in the Utah LTSS system. We recommend that DHHS bolster the promising practices in place today to continue to support inclusion in the community. DHHS can do this by developing a Community First plan. This can be done through several methods and can serve as a blueprint for continuing the shift to community supports. Many states have used Olmstead Plans as their blueprint for prioritizing community systems, to report progress on goals, and to modify them as necessary. About half of the states have an Olmstead plan in place. Olmstead plans can reduce legal risk and are sometimes implemented in response to a lawsuit. The Olmstead plan can demonstrate that the state is meeting the [integration mandate](#) of the ADA.

Utah should consider following the lead of states that have considerable experience developing these plans with the support of the advocacy community. One such state is Minnesota. Minnesota was required to have an Olmstead plan following the Jensen settlement.<sup>72</sup> [Minnesota's Olmstead Plan](#) was advanced starting with the development of a subcabinet responsible for the plan and overseeing progress. After years of implementation of the Olmstead plan, the subcabinet was expanded significantly to include critical partners who could help carry the torch forward and address key issues that were not integrated into the original plan that impact the lives of people who need LTSS. The partners included:

- Department of Corrections
- Department of Education
- Department of Employment and Economic Development
- Department of Health
- Department of Human Rights
- Department of Public Safety
- Department of Human Services
- Department of Transportation
- Department of Veterans Affairs
- Metropolitan Council
- Minnesota Housing Finance Agency
- Office of the Ombudsman for Mental Health and Developmental Disabilities
- Governor's Council on Developmental Disabilities

In 2015, the Olmstead plan was developed to include goals and strategies to support the state as it worked to meet the requirements outlined in the settlement. After the plan was initially completed, the Minnesota Department of Human Services (DHS) committed to updating the plan annually and demonstrated progress in numerous areas. The plan has been modified several times in recent years.

Recently Minnesota DHS decided that a more comprehensive update was needed to really move the needle on the goals they had developed. To complete this update, Minnesota DHS is working with inclusion consultants. There are 18 people with lived experience who are paid to work with Minnesota DHS to help update the plan. Minnesota DHS contracted with a policy consultant to learn about best practices that can inform the plan. Their work is supported by Community Conversations where people throughout the state can contribute, in-person or virtually, sharing their priorities and providing input into the plan. Minnesota DHS administered an inclusion and choice survey throughout the state to provide additional opportunities for Minnesotans to contribute to the plan development. Minnesota DHS also administered a quality-of-life survey to gather specific information from people who live in segregated settings.

Developing a plan for Community First is a significant and important undertaking, and DHHS has taken many crucial steps to prioritize community. These plans can take up to 18 months or more to develop; there is no standard template or process, not even when states develop an Olmstead plan. Each state takes a different approach.

Below are some steps that DHHS may consider to develop its plan for Community First:

- **STEP 1: Demonstrate a strong commitment to integration and inclusion.** Harness existing vision and mission statements, along with strategic plans, to build a vision and principles for community services. For example, DHHS’s vision is that “all Utahns have fair and equitable opportunities to live safe and healthy lives.” And according to its mission, DHHS “will support and serve all individuals and communities throughout Utah. It will do so through effective policy and the operations of an effective and efficient seamless system of services and programs that is centered around the individuals and communities the department serves.” At the highest level, this vision speaks to the principles behind community inclusion. Presumably there are outcomes tied to this vision and mission that can support DHHS’s plan.
- **STEP 2: Develop foundational structures.** Planning for the community requires significant collaboration, meaningful goal-setting, and a strong foundation of shared purpose to meet the community’s primary needs. As a start, DHHS can identify key partnerships needed to support the plan or nominate people receiving services to take a lead on certain aspects of the plan. Another starting point could involve hiring core advisors with lived experience who will inform the plan. At these early stages, DHHS may also want to develop specific processes to bring information to the community, gather feedback, and integrate it into or revise specific aspects of the plan.
- **STEP 3: Build on and employ significant community engagement.** DHHS has involved several advisory groups as part of its recent efforts. DHHS can work with existing workgroups and other interested parties to formulate and enact a system-wide engagement plan to gather feedback from people waiting for and receiving services—as well as from families, advocates, providers, and the larger community—about how to better support inclusion. For example, DSPD has recently collaborated with a workgroup charged with developing a plan related to the settlement agreement for the *Christensen, Weakly, & DLC v. Miner et al* court

case. Since this workgroup has already invested considerable time and energy to come up with solutions to support people better in the community, they could be a resource to charting a path to engage further with the community.

- **STEP 4: Develop an understanding of systemic gaps.** DHHS has also recently commissioned several studies to understand gaps in the service system, rates, and other critical gaps. DHHS can use these existing sources to develop a baseline understanding of available community supports and to identify gaps. This report offers some examples of potential systemic gaps, but only those in LTSS. A complete plan could explore supports and gaps in other areas such as the educational system or the correctional system. Identifying this baseline and gaps will help DHHS to understand where improvements are needed, to determine which data can help to track progress, and to put strategies in place to make strategic improvements.
- **STEP 5: Develop goals.** With foundational structures in place, a robust engagement plan, and an understanding of systemic gaps, DHHS can explore means to bolster supports in the community. These might include the development of new services, stronger collaborations with other agencies, or changes in policy. DHHS can also develop new strategies to resolve barriers to inclusion. Goals should be selected to move the needle and show DHHS's commitment to supporting people in the community.
- **STEP 6: Develop or identify data sources to measure progress.** Once DHHS has identified goals and strategies, DHHS can use existing data sources to measure progress or identify new data sources that are needed. These data sources can include qualitative measures and qualitative data collection. Measures should relate to the recommended [Comprehensive Quality Improvement Strategy](#).
- **STEP 7: Draft the plan and share it.** After completing all of these steps, a draft plan can be formulated. This plan can be shared for public feedback and modified to incorporate that feedback. A plain language version should be shared, and public meetings and other communications can help introduce the plan, its intentions, and the strategies that will be implemented to help the plan come to life.
- **STEP 8: Monitor and update the plan.** DHHS should develop specific timelines for monitoring the plan. Just as plan development involves inclusive and engaged practices, monitoring the plan should also involve such practices. As progress is made, updates to the plan might be needed to support continued growth. Eventually the plan may need to be redrafted.

Developing a formal plan can create an opportunity to engage differently with the community, to move forward in a direction that will set the course for years to come, and to embrace valued Community First practices.

### **Create a Unified Person-Centered Planning Process**

As mentioned, person-centered planning (PCP) is a primary approach for supporting people to achieve their self-determined goals and aspirations, though different programs use different tools and processes to implement it. Several DHHS divisions have recently made changes to their

planning processes, as described below. Yet, people in services do not have the same PCP experiences across Medicaid waivers.

HCBS waivers offered through DSPD use a person-centered support planning (PCSP) process through USTEPS, an online software for support coordinators, service users, families, and service providers. As a step toward complying with the Final Settings Rule and increasing informed choice, community integration, and holistic planning, DSPD revised and updated their PCSP processes. These updates have included promoting and increasing support coordinators' use of CtLC and other planning tools, collaborating to develop a [handbook](#) for service users on preparing for their person-centered planning meeting, creating an [Employment Pathway Tool](#) to help individuals consider and plan for employment, modifying the online planning software to include the life domains from [CtLC](#) throughout the PCSP, and adding a pre-planning component. DSPD provides support coordinators with a series of required training videos on PCSP that include content on what a PCSP is, how to use USTEPS, the importance of human rights, the Final Settings Rule, how to use PCSP tools, and other topics.

In contrast, waivers under DIH and DAAS did not adopt these same tools or PCSP practices. [Person-Centered Care Plans](#) (PCCPs) are the person-centered planning tools implemented with individuals in these waivers. Although the tools include important person-centered questions and planning prompts, simplifying the tools and processes could strengthen planning, ensure access to helpful tools, and support planning teams to brainstorm the best ways to provide support.

To expand these opportunities for *all* service users and embed a quality PCP process across all waivers, DHHS may consider the following recommendations: (a) incorporating a unified PCP process across all waiver programs; (b) creating a more robust Support Coordinator training; and (c) facilitating greater informed choice for service users across community services.

To promote a holistic approach to PCSP for all service users, HSRI recommends that DHHS create a more unified PCSP across waivers that incorporates features from DSPD's PCSP systems. For example, [CtLC's life domains](#) could be embedded into planning and reporting systems to ensure all potential wants and needs for a person are being considered across waivers. In addition, planning teams could use planning tools that promote informed choice—such as the Employment Pathway Tool and tools from CtLC. DHHS could also consider developing tools for service users and adopting pre-planning processes to ensure service users are driving their own plans and leading their meetings.

To embed CtLC's life domains across PCPs, DHHS may consider revising care plans to include sections with each life domain (i.e., advocacy and engagement, community living, daily life and employment, healthy living, safety and security, and social and spiritual) with corresponding prompts to ensure meaningful conversations are captured during planning. Such conversations would include goal setting, strengths and interests in each domain, along with outlining the person's service needs. Currently, DSPD requires all domains to be considered during the PCP process; in contrast, other divisions may require only some domains to be completed and leave the remaining domains for people in services to decide whether to complete them. If DHHS chooses to streamline its PCP and

broaden the questions and prompts, it could also define which planning prompts are required so as to ensure that a minimum set of items are captured by the planning team. Divisions can refer to DSPD's PCSP software and plans as an example for embedding the life domains. Additionally, DHHS may consider promoting tools such as the Employment Pathway Tool, tools from CtLC such as the Life Trajectory Tool, or the Integrated Supports Star used by DSPD across all waivers. These tools are meant to increase informed choice, support the individual with planning and goal setting, allow the person and team to see where the individual is thriving versus needing additional support, and support the person with leading their own PCP meetings. A list of tools and links can be found under DSPD's webpage on [Person-Centered Thinking](#).

Finally, HSRI recommends DHHS consider developing or adapting tools as part of the pre-planning process for individuals in services to better understand their PCP; HSRI also recommends embedding a pre-planning process. One tool that may be considered is DSPD's PCSP workbook for people in services, "Living the Life You Choose," which helps people learn why their choices matter, what their rights are, what PCP is, what PCP tools exist, what to expect and how to prepare for a PCSP meeting, and other topics related to the PCP process and implementation. This workbook may be adapted if needed for specific waivers or used as is. Additionally, DHHS may consider creating a pre-planning process, similar to that in DSPD's PCP process, for PCSP meetings across all waivers to ensure individuals in services are informed and prepared to lead their meeting. Pre-meeting processes may include support coordinators asking when and where the person would like to have their meeting as well as who should be invited (or not invited), providing an overview of tools that may be used during the meeting, and identifying any accommodations or supports that will be needed in the meeting.

By creating a unified PCP process across all waivers, DHHS can ensure holistic planning for individuals receiving services, no matter the waiver they are accessing. An added benefit is that DHHS would only need to maintain one training course and one application for its planning process. And the resulting data could be used across divisions to compare how people access and use the planning process.

### ***Implement Robust Training and Evaluation***

To bolster the streamlined PCP, HSRI recommends the state implement robust Support Coordinator training and evaluation for PCPs. Increasing training and development opportunities may include live trainings and the development of community of practices for novice and experienced support coordinators, and frequently updated self-paced learning modules. Additionally, since CtLC foundations and tools are embedded in DSPD's PCP process and recommendations include extending this across waivers, a selection of, or all support coordinators may be given the opportunity to participate in [CtLC's Ambassador Series](#)—a live, online training where trainees are provided the foundations of CtLC, learn how to implement tools with various people and in various scenarios, and support others to use CtLC tools. This training could also be made available to providers, families, and people receiving services to better support them to participate in the planning process.

DHHS may also consider implementing enhanced PCP evaluations across all waivers such as those exemplified in [Indiana's PCP rubric](#) and [Tennessee's PCP review tool](#). Like DSPD, Indiana embedded CtLC's life domains into their PCP process. To review the quality of PCPs, Indiana developed a rubric for evaluating the degree of person-centeredness (e.g., exemplary—three points, proficient—two points, marginal—one point, and unacceptable—zero points) across three PCP pillars: “Strength Based,” “Person Centered,” and “Integrated Supports.” In each section, the reviewer can offer examples that support the explanation of the score, supporting comments, examples of sections from the PCP, and suggested resources. Tennessee's PCP review tool addresses 70 questions regarding the quality, content, and tone of the PCP. Questions are split into sections such as “Overall,” “Intro/Home,” “Day,” “Relationships,” and “Mealtime.” Reviewers may indicate whether certain criteria are met and provide notes on strengths or opportunities for improvements of the PCP.

In line with the recommendations above, DHHS may consider creating similar reviews aligned with the life domains to better fit Utah's PCP systems and processes and sampling a selection of PCPs to determine further training needs.

### ***Support an Increase in Informed Choice***

Finally, HSRI recommends that DHHS engage in further efforts to bolster its PCP by providing tools and guidance to increase informed choice. Within the disability services field, informed choice is defined as supporting people “to choose from all available options based on *accurate information, knowledge, and experience*.”<sup>73</sup> Informed choice values the following principles:

- Everyone is capable of making choices.
- Support is essential, and some people need help to make choices.
- Choices must be based on what is possible and include information to help the person understand.
- Each person's preferences and values must be respected.
- Informed choice requires skill that improves overtime.

DSPD has a definition of informed choice:

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*Informed Choice – means that the Person has options to choose from, information about those options, and experience with the options. The Person's decision making will be supported to the extent that is necessary to account for their style of communication, strengths, and limitations. Such assistance is provided either by a DSPD Constituent Services Representative, a family member or a Guardian, or by a Support Coordinator or another member of the Person's Support Team. Wherever assistance is provided, the Person's decision making should not be unduly influenced by any other party's interests, including the party who is assisting the Person's Informed Choice.*<sup>74</sup>

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As noted, as part of its PCSP, DSPD addresses each life domain to ensure that services and supports are considered. Incorporating life domains into the PCP and asking the team to address each area should promote the exploration of supports into different areas that may not have been previously considered, offering an opportunity for the planning team to discuss support strategies to overcome barriers that stand in the way of the person’s goals and ambitions. Walking through each domain with the person and their planning team can help to open up possibilities and make new choices that may not have been previously explored.

For example, to address the need for informed choice around employment, DSPD created the [Employment Pathway Tool](#). This tool asks the person receiving services and their team to consider a multitude of employment opportunities and ensure a person is making an informed choice about whether or not they want to work. It highlights “options, information, and experience” as necessary areas an individual needs to consider making an informed decision and asks the team to document proof that each of these areas were addressed. Creating such a tool is not, in and of itself, sufficient to ensure that informed choice occurs; however, the idea of incorporating “options, information, and experience” into each domain and updating these as relevant will help the person and their team to explore options.

To advance informed choice, Minnesota DHS developed an informed choice policy that spans across disability service areas, including employment, community living, self-direction, and technology.<sup>75</sup> To provide the practical tools needed to make informed choice a reality, DHS also created a [Guide to Encouraging Informed Choice and Discussing Risk](#). The Disability Hub [MN’s Informed Choice Toolkit](#) includes training resources and additional tools for case managers that allow them to support informed choice, such as a [Housing Toolkit](#) and [Choice and Control](#) guides for disability professionals.

## **Transition and Diversion from Institutional and Segregated Placements**

As emphasized earlier in this report, Utah has been on a path toward reducing reliance on institutional settings through a range of initiatives at every level—from education to monetary investments in a new model. DHHS invested in the CTW and the NCW to support people as they transition to less institutional settings. People receiving services at USDC were offered opportunities to transition into community settings and, as noted, CTW has supported over 500 people to transition from institutional settings into the community. Along with this program DHHS has provided education to people living at USDC and ICF-IIDs about living in the community, offers tours for people to see what community living might be like, and connects people with peer supporters who have transitioned into the community who can help answer questions about what the transition is like.

Although DHHS has made considerable progress, it need not slow down its ambitious efforts. DHHS should continue to take active steps to help people transition from these settings into the community when it is the best option to meet their needs. It can still be particularly challenging to find community placements for people who are served at USDC, and this limits their ability and options for transitioning into HCBS.

## ***Transition from USDC***

Relatively few people remain served at USDC. As of September 2024, there are 183 people receiving services at USDC. There are three units at USDC, each targeted toward serving people with different needs. Unit 1 serves people with medical needs, many of whom have lived at USDC for a significant time. The average stay for people living in Unit 1 is 42.9 years. Institutional staff have reported that the people in this unit have been offered opportunities to move into the community, but that they identify USDC as their home and are aiming to age in place. HSRI was not able to meet with anyone served in Unit 1 when we interviewed people living at USDC. Unit 2 primarily serves people with complex behavioral needs. Staff report that approximately 43 people with complex behavioral needs reside in Unit 2 and they have been there on average for 8.1 years. Finally, Unit 3 serves people with moderate support needs. According to staff, there are approximately 59 people residing in Unit 3 and they have lived there on average for 28 years. Of all the people served at USDC, approximately 31 people served entered through civil commitment.

### **Affirm USDC's Direction as a Transitional Center**

DHHS staff at USDC have stated that a goal is to focus on transitioning people into the community. This commitment could be expressed in several ways: the facility's name could be changed to incorporate a term that denotes temporary or transitional services; the mission statement and strategic plans could be revised; and public-facing descriptions of USDC could be updated (e.g., on DSPD's website). Additionally, USDC could work to shift its model of support. For example, [North Dakota Life Skills and Transition Center](#) (LSTC) changed its name to reflect its ongoing commitment to restoring people to their communities—and its shift may offer a useful model for other states.

To affirm its commitment to community services, LSTC is accredited through the [Council on Quality and Leadership](#), demonstrating a high quality of services. Moreover, the goal of any admission at LSTC is “to help the person move on to find their 'forever community' as soon as they are ready.” That is, LSTC strives to connect people to lasting supports in their homes and communities. LSTC changed its model from offering permanent placements to expanding the number of crisis beds that are available for short-term use and offering these beds for crisis needs through a streamlined single entry referral process. In this way, LSTC has structured its services to be short term in nature and to help people transition back into the community as soon as they are able.

USDC should have a streamlined referral process that outlines how to explore community services and which needs are best supported short term at USDC. Offering short-term crisis services is consistent with the [USDC Strategic Master Plan](#).

### **Work to Transition All Interested Parties**

USDC should also consider a few strategic goals to harness its aims to support people to transition back into the community when ready. DHHS should continue to educate people served at USDC about their options for transitioning into HCBS—including the support that DHHS provides today, such as a peer supporter and an opportunity to visit a community setting. When someone chooses to transition, DHHS should support each person to transition individually and allow them a time to “try



out” the new setting with the opportunity to move back within a specified window if the person experiences significant challenges during the transitional period.

One goal that might be of interest is targeting specific groups for transition back into the community. DHHS should strive to support people living in Unit 3 to transition back into community settings, while targeted information can be provided to other people living at USDC who claim they want to age in place. Further, DHHS should take steps to reduce the length of stay for people expected to receive short-term supports at USDC. While some people served in Unit 2 are required to receive support due to a civil commitment, USDC should seek to transition people who are not civilly committed as soon as possible. DHHS should also work to reduce the overall average stay for people who are receiving any other type of short-term crisis placement, so that people with crisis needs stay for the shortest time necessary to meet their needs. Finally, DHHS should develop a goal to reduce admissions so that people looking for services continue to be provided education and information about HCBS and can select HCBS that meet their needs rather than choosing to receive services at USDC. DHHS should actively deter entrance for all units to the extent feasible.

### **Transition/Train Staff**

To ensure all staff can help people transition out of USDC, USDC should make sure that staff receive training both on facilitating community transitions and on teaching the strategies and supports that help meet individuals’ needs as they transition to the community. To better support people to remain in the community, USDC and DHHS should ensure there are sufficient transition supports so that USDC staff can help community support teams to learn about and enact strategies that keep the person well supported in the community. Offering this training across USDC and in the community living setting can help provide continuity of care, promote creative approaches to the delivery of community services, and help ensure any necessary modifications to the person’s plan.

### **Individual Transition Plans with Families and Community Providers**

To ensure USDC provides person-centered support, services should be tailored to each person’s needs and delivered according to an individual plan that helps the person achieve their goals. These individualized plans, focused on supporting transition back to the community, should be initiated on day one and revisited routinely to assess how well different supports are helping the person achieve their goals and to identify issues that need redress. This plan should be developed in collaboration with all relevant parties, including the person’s existing community support networks. The person should have the same opportunity to direct their plan as people living in community settings. Family and community supporters, USDC staff, and HCBS staff should all participate in the planning process, to solidify the plan for community transition, identify needs in both settings, and adjust the plan as needed.

LSTC has much shorter stays than reported at USDC, though LSTC notes that discharges may be delayed as staff work to find the right fit for each person, helping each person to transition to their preferred community. LSTC also restricts admission to only those with crisis-level needs, and to only people who chose to reside at LSTC voluntarily. LSTC uses the Residential Decision Profile to generate discussion about moving from LSTC to the community, to figure out from the outset where

the person wants to transition to, and to begin developing partnerships and preparing for that transition. Each year, each person at LSTC, and their legal decision-maker if applicable, reviews their decision to remain at LSTC. This is followed by a judicial review to ensure that each person's rights are respected. LSTC uses this robust process to ensure that people have short-term stays, that transitions to the community are well supported, and that there is sufficient oversight of restrictive placements so that people are moved to less-restrictive settings as soon as they are able.

While we recognize that DHHS must continue to fund USDC at a sustainable level to secure the safety of all individuals served and to provide the highest quality of services, we caution against large-scale future investments that do not embrace a Community First vision. As one key informant from another state shared, such investments may limit DHHS's ability to invest in HCBS instead. HSRI recommends that any changes to USDC are part of a larger plan that reflects a holistic move toward more purposeful community-oriented services and supports.

### ***Transition from ICF-IIDs***

ICF-IIDs are residential settings that provide health and rehabilitative services to individuals with disabilities. All 50 states have at least one ICF-IID, and nationally, more than 100,000 individuals receive support through an ICF-IID.<sup>76</sup> With the amendment of the SSA in 1983, HCBS promoted individuals with disabilities living in their own homes, controlling their own lives, and meaningfully participating in their community through disability waivers. Because of this shift, congregate settings, like ICF-IIDs, are not the first or only option for individuals with disabilities. The state of Utah has embraced this shift with the implementation of their ICF-IID Transition Program and Home and Community-Based Transition grant. Utah currently provides significant support for people who are transitioning from ICF-IIDs by offering people a visit to an HCBS setting of interest, providing rental assistance, and assisting with start-up costs (such as necessary housing items). The state also makes available a comprehensive transition team that provides specific support, such as nursing when needed, and follows the person as they transition into the community. Along with continuing these supports, we suggest DHHS continues to prioritize the education and transition of interested individuals residing in an ICF-IIDs to HCBS settings. Recommendations and associated activities are provided below.

### **Enact Transition Strategies**

As part of the Home and Community-Based Services Transition grant that aligns with the American Rescue Plan Act of 2021 (ARPA) Section 9817, Utah State University (USU) conducted listening sessions with ICF-IIDs that transitioned to HCBS. USU identified specific strategies to support the transition from ICF-IID to HCBS. These strategies included (a) targeted Final Settings Rule training, (b) training for direct support professionals on their roles and responsibilities, (c) discouragement training and guidelines to prevent discouraging people from choosing community-based supports, (d) training on staff roles in HCBS, (e) guardianship and choice training, and (f) one-hour targeted technical assistance for staff who transitioned from an ICF to HCBS. HSRI would suggest similar funding for continued contracts to support ICFs' transition to HCBS.

USU provided technical assistance to ICF-IIDs transitioning to HCBS through five key tasks. We suggest that future activities follow a similar technical assistance plan to facilitate transition to HCBS including the following tasks:

- Upon request from DHHS or an ICF-IID that is transitioning, conduct an initial needs assessment.
- Based on the needs assessment, develop a technical assistance (TA) plan that outlines the scope and timeline for training and TA, including training for families, individuals with disabilities, ICF-IID staff, and relevant support coordinators on compliance with HCBS as well as strategies to promote meaningful community-based activities and CIE.
- Coordinate an HCBS support team that will advise and support the ICF-IID transition to HCBS.
- Respond to requests for training related to increasing community-based access and compliance with HCBS, as needed.
- Connect ICF-IIDs with others who have made the transition to HCBS to help ease navigation and share learnings.
- Provide TA that focuses on problem solving and tangible solutions to resolve issues that threaten HCBS placement during transition.

### **Grant and Contracting Strategies to Facilitate Transition**

HSRI suggests the state continue and expand its current transition grant program to help providers and individuals transition from ICF-IIDs to HCBS. Currently DHHS offers the ICF Transition Program, which they define as “... a way for Individuals with disabilities living in an Intermediate Care Facility for People with Intellectual Disabilities to move to another place, like a group home or other community setting.” They stipulate that the person can choose where to live and will continue to receive support similar to what they receive in the ICF-IID. This transition program also states that people can make a choice to transition now or in the future. Currently, the ICF Transition Program requires the state to provide education on HCBS to individuals who live in ICF-IIDs through the [Education and In-Reach \(EI\) team](#).

If Utah is interested in modifying its transition program, it may consider a similar program to the [STEP program](#) in Connecticut. The Connecticut STEP program assisted and monetarily incentivized engaged providers to support individuals residing in ICF-IID settings who wanted to transition to HCBS. This included providing financial incentives for developing a plan and for successfully transitioning someone into HCBS. To support ICF-IIDs with bed vacancies, Connecticut paid for the individual’s bed at the ICF for 60 days to ensure the bed remained open in case the person needed or wanted to go back to the ICF-IID; simultaneously, this supported the ICF-IID by offsetting the potential loss of income. Connecticut also provided a temporary increase in the HCBS rates and an outcome payment if the transition was successful. The STEP program looked to support specific individuals who wanted to transition to more integrated settings instead of supporting entire provider agencies to transition their services. As providers previously had the opportunity to close beds, offering incentives at the individual level may enable continued transitions of people who remain in ICF-IIDs to community settings.

Other contracting strategies may prove useful to pursue—including building into contracts individual acuity tiers for each person served. In this way DHHS would be paying more for people with higher support needs, ensuring that only those with significant support needs, who may benefit from the services provided in ICF-IIDs and not available in the community, are accessing this support. DHHS could also look at using contracting strategies that incentivize smaller settings. Building these incentives into the contract can help ICF-IID providers move toward offering services in ways that are similar to HCBS while maintaining skilled staff and rigorous standards preferred by families.

Finally, DHHS can look at contracting strategies that tie funds to future goals. DHHS can use a combination of strategies to support ICF-IIDs to move toward more community-oriented service offerings. For example, DHHS could allow for bed buybacks for ICF-IIDs that are looking to transition fully to HCBS service provision. For providers who wish to continue providing ICF-IID services, DHHS could target funds to individuals who want to transition to HCBS, to help each person make a plan that works for them. They could support the ICF-IID to maintain beds while people transition into the community for a set period of time and could incentivize quality through the contracts as well by paying for specific outcomes. Ultimately any efforts to promote quality in the ICF-IID setting should be tied to contracting strategies. For example, ICF-IIDs should be required to meet certain quality metrics important to people receiving services and their families and that match the values of community integration, which are tied to payments. This approach can help ensure that ICF-IIDs make meaningful progress toward supporting people to have good lives in the community.

### **Reduce Size, Create More Homelike Settings**

HSRI also suggests that Utah reduce the size of ICF-IIDs and create more homelike settings. This recommendation is consistent with the Advisory Strategy Workgroup Report,<sup>77</sup> a requirement from the *Christensen v. Miner* settlement. This strategy report emphasized a goal of ICF-IIDs that support no more than six residents. It noted that of the current seven ICF-IIDs, five are large (serving more than 16 people), and two are medium. Working toward the goal of smaller ICF-IIDs that continue to provide facility level of care while mimicking homes in the community may help meet aims of supporting people to be included in their communities and providing a continuity of care for current residents. This can be supported through individual transition plans, such as those noted earlier, and ICF-IID transition plans (described in the next section). Such changes would require a thorough review of the contracting structures that are in place today and modifications to support reducing the number of people in each setting and the increased staffing costs. (See [Contracting Strategies to Facilitate Transition](#).)

To support ICF-IID settings to take on a more homelike feel, DHHS can use its [self-assessment tool](#) for HCBS providers, used as part of Utah's [HCBS Transition Plan](#), or a potentially modified version that could be used by ICF-IIDs to determine if they are providing supports that promote a more homelike atmosphere for individuals living in an ICF-IID. For example, questions can include items related to the Final Settings Rule that assess whether people receiving services in ICF-IIDs have access to the same rights that people living in community settings do, such as having the freedom to participate in the activities of their choosing at the time of their choosing or having free access to

food and drink of their choosing at the time of their choosing. Questions should also align with Residents Rights.<sup>78</sup>

Of note is that addressing the waiting list (see [Recommendations for Addressing the DSPD Waitlist](#) for more information) may be a way for the state to reduce the size of ICF-IIDs. In November 2024, HSRI conducted interviews with people living in ICF-IIDs, and a major theme we noted was that people sometimes enter ICF-IIDs due to no longer having support at home or due to an emergency situation. If individuals have some formal support in addition to their family or other natural supports, they may be less likely to need to enter a congregate setting when these situations arise. Waiver services can significantly supplement natural supports. Addressing the continuous growth of the waiver waiting list in Utah may help people choose between ICF-IID or HCBS settings, rather than having to choose an ICF-IID setting because no other supports are available—therefore potentially reducing the need for ICF-IIDs. Additionally, the state may consider restructuring their waivers to include the services that people require, along with services that promote Community First. For example, many individuals choose to live in an ICF-IID because they can receive residential and nursing support. In [Recommendations for Restructuring HCBS Waivers](#) we describe recommendations to alter the waivers to better meet people’s diverse needs.

### **Ensure Strong Family Collaboration**

Finally, Utah should ensure strong family collaboration as it considers transition support. The state can collaborate with the [Utah Parent Center](#) (UPC) to make sure that families are included in the development of transition plans for ICF-IIDs and can include their input throughout the transition process. UPC plays a collaborative role in Utah, and “UPC staff have built collaborative networks with education, health and human service professionals, agencies and organizations. The Center promotes change within community through various projects and activities.” UPC also includes opportunities for advocacy and networking on their website. This is an opportunity for the state to collaborate with them through a committee, workgroup, or community conversation that can also be highlighted on their website.

DHHS should continue to fund positions for Education and In-Reach staff to support and educate families. Education and In-Reach staff should continue activities outlined in the Utah Administrative Code, Rule 414-510. Activities include education, materials, and referrals to individuals living in ICF-IIDs and their families. The team may also consider holding focus groups to guide their support and training. Focus groups should include individuals who live in ICF-IIDs, have transitioned out of ICF-IIDs, and their families.

In the 2019 Utah outlined an action item to “Establish Transition Plan Workgroup.” The workgroup was composed of HCBS participants who met to review draft documents of the transition plan and implementation process. The group also worked to disseminate information to a broader audience of community members to assist constituencies to participate in public comments. The state could use this same model for their ICF-IID transition plan.

DHHS should actively collaborate with families experiencing a transition. Connecting them with families whose loved ones have successfully moved out of institutions can provide valuable lived-experience insights into the process—and offer hope and the reality that such a transition can be successful.

The Unfinished Business Toolkit<sup>79</sup> recommends actively listening to families' concerns (often rooted in fears about safety, quality of care, and continuity) and addressing them through transparent communication and individualized planning. By involving families in person-centered transition teams and offering real-life examples of successful community living, states can build trust and demonstrate that people with IDD can thrive outside institutional settings. The toolkit also encourages states to support families beyond the transition phase by engaging them in advocacy, legislative outreach, and quality assurance efforts to help ensure that community-based systems are not only inclusive but also responsive to individual needs.

DHHS should consider implementing one or more of the options outlined in this section to transition individuals living in ICF-IIDs into more integrated settings. HSRI suggests the state implements these activities through ICF-IID provider self-assessment tools, develop transition plans with transition teams to individuals who want to transfer out of ICF-IIDs, hold focus groups targeted for each specific activity, collaborate with families and individuals who know the ICF-IID and HCBS systems, and build workgroups targeted to each activity.

### ***Diversion from Nursing Facilities***

Within the LTSS continuum, nursing facilities are a common institutional setting, especially for older adults with complex medical and functional needs. Nursing facilities are subject to numerous state and federal regulations that address resident rights, staffing, safety, abuse prevention, quality and quality improvement, and other care requirements.<sup>80</sup> Medicaid is the leading payment source for nursing facility care, with over 60% of residents nationwide having Medicaid as their primary payer in 2024.<sup>81</sup> Nursing facility care is expensive; the American Council on Aging estimated the average annual cost of a shared room in Utah as just over \$100,000 in 2024.<sup>82</sup>

Nationally, nursing facility occupancy rates have been decreasing for the last several decades,<sup>83</sup> and research shows that people prefer to age in place rather than enter an institution.<sup>84, 85, 86</sup> In addition to meeting personal preferences, aging in place can be more cost effective compared to institutional settings,<sup>87</sup> and it can increase quality of life by allowing older adults to maintain more independence and autonomy and to keep their social ties and community connections.<sup>88</sup>

Recent research provides some insight into factors that increase risk for nursing facility admission; it also provides insight into interventions and services that have shown a positive impact on delaying admissions. The recommendations below focus on some promising practices and proven strategies to delay or deter nursing facility admission to align with the preference for aging in place and support efficient allocation of state LTSS funding. They are intended to build on the foundation of current state programs as well as provide guidance on priorities for new state investment.

Utah has a [Master Plan for Aging](#) that focuses on wide-ranging goals to improve the broader community so that people can derive the benefits of community supports as they age. This plan includes goals and strategies to make sure that older adults can live connected, supported lives in affordable, age-friendly communities. Utah has a system that offers a range of supports to older adults. In addition to the two waivers that support older adults, Utah has an [Alternatives Program](#), operated by the state's 12 AAAs, that is designed to meet the needs of low-income older adults who do not qualify for Medicaid but who could benefit from in-home services that help them remain in their own homes and maintain their independence. Following an assessment of an individual's needs, the program offers services such as homemaking and personal care; respite and other short-term services are also available to provide a temporary break for informal caregivers of people being cared for at home. The [Utah Caregiver Support Program](#) offers services that support family caregivers with the goal of helping them to continue caregiving as long as possible and delay facility placement for their loved one. Program offerings include information about available community resources and assistance accessing them, individual counseling and support groups, temporary respite, and supplemental services such as assistive technologies and supplies. Additional AAA supports that can help people age in place are transportation services and food and nutrition—such as home-delivered meals and community lunches through Utah's senior centers. Finally, DHHS is engaged in the WISE Initiative, which focuses on improving important pillars of aging well—including wealth, independence, security, and engagement—and brings together many organizations and advocates to better plan for helping older adults to meet their needs. This initiative will result in an updated Master Plan for Aging. Together these supports offer a strong foundation for deterring nursing home placements. The recommendations below focus on meeting basic needs for affordable accessible housing, providing comprehensive caregiver education, and expanding existing programs to build on and bolster these existing supports.

### **Help People Remain in Accessible and Affordable Homes**

Older adults may experience difficulty accessing or paying for housing in the community, putting them at risk of institutional supports. We recommend some modifications to help people who are at risk of losing their homes, who require affordable housing, and who need modifications so that they can safely access their homes.

#### *Housing Stabilization*

DHHS can expand efforts to connect older adults with affordable housing, including partnerships with state, local, and community-based housing resources and navigation support. One study found that low- and moderate-income renters with a high housing cost burden had the greatest likelihood of moving to a nursing home.<sup>89</sup> DHHS can explore housing stabilization services and others with disabilities to maintain stable housing, especially those at risk of institutionalization or homelessness. This service could be added as a waiver benefit or could be offered more broadly, through the state plan, to provide the most extensive access and support to people before they need waiver services. Housing stabilization services help people to find and keep housing; this may involve consultative services for people who may not otherwise have a support coordinator or person available to help them plan for housing and to complete routine check-ins on the person. This consultative aspect

aims to place the person’s goals first when addressing housing needs. To help people to keep their housing, housing stabilization services provide education that helps people understand their tenant rights, supports the person to avoid eviction, and connects the person with legal supports in disputes. When necessary, these services can also help a person find housing or to relocate. These services can be especially important after someone has been hospitalized for an extended time period or for people who are transitioning from a nursing home or other institutional support back into the community. Some of these services may offer limited funds to help the person with home-related purchases.

### *Accessible Housing*

To help older adults remain and age in their homes, DHHS can consider expanding investment in home modifications, including for people not eligible for Medicaid HCBS or the Alternatives Program. Modifications such as adding grab bars, installing ramps, widening doorways, removing thresholds, and installing roll-in showers can make homes more accessible and aligned with changing functional needs. A recent systematic review found home modifications support aging in place, were cost-effective, and yielded benefits such as falls prevention, increases in functional independence and quality of life, and decreased caregiver burden.<sup>90</sup> Our conversation with a provider from another state who was involved in a recent home modification pilot highlighted the impact of personalized modifications to help homes “catch-up” to aging-related needs. This provider additionally credited the involvement of a registered nurse (RN) home modification specialist, who could review medical records and provide insight on individual clinical needs, as important to the initiative’s success; the provider also underscored the need to work with the local construction/handyman marketplace.

One option is to explore piloting the Community Aging in Place – Advancing Better Living for Elders (CAPABLE) program. The CAPABLE program is a five-month, evidence-based intervention that has shown favorable impact.<sup>91, 92, 93</sup> Participants work with a team—made up of an RN, an occupational therapist (OT), and a handyman—to set and achieve person-centered goals to support them in living safely and independently.<sup>94, 95, 96</sup> The CAPABLE National Center reports a return on investment of over 6 to 1.<sup>97</sup>

DHHS could explore piloting the CAPABLE model as one tool for helping delay the need for more intensive LTSS, including institutional care. Based on conversations with providers and the CAPABLE National Center, as well as review of published materials, the following are some considerations to inform exploration:

- **Funding:** There are both upfront and ongoing funding considerations. There is an initial \$21,000 CAPABLE two-year licensing fee that covers staff training and additional support; subsequent licensing renewal fees are tied to caseload. The per-person cost is approximately \$3,000-\$5,000 over the five-month period, with generally \$1,300 set aside for modest home repairs and modifications. Organizations have leveraged a variety of funding sources to implement CAPABLE, including grant funding, Medicaid, and evidence-based practice funding through AAAs, or may combine multiple funding mechanisms.

- **Fidelity:** Organizations participating in the licensed CAPABLE program are required to sign a contract indicating they will maintain fidelity to the model, including duration, staffing mix, and other elements.
- **Internal support:** Strong leadership support and/or an internal champion have been important factors for successful implementation.
- **Workforce:** The prescribed staffing mix (an RN, OT, and handyperson) means implementation requires sufficient clinical staff, an important consideration, especially in rural areas.
- **Implementation:** Sites have opted for different ways to implement the model; grant-funded demonstrations and other pilots are common. One state has folded CAPABLE into their HCBS waivers, which allows them to bill Medicaid.
- **Sustainability:** Funding has been a key constraint on sustaining CAPABLE programs, even when they have been successful; workforce has been another constraint. Ongoing funding and leadership support can facilitate sustainability as can creative workforce solutions, such as engaging academic OTs.
- **Accessing Support:** Johns Hopkins, where the CAPABLE model was developed, funds the CAPABLE National Center to provide support for implementation and scalability. As part of its exploration process, DHSS could consult with the center to learn more about other states' experiences and strategies.

One state has implemented CAPABLE through its waiver program. DHHS might explore several options for implementing a CAPABLE program.

### *Explore Opportunities to Expand Services*

To maximally offer supports to people who need them, Utah could explore options to supplement Older Americans Act (OAA) Title III funding—including “braiding” different state, local, and federal funding sources, or “blending” them into one funding pool. Other sources to explore include OAA Title VI funding to support Native Americans, the Medicaid state plan, the Veterans Health Administration, and state general revenue funds.

Combining funding sources could help expand access to core services such as caregiver support, respite, meals, transportation, home-health and case management to older adults who may not be eligible for Medicaid HCBS waivers. These services at higher intensity levels were found to reduce nursing facility placement;<sup>98</sup> one study found that home health services helped people stay home an average of 8 months longer.<sup>99</sup>

### *Leverage Education to Help Delay Admissions*

Proven strategies that help delay nursing home admission include promoting physical function and physical activity,<sup>100, 101</sup> cognitive stimulation, and specialty geriatrics care.<sup>102</sup> The [Utah Commission on Aging](#) shares numerous resources that benefit family caregivers and that provide necessary information to help them support aging family members. Through AAAs and national resources, DHHS provides free trainings, and shares information on free trainings that may be helpful for family caregivers. Many of the available trainings focus on dementia or Alzheimer’s needs. Caregivers

supporting older adults would likely benefit from trainings covering a wide variety of topics, such as training for:

- Basic caregiving skills
- Basic first aid
- Developing a family plan of care
- Treating specific diagnoses
- Managing chronic conditions
- Helping seniors maintain housing
- End-of-life care
- Stress management and self-care

First, DHHS should take stock of the training and education that exists today. DHHS could develop communications campaigns to better point caregivers to new and existing resources and work within existing networks, such as the AAAs, to share information with caregivers and others about strategies that help older adults remain at home.

### ***Diversion from Sheltered and Segregated Work***

Sheltered workshops are a job environment where people with disabilities work in a segregated, congregate setting with other people with disabilities; they are regarded as the “train then place” model for employment. While sheltered work may be touted as a temporary pre-work “training” opportunity, it is common that people do not exit sheltered work or transition to competitive integrated employment. Utah DHHS limits the employment preparation services to 24 months.

Sheltered work programs typically use 14(c) certificates to pay service users subminimum wages. Authorized under the Fair Labor Standards Act, 14(c) certificates may be used by employers who employ a person whose “earning or productivity capacity is impaired by age or physical or mental deficiency.”<sup>103</sup> That is, employers who hire a person with a disability may be issued a 14(c) certificate to pay the individual subminimum wages. While initially proposed to support the employment of people with disabilities, 14(c) certificates and sheltered work settings are largely now regarded as outdated and misaligned with best practice for supporting people with obtaining CIE.

Instead, employment models that promote “place then train” are widely adopted across the United States (e.g., Supported Employment) as best practice. Across the country, states are trending toward adopting policy that eliminates the use of 14(c) certificates. In fact, in December 2024, the Department of Labor issued a proposal to nationally eliminate 14(c) certificates over a five-year period, though the proposal was withdrawn in July 2025. Utah currently has 317 14(c) certificates in use across six Community Rehabilitation Partners (i.e., disability service providers; [DOL, 2025](#)). To fully promote CIE outcomes for people with disabilities and align with Utah’s Employment First policy, we recommended that Utah eliminate the use of 14(c) certificates and sheltered workshops, consider restructuring employment services, bolster employment providers with additional training and create incentives for employment services, and ensure collaboration between DHHS, Vocational Rehabilitation (VR), and Utah State Board of Education (USBE). Recommendations and associated activities are provided below.

## Reduce Sheltered Work, and Ensure Minimum Wage for All Workers

Several states have successfully phased out 14(c) certificates, closed sheltered workshops, and ensured minimum wage for all working individuals. HSRI recommends that the State provide financial support to encourage 14(c) certificate holders to transition from sheltered work to CIE.

Similar to USU's work to support transition of ICF-IID providers to HCBS, HSRI suggests the State use a similar model for supporting 14(c) certificate holders to transition from sheltered work. Additionally, HSRI recommends the State build off their Employment First policy and explore designating employment services as the first service option (prior to day programming). In 2006, Washington state issued the "[Working-Age Adult Policy](#)", a policy which "establishes supported employment services as the first use of employment and community inclusion funds for working age adults and ensures that after nine months of supported employment services the client may choose to also receive community inclusion services [i.e., day programming]." Another example of prioritizing employment services can be found in [Delaware's DDDS Lifespan Waiver](#) under Prevocational Services. Per Delaware's Employment First law, agencies and organizations providing day program services are "required to consider competitive and integrated employment, including self-employment, as the first option when serving people with disabilities who are of working age." See [Appendix B](#) for more details.

## Restructure Employment Services

The second recommendation is to restructure and expand employment services. Currently, the only waivers that offer Supported Employment as a service are CSW, ABI, CTW, and LSW. HSRI recommends expanding Supported Employment services to all waivers and expanding the types of employment services individuals can choose from. This includes exploring discovery and navigation type services to replace current sheltered work services (Indiana's Career Exploration and Planning service and Hawaii's Discovery and Career Planning service can serve as examples), creating a "Workplace Assistance" service, and expanding the Supported Work Independence program for individuals on the waiting list.

[Indiana's Career Exploration and Planning](#) service is meant to support individuals with making an informed choice about whether they wish to pursue CIE, provide information on myths around CIE, and gather more information before connecting to Vocational Rehabilitation. The service should result in (if CIE is desired) connection to other employment supports (such as Vocational Rehabilitation). Services are typically offered at 1:1, but up to 4:1 may be appropriate if shared employment interests exist among the group of people sharing the employment service. Services are provided in community settings as a one-time limited service for up to six months. Additionally, through discovery and navigation services, people should have access to or support with, accessing benefits planning to ensure individuals and families are knowledgeable on how employment may or may not impact other benefits.

[Hawaii's Discovery and Career Planning](#) service is meant to support individuals who are not in CIE, including those in sheltered work, to "1) acquire skills to achieve underlying habilitative goals that are associated with building skills necessary to perform work in integrated community employment;



2) explore possibilities/impact of work; and 3) develop career goals through career exploration and learning about personal interests, skills and abilities.” The outcome of Discovery and Career Planning service is to complete or revise a career plan and develop the knowledge and skills needed to get a job in a competitive, integrated workplace. This service is time limited and is not required prior to a person receiving Individual Employment Supports (such as Supported Employment). The service is not allowed to support any activities that involve or have an outcome of subminimum wage unless it is supporting an individual to move into CIE. The service may include exploring employment goals, mobility training to support transportation needs, internships or apprenticeships, job seeking activities, and transitioning from volunteer or subminimum work.

Workplace Assistance, offered in Colorado, supports individuals who need safety assistance on the job but who no longer need—or never needed—job coach supports. The service can work in tandem with job coaching, or after job coaching fades, to provide help with integration at work, encourage the development and maintenance of natural supports, reinforce and model safety skills, and assist with behavioral support needs and outlined supervision needs.

In developing new services, the state should consider whether to include transportation support in employment services. Currently, the only waiver that does not include transportation activities in the supported employment service is the ABI Waiver. At minimum, HSRI suggests the state keep transportation as an activity under supported employment services in the CSW, CTW, and LSW and include the language pertaining to transportation in the ABI Waiver. Current language states, “Transportation between work or between activities related to employment. Other forms of transportation must be attempted first. (Transportation furnished during the provision of the service is included in the rate paid).” Additionally, to ensure providers are offering the most comprehensive transportation for supported employment services, the state may want to include more targeted transportation in supported employment services. To ensure comprehensive support, Utah may want to adopt and modify transportation support services from other states. HSRI suggests Utah adopt models similar to those of Connecticut and Hawaii. Through its Employment and Day Supports waiver, Connecticut offers services to ensure individuals can get to and from work: “[C]an include pre-purchased tickets or bus passes. Payment per mile is made for a maximum of one round trip daily. Wheelchair accessible transportation is paid at a higher rate only if the individual requires the use of a wheelchair accessible vehicle.” This waiver also offers vehicle modification for transportation needs: “Alterations made to a vehicle which is the individual’s primary means of transportation, when such modifications are necessary to improve the individual’s independence and inclusion in the community. The vehicle may be owned by the person, a family member with whom the person lives or has consistent and on-going contact, or a non-relative who provides primary long-term support to the individual.” Vehicle modification also aligns with tax exemptions for vehicle modification passed in the previous Utah legislative session.<sup>104</sup> Hawaii’s supported employment service states, “The job coach may transport the participant to and from the workplace on a temporary, transitional basis to assist the participant to retain employment while learning how to arrange and use transportation on an ongoing basis.” HSRI suggests for a full list of employment-related services and service definitions within this section. See Appendix B for a full list of employment-related services and service definitions within this section.

## **Bolster Employment Service Providers**

HSRI recommends bolstering employment service providers. Well-trained and well-supported employment service providers are integral to minimizing sheltered work and increasing CIE. We recommend DHHS provide increased training and technical assistance opportunities, such as those provided through the [National Expansion of Employment Opportunities Network \(NEON\)](#) from the Office of Disability Employment Policy (ODEP); ensure providers have access to quality job coaching and supported and customized employment trainings; and offer mini-grants (such as those offered in Oregon<sup>105</sup>) to support the creation of provider training materials and resources. NEON offers TA to national provider organizations and their affiliated local provider organizations in promoting and advancing CIE. Depending on the entity receiving TA, NEON can support states with policy and systems-level change that will promote CIE outcomes or assist providers with transforming employment services from congregate work settings to CIE. We also recommend that DHHS consider funding required training (e.g., ACRE) in order to offset costs and promote training and technical assistance to employment service providers. Finally, DHHS may consider funding “mini-grants” to disability organizations and service providers to create training resources or materials related to employment. For example, [Oregon](#) issued innovation grants to providers to support capacity-building and training and outreach efforts in areas such as family engagement, provider model work, and training tools.

## **Add Incentives for Providers to Support Employment**

DHHS can explore options for adding incentives for providers to support employment. As Connecticut does with its [STEP Program](#), DHHS may consider implementing a payment model that incentivizes the providers who are serving individuals in sheltered workshops or day programs to support these individuals to find and maintain CIE. In this model, service providers supporting individuals in sheltered work or day programs would be paid an enhanced service rate for transitioning a service user to CIE and be offered a one-time outcome payment for successful supported employment services that result in an individual being employed for a set amount of days with a plan for maintaining employment. To ensure incentives are not only offered to providers who are currently operating sheltered work, DHHS may consider implementing outcome payments for all supported employment providers who have successfully supported someone to obtain and maintain CIE. Similar to models like Connecticut’s or Maryland and North Carolina (described below), DHHS may consider providing incentives to providers. [Maryland’s Fiscal Incentive Program for Employment](#) allowed providers to receive a payment of 10% of an individual’s annual funding. The provider was required to complete an application of reimbursement and provide pay stubs showing that the individual was employed in the community for the last six months, evidence that individualized ongoing supports and services were provided in order for the individual to maintain their job, a written statement from the individual stating they are satisfied with their job, and any other information. [North Carolina’s Inclusion Works Competitive Integrated Employment Incentive Plan](#) provides funding to providers who support an individual to find CIE. Providers receive an initial payment of \$2,500 for each eligible individual who starts a job in a CIE setting. If the individual is still employed after 180 days, the provider will receive an additional \$2,500. We also recommend DHHS

continue forward with efforts under “Services and Service Innovation” in the 2024-2025 Employment First Strategic Plan which includes discussions on rate restructuring to incentivize CIE outcomes.

### **Ensure Coordination with VR, USBE, DHHS**

Finally, HSRI recommends the State ensure coordination with Vocational Rehabilitation (VR), USBE, and DHHS. DSPD’s previous 2019 State Employment Leadership Network (SELN) plan has a focus on interagency collaboration including:

- Developing a process map to detail agency and staff roles and responsibilities when referrals are made to other systems and when people move between systems.
- Ensuring every Utah community has the resources and information needed to support integrated employment for all transition-aged youth.
- Engaging in a joint initiative with VR to develop and strengthen the provider network.

One way to support coordination among VR, USBE, DHHS is for DHHS to develop a formal process and ongoing collaboration effort with these agencies. This process should help eligible students join the DSPD waiting list and access VR while still in school, and should also include increasing funding for the SWI program for individuals on the DSPD waiting list. In this way, agencies can support students while they are still in school to obtain and maintain CIE and continue to support those who need extended or long-term employment supports after they complete the two years of funding from VR; this would create a seamless transition and avoid any gap in employment services. An agreement outlining the collaborative responsibilities of VR, USBE, and DHHS can help ensure that people of all ages do not experience service gaps by clarifying the sequence of services, identifying the entity responsible for each service, and defining how to most effectively support people as they transition between different agencies.

### ***Supporting Complex Needs in the Community***

While the definition of complex needs varies across states, complex needs generally refer to needs that have a substantial impact on a person’s ability to complete activities of daily living (either on their own or when considered in combination with other aspects of the person’s underlying disability) and which are of a seriousness or intensity that can imminently impact the health or safety of that person or others.<sup>106</sup> In other words, complex needs have an identifiable impact on the day-to-day activities of a person receiving LTSS, including older adults and individuals with a range of disabilities. While not common, it is important to note that individuals with the most complex needs often have both medical and behavioral support needs. People with complex needs may require a significant amount of services or specialized services, making their needs costly to support. One study found that people with complex medical needs spend approximately \$33,000 more annually than HCBS users with lower needs.<sup>107</sup> This highlights the importance of properly identifying and supporting people with complex needs. Furthermore, people with disabilities may be significantly more likely to be admitted to emergency rooms than people without disabilities.<sup>108, 109</sup> This is, in part, attributed to a lack of preventative care. Offering services to make sure that people with complex care needs are well supported not only prevents needs from magnifying but also helps to keep people supported in the community. This can be difficult because there are often waits for services in the community.

## Ensure Medical Supports Are Available Across All Waivers

While everyone has access to state plan nursing services, only the CTW and TDW offer extended skilled nursing services. CSW, CTW, ABI, NCW, and TDW offer a medication monitoring service. Medication monitoring provides limited nursing services related specifically to taking and refilling medication, monitoring medication, providing medication-related education, and reviewing and monitoring medication-related lab work. Most people with complex medical needs have access to these services; however, because the services focus primarily on medication, they are not flexible enough to meet the oversight and skilled-nursing needs of management people who require more support than the state plan can provide. DHHS should expand these skilled nursing services to all waivers so that all people receiving services who require additional nursing support can access this support. Offering nursing services in all waivers ensures every individual receiving services can access their community in the most integrated settings, which aligns with the Final Settings Rule. Many states offer comprehensive nursing services on their waivers. Alaska offers a unique approach in two of its waivers (see [Children with Complex Medical Conditions](#) and [People with IDD](#) waivers in [Appendix B](#)). This service offered in Alaska requires a nurse to make a nursing plan to be included in the person's support plan. The nurse may also train the individual's family or service provider(s) to administer nursing support, allowing the individual to participate in their home and community while still receiving nursing support.

To most effectively facilitate the nursing service, DHHS can make sure that its nursing plan outlines specifically the precise support that each person needs, whether those supports are delegated, and an approximation of how much nursing services are needed. Using this information, DHHS can determine how best to authorize the nursing service for each person who needs it. The relationship between state plan nursing services and waiver services should be seamless (e.g., nursing services as extended state plan services). Since there are access issues, it may be important to also review these services for issues impacting the provider network—for example, rates that may be too low to allow for a sufficient network.

People with complex medical needs, in particular, benefit from coordinated care that can blend their everyday needs with their highly specialized medical regimen. Since these complex medical needs often have far-reaching effects on daily needs for support across all activities, it is important that there are professional dedicated staff who can oversee the person's overall plan of care. Beyond providing medication, professionals serving in this role can help coordinate care for routine and emergent medical needs, attend appointments with the person, ensure that follow-up care is provided adequately, monitor health conditions, educate family and staff members about how to monitor for changes in health conditions and medication side-effects, and make sure that all providers in all settings are able to follow the nursing plan.

Through Integrated Health Care Coordination (see the [Pathways for Aging Waiver](#) and [Traumatic Brain Injury Waiver](#) in [Appendix B](#)), Indiana ensures individuals with nursing needs receive a collaborative approach to their services so they can participate in integrated settings while still receiving nursing support. This service requires health care providers and community providers to collaborate and integrate their services. For individuals who may not need constant, full-time nursing

care, [Michigan](#) offers a service that focuses on prevention of hospitalization and nursing facility enrollments. An RN or Licensed Practical Nurse (LPN) will intermittently visit the person for observation and evaluation. This service also allows the nurse to train family members or providers in the proper techniques of health-related tasks. HSRI recommends that DHHS implement similar nursing services in all its waivers. For a full list of nursing services in state waivers, see [Appendix B](#).

### **Ensure Behavioral Supports Are Consistently Available Across All Waivers**

Like medical supports, behavioral supports are critical to help people with intensive behavioral needs remain in the community. Behavioral services help family members and other caregivers offer assistance that focuses on positive supports and enables the person to manage their own behavior. This service is provided by highly qualified professionals with expertise in developing positive behavior supports plans and helps the person's support team to implement effective strategies for managing behavior. A critical aspect of behavior support is evaluating and modifying goals, measuring progress, and providing adequate intervention to help mitigate behavioral concerns.

Behavior support services are currently limited to four of Utah's HCBS waivers: CSW, CTW, ABI, and LSW. We recommend that DHHS explore whether these services should be available on the remaining waivers, and that services are streamlined across the different waivers. In addition, improving access to behavioral supports could include adding positive behavior supports across Utah's waivers or allowing behavioral supports to be provided via telehealth.

### **Implement Rate Tiers for People with High Behavioral/Medical Support Needs**

People with complex care needs, more so than others receiving services, have needs that may impact their ability to sustain services or that may lead to a provider incurring additional costs. For example, some people with intensive behavioral needs may move from one provider to another, limiting the continuity of their care and consistent application of needed behavioral support. Additionally, support staff who deliver their services often must receive additional training (e.g., training on their positive behavior support plan) and may have increased liability. Because providing these intensive supports can be daunting and stressful for support staff, people with complex needs may also have a revolving door of staff members delivering highly complex care.

In recognition of these unique aspects of service delivery, many states have developed rate tiers that pay a higher amount when someone has been determined to have complex medical and/or behavioral needs. Rate tiers are most often informed by an assessment to determine the extent of each person's medical or behavioral needs and a framework that determines the rate based on these identified needs. Many states implement these rate tiers as part of a more comprehensive individual budget model. See [Equitable Resource Allocation Models](#) for more information. We recommend that, as part of the recommendation to develop a resource allocation model, Utah pursue rate tiers.

Paying providers adequately for delivering these services can help to retain highly trained staff to deliver services, reducing the need to have newer or untrained staff working with people with the most complex needs. It can also allow providers to proactively train support workers to deliver complex supports. These factors combined may create the conditions necessary for sustained,

supportive relationships between providers, support staff, and people receiving services that help people to develop and self-manage their behavior.

### ***Supporting Individuals and Families***

People with disabilities and older adults compose a significant portion of our families and communities. Often, they benefit from a variety of supports to live the life they want and to participate in community life. People receiving services at home may have to rely on family caregivers to provide a level of support. Family caregivers have significant responsibilities to provide support for their loved ones—and they are critical partners in advancing Community First. They can benefit considerably from support from people in their shoes: peer and family supporters.

### **Partnering with Families to Advance Community First**

For people with IDD who remain connected to their families, deinstitutionalization must be considered within the family context. Many of today’s aging parents of adults with IDD raised their children during a time when institutionalization was encouraged, or in some cases, the only option of support extended.<sup>110</sup> Understanding parental perspectives and the impacts of deinstitutionalization on individuals and their families is essential for successful transitions; in addition to identifying the services and supports needed for people with IDD to successfully transition to community living, intentional supports must be developed and implemented for families during this transition to ensure success.<sup>111</sup>

One study from 2016 explored how families’ views on moving away from institutional care have changed over time, especially during the closure of the last two state-run facilities for people with IDD in Oklahoma.<sup>112</sup> Initially, many families opposed the move to community living, often due to long-standing beliefs that institutional care was the safest and most appropriate option. These beliefs were shaped by decades of societal norms and professional recommendations that favored institutionalization. However, the study found that over time, most families transitioned from opposition to satisfaction, recognizing the benefits of community living—such as improved quality of care, increased autonomy for their relatives, and more meaningful engagement in daily life.

Importantly, this study revealed that the shift in attitudes was not just about the outcome of satisfaction but about the emotional and relational journey families experienced. Families expressed a strong desire to be involved in decision-making and to be seen not just as guardians but as integral members of the care team. While many ultimately embraced community living, they also voiced concerns about staffing consistency, training, and the emotional toll of transitioning their loved ones from what had long been considered “home.” The study underscores the importance of family-centered approaches and ongoing support during transitions to promote resilience and positive outcomes for both people with IDD and their families.

We recommend bolstering support for families during the development of the Community First strategy. Families must be considered an integral part of any transition. It is critical that families are engaged early and often. Along with people receiving services, the questions, concerns, perspectives, and anxieties of families must be prioritized.

## Peer Support for Individuals and Families

Peer-delivered services are an increasingly integral part of supporting people with disabilities, and they offer people with lived experience the opportunity to support others through empathy, shared understanding, and practical strategies. Peer support has been shown to improve outcomes such as self-esteem and self-efficacy and to reduce hospitalizations.<sup>113, 114</sup> While widely adopted as part of mental health and/or substance use support, peer support has traditionally focused on populations without significant disabilities; however, emerging programs are beginning to address this gap and are also seeing positive outcomes.

Nationally, certified Peer Support Specialists learn skills through training to deliver services to people with shared living experiences. Family Peer Support Specialists use their lived experience as a family member to deliver services to other families. Both types must go through formal training.

Encouragingly, Utah has individual peer supports available on the LSW. Ensuring that all people receiving services are aware of these available supports—how they can be accessed, what they look like, and potential benefits—can help people receiving services to best benefit from these resources. Utah also has family peer supports available on the LSW. In addition to peer supports, DHHS offers family support services to help families learn skills to better support their family members who are aging or have disabilities. Family support services are offered on the TDW, while individual and family training services are offered on the CSW and CTW.

The current definition of Individual and Family Peer Support under the LSW is broad, which allows flexibility in how peer supports can be used. The service emphasizes lived experience and relationship-building, extending beyond navigation of waiver programs to include community resources, self-advocacy, and skill development, allowing for a holistic use. Overall, peer support on the LSW provides a solid foundation but could benefit from explicit guidance on telehealth, group service options, self-direction, and transportation. Drawing on best practices from other states would make the service more comprehensive and participant friendly.

The Utah Substance Use and Mental Health (SUMH) Peer Support Program certifies peer and family peer support specialists through training to learn skills to deliver supportive services to people with shared living experiences. Currently, this program focuses on individuals with mental health conditions and/or substance use disorders; however, DSPD could modify the SUMH peer support program to fit the needs of people with disabilities and their families.

DHHS should ensure that these supports are available for people across all waivers by expanding peer and family supports to all waivers.

# Improving Quality

Throughout this project, we heard from community members, as well as from DHHS, about what quality means to people receiving services and their families. People receiving services and their families expressed that a quality service system should make sure that people are being supported in the community, and that there are enough service providers to support their needs. Data collection, along with continuous quality improvement, can create a positive and lasting impact on the way services are provided. As a result of the expansion of community-based services during the 1980s and throughout the 1990s, states and organizations began to implement means to measure how service providers operated and provided services to individuals with disabilities.<sup>115</sup> Historically, these measures were based on whether or not specific strategies, practices, or treatments were visible during service provision. Measures for service quality, however, have shifted over the last 20 years to not only focus on processes but also on individual outcomes, experiences, and overall impact on the quality of life of people receiving services.<sup>116</sup> During this time, various measures, such as the [National Core Indicators®](#) (NCI®), administered by HSRI, and [Personal Outcome Measures](#) (POM), began to emerge as a way to measure the quality of services.

In this section, we provide background for understanding our specific recommendations to improve the quality of the Utah LTSS system.

## Background for Improving Quality

DHHS has several entities charged with developing quality improvement strategies and monitoring the quality of services. The Division of Continuous Quality and Improvement (CQI) was created during the consolidation of DHHS and contains the [Office of Service Review and the Office of Innovation](#). CQI has helped streamline various DHHS quality initiatives and promotes collaboration; it has also helped consolidate processes in order to provide iterative, high-quality practices to help improve outcomes for Utahns. CQI carries out a variety of tasks, including monitoring contract performance, executing action on noncompliance, and providing frameworks for continuous quality improvement.

CQI intends to promote a culture of continuous quality improvement within DHHS. It has begun the Quality Framework Project to develop tools to explore individual and family experiences, in addition to the experiences of case managers and the providers they work with within DSPD. This tool intends to employ experience surveys that target the person receiving services, caseworkers, and parent/guardian(s) (as applicable). These surveys cover three domains: service planning, service delivery, and reliability and engagement. The goal of this tool is to use feedback from people receiving services to improve service delivery, offering a more robust way of providing feedback. The tool is also intended to help providers identify how they can increase quality in their programs and to determine where extra support and technical assistance may be needed.

The Quality Improvement Committee consists of representatives from the Utah Department of Health, DSPD, the Office of Quality and Design, and the Office of Licensing. They meet at least monthly to perform various tasks related to quality improvement of services, including reviewing and analyzing discovery and remediation information, recommending system improvements, and evaluating the effectiveness of the improvement initiatives. The committee may also generate or request quality improvement reports to monitor outcomes, evaluate the effectiveness of process and system improvements, and track and trend performance measures.<sup>117</sup> They also review quality improvement strategies of specific waivers after a certain period of time—and have an overarching awareness of strategies across different waiver populations.

While Utah has been making progress in assessing and monitoring the quality of services, a substantial change is coming that will require HCBS systems across the United States to alter their quality improvement measurement. CMS has made concerted efforts to enhance the quality of services. CMS specifically targeted access to care and services for people enrolled in Medicaid through the Ensuring Access to Medicaid Services Final Rule or “Access Rule,”<sup>118</sup> which addresses essential aspects of access within both Medicaid Fee-for-Service (FFS) and managed care delivery systems, including HCBS. These enhancements aim to foster transparency and accountability, standardize data and monitoring processes, and create avenues for states to encourage active participation of beneficiaries in their Medicaid programs, ultimately striving to improve comprehensive access to care.

The Access Rule introduces new requirements related to the direct care workforce, access to HCBS, health and safety safeguards, and quality metrics. One component of the quality measures is the HCBS Quality Measure Set (QMS), a collection of nationally standardized quality measures specifically designed for Medicaid-funded HCBS. The purpose of the QMS is to encourage uniform and consistent evaluation of HCBS program quality across states, facilitate the availability of comparative quality data on HCBS programs for both CMS and states, and promote enhancements in the quality of care and outcomes for people receiving HCBS.<sup>119</sup> Within the QMS, the Experience of Care section is aimed at evaluating the experience and quality of care for one or more demographic groups participating in HCBS programs, including older adults, adults with IDD, adults with physical disabilities, and adults with serious mental illness. The section encompasses measures derived from National Core Indicators-Intellectual and Developmental Disabilities (NCI-IDD) and National Core Indicators-Aging and Disabilities (NCI-AD), both administered by HSRI, as well as measures from CAHPS and POM. To assess DHHS’s readiness for QMS implementation, we reviewed the quality measures used in Utah and used this analysis to begin shaping recommendations that align with QMS requirements. Additionally, HSRI reviewed the current waiver performance standards for opportunities for improvement.

In Utah, there are multiple ongoing efforts to improve the quality of care for people receiving services and their families. The state is committed to exploring ways in which quality can be measured and improved across the different agencies delivering services. Here we outline the current quality measures used by DHHS and the measures required to meet QMS requirements as well as provide guidance on ways to set performance targets and use the results to continuously improve services in

Utah. Measuring quality and using strong data sources to assess the quality of services is crucial and allows for the fair, accurate, and meaningful measurement of quality care. Using these measures also allows for reporting on, and improving the quality of, services. We describe areas where DHHS should pay particular attention and also outline steps for a Continuous Quality Improvement Plan shaped by other efforts.

## Overview of the Access Rule

The Medicaid Access Rule aims to enhance access to care for people receiving services by improving transparency, accountability, and the quality of services provided under Medicaid.

### **Key Objectives**

The Access Rule, established by CMS, focuses on several critical areas to improve access to care for Medicaid beneficiaries. The rule is part of a broader initiative to strengthen Medicaid and the Affordable Care Act (ACA) and ensure high-quality healthcare is accessible to all Americans. The rule has specific provisions and includes a timeline for implementation that all state programs are expected to follow.

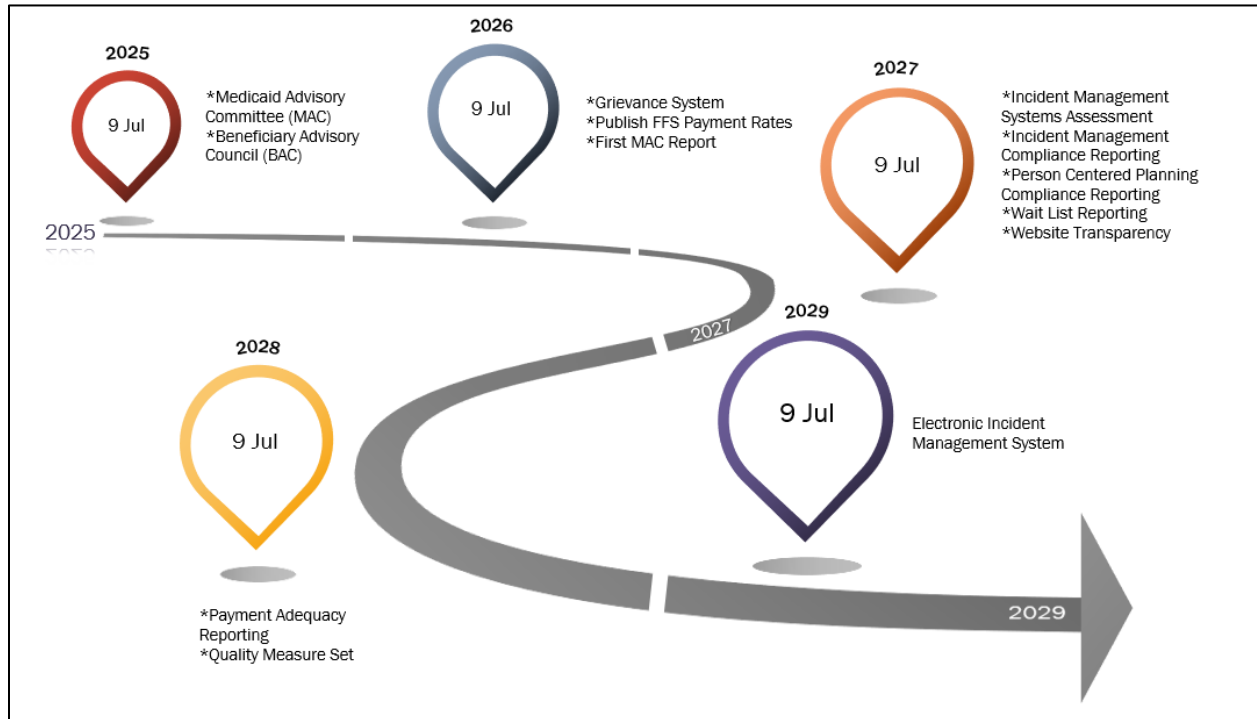
### **Main Provisions**

- **Advisory Committees** – The rule mandates the establishment of Medicaid Advisory Committees (MAC) and Beneficiary Advisory Councils (BAC) to ensure that beneficiaries have a voice in the Medicaid program and that their needs are addressed.
- **HCBS** – The rule emphasizes the importance of HCBS and requires states to enhance the quality and accessibility of these services. States must report on HCBS quality measures to ensure accountability.
- **Transparency and Accountability** – The rule aims to increase transparency in Medicaid services by requiring states to maintain clear web resources detailing payment rates and reimbursement methodologies. This is intended to improve public accountability and engagement.
- **Grievance and Incident Tracking** – States are required to create centralized systems for tracking grievances and incidents related to Medicaid services, which will help improve the quality of care and address issues more effectively.
- **Payment Adequacy Standards** – The rule establishes standards for HCBS payment adequacy, mandating that a significant portion of reimbursement for services must be allocated to employee compensation, thereby improving service quality.

Below we provide the timeline for implementation. Implementation varies by whether a state participates in the Money Follows the Person (MFP) demonstration or not. We note that Utah does not participate in the MFP demonstration and therefore has a longer timeframe for implementing the requirements outlined in the Access Rule.

## Timeline for Implementation and Activities

Figure 5. Access Rule Timeline



## Fee for Service Requirements

The Access Rule includes specific provisions so that states adopt a rigorous process for developing fee-for-service payment rates, ensure transparency in the rates process, and include important parties in the development of the rates. We include these provisions on the table below.

Table 21. Access Rule – Fee-for-Service Requirements

Citation	Content Summary	Applicability Date
Rate Reduction and Restructuring SPA procedures § 447.203(c)(1) and (2)	Requires states to demonstrate access sufficiency through an initial analysis when submitting a state plan amendment with a rate reduction or restructuring in circumstances that could result in diminished access, for all services. If the state does not meet the requirements of the initial analysis, they must perform an additional, more extensive analysis.	July 2024
Payment Rate Transparency Publication § 447.203(b)(1)	Requires states to publish all FFS Medicaid fee schedule payment rates on a publicly available and accessible website.	July 2026 Then updated within 30 days of a payment rate change.

Comparative Payment Rate Analysis Publication § 447.203(b)(2) to (4)	Requires states to compare their FFS payment rates for primary care, obstetrical and gynecological care, and outpatient mental health and substance use disorder services to Medicare rates and publish the analysis every two years.	July 2026 Then every 2 years
Payment Rate Disclosure § 447.203(b)(2) to (4)	Requires states to publish the average hourly rate paid for personal care, home health aide, homemaker, and habilitation services, and publish the disclosure every two years.	July 2026 Then every 2 years
Interested Parties Advisory Group § 447.203(b)(6)	Requires states to establish an advisory group for direct care workers, beneficiaries, authorized representatives, and other interested parties to meet at least every two years and advise and consult on payment rates paid to direct care workers for personal care, home health aide, homemaker, and habilitation services.	July 2026 Then every 2 years

### **Medicaid Advisory Committee and Beneficiary Advisory Council Requirements**

The Access Rule includes specific provisions related to the MAC and BAC to give a voice to those who use the program, ensuring that lived experience is considered in decisions about care quality, eligibility, and services. We include these provisions in the table below.

*Table 22. Access Rule MAC and BAC Requirements*

<b>Citation</b>	<b>Content Summary</b>	<b>Applicability Date</b>
MAC & BAC § 431.12	Renames and expands the scope of states' Medical Care Advisory Committees. The renamed Medicaid Advisory Committees (MAC) will advise states on an expanded range of issues.	July 2025
MAC & BAC § 431.12	Requires states to establish a Beneficiary Advisory Council (BAC) comprised of Medicaid beneficiaries, their families, and/or caregivers.	July 2025
MAC & BAC § 431.12	Establishes minimum requirements for MAC membership, including a requirement that 25% of the MAC members will be drawn from the BAC.	July 2025
MAC & BAC § 431.12	Requires states to make information about the MAC and BAC activities publicly available—including bylaws, meeting schedules, agendas, minutes, and membership lists.	July 2025

MAC & BAC § 431.12	Requires states to make at least two MAC meetings per year open to the public. These meetings must include a public comment period.	July 2025
MAC & BAC § 431.12	Requires states to provide staff to support the planning and execution of the MAC and BAC activities.	July 2025
MAC & BAC § 431.12	Requires states to create and publicly post an annual report summarizing MAC and BAC activities.	July 2026

### **Home and Community-Based Services Requirements**

The Access Rule includes specific provisions related to HCBS requirements to improve transparency about the number of people on wait lists for services, to report on the QMS, to have electronic grievance systems, and to set minimum standards for payment for specific services. We include these provisions in the table below.

*Table 23. Access Rule HCBS Requirements*

<b>Citation</b>	<b>Content Summary</b>	<b>Applicability Date</b>
Grievance Systems §§ 441.301(c)(7), 441.464(d)(5), 441.555(e), and 441.745(a)(1)(iii)	Requires that states establish a grievance system for HCBS delivered through FFS.	July 2026
HCBS Quality Measure Set §§ 441.312, 441.474(c), 441.585(d), and 441.745(b)(1)(v)	Requires states to report on waiting lists in section 1915(c) waiver programs; service delivery timeliness for personal care, homemaker, home health aide, and habilitation services; and a standardized set of HCBS quality measures.	HHS to Identify Quality Measures Beginning December 2026
Website Transparency §§ 441.313, 441.486, 441.595, and 441.750	Promotes public transparency related to the administration of Medicaid-covered HCBS through public reporting of quality, performance, and compliance measures.	July 2027
Person-Centered Service Plans §§ 441.301(c)(1) and (3), 441.450(c), 441.540(c), and 441.725(c)	Strengthens oversight of person-centered service planning in HCBS.	July 2027

<p>Incident Management System</p> <p>§§ 441.302(a)(6), 441.464(e), 441.570(e), 441.745(a)(1)(v), and (b)(1)(i)</p>	<p>Requires that states meet nationwide incident management system standards for monitoring HCBS programs.</p>	<p>July 2027</p>
<p>Reporting Requirements</p> <p>§§ 441.311, 441.474(c), 441.580(i), and 441.745(a)(1)(vii)</p>	<p>Requires that in three years, states report on their readiness to collect data regarding the percentage of Medicaid payments for homemaker, home health aide, personal care, and habilitation services spent on compensation to the direct care workers furnishing these services.</p>	<p>July 2027</p>
<p>Reporting Requirements</p> <p>§§ 441.311, 441.474(c), 441.580(i), and 441.745(a)(1)(vii)</p>	<p>Requires that in four years, states report on the percentage of Medicaid payments for homemaker, home health aide, personal care, and habilitation services spent on compensation to the direct care workers furnishing these services, subject to certain exceptions.</p>	<p>July 2028</p>
<p>Incident Management System</p> <p>§§ 441.302(a)(6)(i)(B)</p>	<p>Requires that states establish an electronic incident management system.</p>	<p>July 2029</p>
<p>HCBS Payment Adequacy</p> <p>§§ 441.302(k), 441.464(f), 441.570(f), and 441.745(a)(1)(vi)</p>	<p>Requires that in six years, states generally ensure a minimum of 80% of Medicaid payments for homemaker, home health aide, and personal care services be spent on compensation for direct care workers furnishing these services, as opposed to administrative overhead or profit, subject to certain flexibilities and exceptions (referred to as the HCBS payment adequacy provision).</p>	<p>July 2030</p>
<p>HCBS Payment Adequacy</p> <p>§§ 441.302(k), 441.464(f), 441.570(f), and 441.745(a)(1)(vi)</p>	<p>The HCBS payment adequacy provision provides states the option to establish: (1) a hardship exemption based on a transparent state process and objective criteria for providers facing extraordinary circumstances and (2) a separate performance level for small providers meeting state-defined criteria based on a transparent state process and objective criteria. The HCBS payment adequacy provision also exempts the Indian Health Service and Tribal health programs subject to 25 U.S.C. 1641 from complying with its requirements.</p>	<p>July 2030</p>



## ***Grievance System***

In the Access Rule, grievance is defined as an expression of dissatisfaction or complaint related to the state's or a provider's performance of activities related to person-centered service planning and/or HCBS settings. Creating a transparent and well-defined grievance system is an important aspect of the Access Rule and can allow for uniform tracking of grievances, responses, and reporting.

Key components of the requirements include:

- Updating processes to file grievances related to state or provider compliance with person-centered care planning requirements and the HCBS Final Settings Rule
- Providing direction on how beneficiaries can file routine and/or expedited grievances orally or in writing
- Requiring that resolution of grievance and notice to affected parties must occur:
  - Within 90 calendar days for standard grievance
  - Within 14 calendar days for expedited grievance
- Sharing information on how to request extensions of time to file
- Allowing disinterested third parties to file grievances on a beneficiary's behalf with their consent
- Ensuring beneficiaries know there is no retaliation against them when they file grievances
- Providing information about acknowledging receipt of grievances
- Standardizing the process for reviewing grievances
- Ensuring that individuals not previously involved in related decision making, and with appropriate expertise, can only make grievance decisions
- Providing beneficiaries with a reasonable opportunity, face-to-face (including through the use of audio or video technology) and in writing, to present evidence and testimony and make legal and factual arguments related to their grievance
- Providing information that the state will supply copies of case files without charge
- Requiring the state to maintain records of grievances and reviews as part of their ongoing monitoring procedures
- Requiring the state to accurately maintain grievances in a manner that can be available upon request containing:
  - A general description of the reason for the grievance
  - Date received
  - Date of each review or review meeting
  - Resolution and date of the resolution of the grievance
  - Name of the beneficiary for whom the grievance was filed
  - Language-accessible notice of rights and process for grievances, as well as assistance in navigating the process

- Providing beneficiaries with notices and other information related to the grievance system, including information on their rights under the grievance system and on how to file grievance, and ensure that such information is accessible for individuals with disabilities and individuals who are limited English proficient
- Providing information on the grievance system to providers and subcontractors approved to deliver services under section 1915(c) of the Act

Through interviews with key staff, we heard that the grievance system now is informal and that an overarching policy that reflects access rule requirements is needed and is being developed internally. HSRI also reviewed the state website to determine how easy it would be for someone to navigate to find processes for reporting a grievance.

### **Quality Measure Set**

In July 2022, CMS released the first ever HCBS QMS through State Medicaid Director Letter (SMDL) 22-003.<sup>120</sup> The HCBS QMS is a set of nationally standardized quality measures intended to promote common and consistent measurement of HCBS program quality across states and drive improvement in quality of care and outcomes for people receiving HCBS. The Experience of Care section of the QMS includes measures from NCI-IDD, NCI-AD, CAHPS, and POM to assess the experience and quality of care of one or more population groups included in HCBS programs (older adults, adults with IDD, adults with physical disabilities, adults with serious mental illness).

The key priorities of the HCBS QMS are access, rebalancing, and community integration.

- **Access:** Beneficiary and caregiver awareness of resources that support overall well-being and HCBS.
- **Rebalancing:** Finding a more equitable balance between spending on institutional care and HCBS care in communities.
- **Community Integration:** Ensuring self-determination, independence, empowerment, and full inclusion of children and adults with disabilities and older adults in all parts of society.

These priority areas focus on equity and accessibility of services in the least restrictive setting. The QMS is intended for use with all HCBS programs except when the identified measures are not applicable (e.g., managed care measures for states with only fee-for-service programs, measures derived from experience of care surveys other than those being used to assess beneficiary experience in the HCBS program). Most measures in the set have only been tested with adults and have not been tested with children and adolescents. As a result, the measure set may not be appropriate for use in HCBS programs that serve children and adolescents.

In April 2024, when CMS issued the Access Rule, it mandated the use of the QMS to be implemented by 2028 for states that do not participate in the Money Follows the Person demonstration, such as Utah.

The QMS is comprised of measures that assess quality across a broad range of areas identified as measurement priorities for HCBS. The measure set includes claims-based measures, measures

derived from various experience of care surveys, and several other nationally standardized and tested measures in key areas.

Through interviews with key staff as well as a review of a tool provided by NASDDDS to help states track their progress on Access Rule requirements, it was clear that Utah has begun the work to come into compliance with upcoming changes. Recommendations in this report are intended to assist Utah in enhancing these efforts.

## Overview of Waiver Quality Improvement Assurances and Performance Measures

The assurances and sub-assurances of HCBS 1915(c) waivers are essential elements of measuring quality. Within waivers, there are six assurances that aim to guarantee that states adhere to particular standards while managing HCBS programs, with an emphasis on safeguarding the health and welfare of individuals who receive services. These assurances fall within the following waiver appendices:

- Appendix A: Administrative Authority
- Appendix B: Level of Care
- Appendix C: Qualified Providers
- Appendix D: Service Plan
- Appendix G: Health and Welfare
- Appendix I: Financial Accountability

Within the six assurances, there are 18 sub-assurances. The sub-assurances act as criteria for assessing and enhancing quality of care, ensuring that services are provided efficiently and safely to fulfill the requirements of individuals in home and community environments. States outline performance measures that describe how they will assess compliance for specific sub-assurances. Many of the sub-assurances in the Quality Measure Set are similar to sub-assurances within Appendix D (Service Plan) and Appendix G (Health and Welfare). To comply with federal regulations, states must achieve a threshold of 86% or greater for all sub-assurances.<sup>121</sup>

To understand the feasibility of aligning existing performance measures across all of DHHS's current waivers—as discussed in more detail in the "[Restructuring HCBS Waivers](#)" section below—HSRI cross-walked the performance measures across each of DHHS's nine waivers. This analysis was done in Excel, by manually comparing the content of each waiver's performance measures. For a performance measure to be considered in alignment, a one-to-one language match was not needed; instead, the content needed to be contextually similar. Similar performance measures appear in the same row as one another. Differences between otherwise similar performance measures were identified by highlighting differences in purple text (see [Appendix C](#)). Currently, DSPD administers the most waivers (five), with DIH administering three waivers and DAAS administering one waiver.

The crosswalk analysis showed that many performance measures align across many waivers; however, there are a number of performance measures that do not align across all waivers. Additionally, though many waivers have the same number of performance measures for a given

appendix (see Table 24), in no case did all nine waivers have identical performance measures within an Appendix. Under many appendices and sub-assurances there were “one-off” performance measures related to only one waiver; in some cases, this appeared to be because of the specific nature of a waiver (e.g., the New Choices Waiver). This may also be explained by the fact that the waivers currently serve more narrowly defined populations, the fact that different assessments are used across divisions for eligibility and level of care, and the use of different IT systems across divisions. Indeed, waivers run by the same division seemed more likely to have performance measures that aligned.

Below, we detail the number of performance measures within each appendix of each DHHS waiver. The CTW, administered by DSPD, had the most performance measures (n = 39), and the AGW and MCCW had the least number of performance measures (n = 26). On average, DHHS waivers have 33 performance measures.

*Table 24. Number of QIS performance measures across DHHS waivers.*

Appendix	CSW	CTW	LSW	PD	ABI	Aging	NCW	MCCW	TDW	All Waivers
<b>A</b>	5	6	5	5	5	3	0	0	3	32
<b>B</b>	3	3	3	3	3	4	5	4	4	32
<b>C</b>	6	7	5	3	6	3	6	4	3	43
<b>D</b>	9	9	9	8	9	4	9	7	8	72
<b>G</b>	10	9	10	9	8	7	9	8	8	78
<b>I</b>	5	5	5	6	5	5	7	3	3	44
<b>Total PMs</b>	<b>38</b>	<b>39</b>	<b>37</b>	<b>34</b>	<b>36</b>	<b>26</b>	<b>36</b>	<b>26</b>	<b>29</b>	<b>301</b>

## Overview of National Core Indicators

NCI is a collaborative effort between the National Association of State Directors of Developmental Disabilities Services (NASDDDS), ADvancing States, and HSRI. The purpose of the program, which began in 1997, is to support state human services systems to gather a standard set of performance and outcome measures that can be used to track their performance over time, to compare results across states, and to establish national benchmarks.

The primary aim of NCI is to collect and maintain valid and reliable data about the performance of public human service systems. NCI states and project partners use NCI data not only to improve practice at the state level but also to add knowledge to the field, to influence state and national policy, and to inform strategic planning initiatives.

Since 2014 Utah has participated in the NCI-IDD survey; Utah also participated in the NCI-AD survey in 2018 and 2019. The state currently employs experience surveys for some of the waiver

populations. In survey data collection, selecting a sample that is representative of the general population (or in this case, the population being served) is an important part of rigorous research. DHHS must continue to work to pull a sample for NCI-IDD that is representative of the overall population. NCI asks states to pull a representative sample of 400 surveys with the aim of compiling a data set that can provide a high level of statistical accuracy. Statistical accuracy is largely a function of sample size: The larger the sample size, the smaller the margin of error and the greater the accuracy. Historically, Utah has conducted a simple random sample, surveying adults from the HCBS 1915(c) CSW, ABI, LSW, CTW and USDC and ICF-IIDs. Because this is a random sample, the final sample sizes from each waiver, USDC, and ICF-IIDs are not necessarily proportional to the service population.

## **Recommendations for Improving Quality**

Recognizing the requirements stemming from the Access Rule, here we largely outline recommendations that help to shift DHHS toward implementation, highlighting areas that require additional attention such as the grievance system requirements and the QMS implementation.

### **Improve Quality Systems and Measurements**

DHHS will be required to follow the timelines provided by CMS for adherence to the Access Rule. While DHHS will have to comply with these timelines and the requirements in the Access Rule, we recommend that DHHS give particular attention to two aspects of the Access Rule. The first relates to development of a grievance system and the second relates to the implementation and measurement of the QMS. Finally, we recommend that DHHS better stratify its NCI measures.

#### ***Formalize the Grievance System***

DHHS is currently engaged with Alvarez & Marsal to develop plans for mitigating abuse, neglect, and exploitation within the service system. This work will likely inform DHHS's grievance system. Building on this work, HSRI recommends developing an overarching grievance policy, process, and procedures to meet the requirements of the Access Rule and to ensure consistency across different populations served by DHHS. The policy should clearly spell out what a grievance is, who can file a grievance, and how each grievance is reviewed and assessed; it should also outline the follow-up actions for grievances and explain how people will be informed of their rights to file a grievance.

To support people receiving services to effectively use the grievance policy, DHHS should provide plain language information to people receiving services as part of their PCP. Additionally, we recommend providing all grievance policy-related information in easily discoverable locations on the DHHS website. This page should include detailed information about how to file a grievance, including links to any forms or contact information that is required. This page should also link to the notice of rights, including a plain language version explaining each person's rights. This information must also be made available to support coordinators and service providers, so that they can help people receiving services with grievances and, when needed, file on behalf of a person receiving services.

The process should indicate how grievances are addressed. For example, the process may outline how grievances are elevated, how they are investigated, how findings are reported back to the

person, and specific timelines. Additionally, DHHS will identify appropriate actions related to grievances, including corrective action plans for providers, when to refer to other agencies, and other appropriate actions. DHHS should develop a procedure for tracking and trending grievances. This procedure should include routine review of grievances to identify problematic areas that may need more systematic redress to prevent future problems.

To support this enhanced grievance procedure, DHHS may need to strengthen internal processes or develop enhanced partnerships with other agencies. DHHS may need to enhance its internal systems to ensure that appropriate actions are systematically supported; for example, if a specific grievance should result in the loss of a provider license, a clear connection must be made and supported internally. To effectuate this grievance policy, DHHS may rely on partnerships that fall outside of DHHS, such as partnerships with the Utah Division of Child and Family Services, to assure that the grievance system is adequate regardless of the person's age or circumstances. DHHS may also need to invest in technological reporting systems. This may involve software to document and trend grievances or technological solutions for using data captured elsewhere.

Finally, apart from the formal grievance system, DHHS should explore means to allow people to raise informal concerns that are treated consistently and tracked and trended in a similar way as the formal grievance process, allowing all people to raise concerns regardless of the level of significance. A system for informal concerns could also help DHHS understand how well services are meeting people's needs, and it can create additional trust in the service system. Arizona Department of Economic Security, Division of Developmental Disabilities offers a [Customer Services Center](#) call line, staffed at specific times, as well as a form that can be completed to share information. This allows Arizona to collect feedback on all facets of the service system to continually engage in understanding people's experiences and problems that prevent them from benefiting fully from their services. Capturing information from service recipients, either through routine data collection activities such as satisfaction surveys or regularly through feedback forms, will enable DHHS to gain a better understanding of how well its system is meeting the needs of people with disabilities and older adults.

### ***Implement HCBS Quality Measure Set***

HSRI has created a sample tool that can allow Utah to track the QMS and the data available for each measure. See the Sample HCBS QMS (attached as [Appendix D](#)). This tool is a sample crosswalk that consists of the parts of HCBS Quality Measure Set with measures already being collected as NCI items and waiver performance measures. The tool includes:

- QMS assurances for each topic area (service plan, health and welfare, access, rebalancing, community integration)
  - Sub-assurances for each assurance
    - Table of NCI items/current waiver performance measures that fall under sub-assurance
      - Utah's measure for 2022-2023 and 2023-2024
      - QIS Performance Measures currently being reported on

This setup allows DHHS to not only explore the measures available for the QMS but also to track DHHS progress on the QMS. Further the tool can be modified over time to add additional items under a sub-assurance if needed (adding a row to the table) or to add additional years of outcomes (adding a column to the table). This will allow Utah to see how they are performing across measures each year as well as progress or change over time. To navigate the Sample HCBS QMS tool (attached as [Appendix D](#)), click on the arrow on the left beside each assurance or sub-assurance to open that section. The table of NCI/performance measure items will be underneath the sub-assurance where applicable.

We recommend the use of the tool, or a similar tool, for an easily accessible tracking mechanism prior to the 2028 deadline for QMS reporting. This way, DHHS will be prepared to implement the QMS. This tool can also inform a Continuous Quality Improvement Plan since the measures can be documented and updated as needed.

Of note, NCI compares a state's In-Person Survey data to the weighted NCI-IDD average. NCI measures significant differences set at  $\alpha = .01$ , with effect size considered. In the attached tool, significance is indicated on the measure with either \* = significantly lower than the national average, or \*\* = significantly higher than the national average. This information can help Utah to find measures that might indicate the need for exploration or performance improvement initiatives.

### ***Streamline Waiver Performance Measures***

Currently, DHHS reports yearly on a total of 301 waiver performance measures across the nine waivers (see Table 24, above). DHHS should consider aligning and consolidating waiver performance measures across current waivers to reduce the administrative burden and improve comparability. Alignment would require substantial time and effort upfront, but it would likely lead to long-term efficiencies. Many performance measures across waivers assess similar outcomes, indicating that consolidation could allow for streamlined reporting—measuring once instead of multiple times—without compromising data quality or oversight. Additionally, this alignment would help to position DHHS for potentially simplifying the HCBS waivers as noted in [Recommendations for Restructuring HCBS Waivers](#), promoting a more integrated and person-centered approach to service delivery.

We recommend DHHS consider adding waiting list performance measures for all waivers to accurately capture the number of people waiting and their level of need (prior to receiving services). Adding this measure will better position DHHS for the implementation of the Access Rule and its requirements, and it will better position DHHS to report on the wait for services.

In regard to the waiver performance measures, HSRI recommends that DHHS establish a standardized set of performance measures relating to provider qualifications for services. While these qualifications vary by waiver and service, DHHS can identify and explore requirements that are consistent across all waivers and measure those that are common. This will assist DHHS to monitor and report on provider qualifications, which are critical to overall service quality.

## ***Stratify NCI Sample***

In addition to other efforts, Utah could consider stratifying its NCI sample to understand disparities/differences by characteristics or demographics of interest. The NCI-IDD In-Person Survey National Report from 2022-23 shows that the number of valid surveys was 359 and 346 for the 2023-2024 survey.<sup>122</sup> Utah should strive toward the 400-survey threshold to provide a representative sample for data collection and analysis. By collecting a minimum of 400 surveys, DHHS would be able to identify accurate statistics related to service system-related quality issues. If DHHS wishes to further stratify its sample, it may be able to better report on populations of specific concern, such as tribal members or other groups.

While DHHS no longer completes the NCI-AD survey for older adults, doing so will enable DHHS to have many of the measures required through the QMS. Should DHHS choose to use NCI-AD again, we also recommend that DHHS collect a stratified sample of a minimum of 400 surveys to ensure representation—and more if DHHS wishes to report on specific populations.

## **Develop a Comprehensive Quality Improvement Strategy**

As we conducted our work, our team noted an area for development: the need for a comprehensive quality improvement strategy. Implementing the QMS will enable DHHS to develop a more comprehensive quality improvement strategy. We recommend that the strategy not only builds on DHHS's work to implement the QMS but also expands those efforts to create a clear path for understanding how the system meets people's needs and for driving ongoing improvement.

To this end, we recommend the state take the following steps:

- ***STEP 1: Convene a Steering Committee.*** DHHS should convene a cross-disciplinary, cross-division committee of people from various roles who can help develop a comprehensive plan for measuring and monitoring quality, reporting quality findings to the community, and determining how best to act on the information to improve the quality of services.
- ***STEP 2: Gather Public Feedback through Engagement.*** Using the QMS, DHHS should present baseline findings and have community conversations regarding the quality of services—with people receiving services, their families, support coordinators, providers, advocates, and other people interested in quality improvement. This engagement should be structured so that DHHS can hear what the community regards as the most important aspects of quality improvement to be measured.
- ***STEP 3: Prioritize Quality Goals.*** Following the community engagement step, the steering committee should establish goals that build on those in the QMS and include those important to the community. Taken together, the goals, measures (existing and future), and means to communicate them will form the strategy.
- ***STEP 4: Determine Necessary Additional Measures and Collection.*** In addition to those measures required through the QMS, DHHS will likely want to monitor other quality measures to better understand specific aspects of the service system. For example, building

on the Community First plan recommended in [Planning for Community](#), DHHS will want to monitor key aspects outlined in the plan. These may not be required in the QMS, but they are still important to DHHS. In this case, DHHS would need to explore means to collect measures related to goals outlined in the plan, such as the number of people diverted from segregated placements. DHHS may need to develop new collection activities to measure these additional measures.

- **STEP 5: Establish Communication Channels and Cadence.** Once all measures have been established, DHHS can determine the means to communicate the measures and baselines with the broader community. This may include publications, reports, presentations shared through existing channels or other methods to share information. Information should routinely be shared with the public so that service recipients, family members, providers, advocates, and others can evaluate the quality of the service system and provide input about what changes would further improve quality.
- **STEP 6: Develop Tactics for Improving Quality.** Following the collection of baseline data, the steering committee can take stock of the measures and reported data. This will enable the steering committee to explore areas where DHHS can make improvements. Using this data, the steering committee can outline specific strategies to address issues and improve services and supports. These tactics may need the support of other agencies or may require that new services or supports are developed.
- **STEP 7: Implement Long-Term Solutions for Continuous Quality Improvement.** The comprehensive quality improvement strategy should be a living strategy that is updated over time to reflect DHHS's current service system and what people receiving services identify as most important to their experiences and outcomes. Updates should be carefully considered to ensure that long-term data collection is not affected when such data is important. Finally, structures may need to be in place to ensure that tactics can be implemented, that the strategy measures quality, and that the focus is on continual improvement.

It is imperative that quality is driven by a shared vision of the future and strong relationships that help to move the strategy forward. As noted, DHHS has a Division of Continuous Quality and Improvement (CQI) that regularly performs tasks related to quality improvement of services. CQI may be instrumental in the development of a comprehensive quality improvement strategy. In addition to beginning this development, DHHS should continue to cultivate inter-governmental relationships as beginning steps to determine what possibilities exist for strengthening the strategy. DHHS should also consider adding cross-sectional representation to the CQI, such as service recipients and their families, providers, and advocates, or creating a comparable council of people to collaborate with the CQI on its quality improvement initiatives.

DHHS may also choose a more flexible approach that determines the composition of the council based on the specific topic or initiative. Building these relationships with intergovernmental agencies, people receiving services, family members, and provider agencies could lead to potential new data sources that were previously unavailable. With these data sources, DHHS may also be able to assess disparities in the service system. Data on disparities could potentially shed light on system

improvements that could make the system more equitable and efficient as well. With a comprehensive strategy, DHHS has the potential to move their service system forward. QIS implementation would allow DHHS to take tangible steps to meet its aims to improve quality and focus all people involved in the service system on improvement.

# Restructuring HCBS Waivers

DHHS currently operates nine different 1915(c) HCBS waivers across three operating divisions—DSPD, DIH, and DAAS. DHHS’s current strategy for matching people to available resources is to use separate 1915(c) waivers to:

- Target unique populations with narrow eligibility criteria
- Tailor service offerings to the primary needs of the targeted population
- Establish limits on entrance, cost limits and/or individual service limits to contain costs

At the onset of this LTSS project HSRI asked interested parties what they thought about the structure of Utah’s LTSS programs, and we learned that people often do not have knowledge of what waivers exist or what services are available. One support coordinator noted “I’ve been a support coordinator for 14 years and I didn’t know there are nine waiver programs.” This lack of knowledge felt particularly acute at different times in people’s lives. For example, one parent said “too many parents are in emergency mode while raising kids with disabilities and they hit the service cliff at graduation. I don’t think they know what’s offered.” Providers expressed concern with the number of differences between divisions and the need to have separate contracts depending on the various requirements for each service they deliver, since the services, while similar, vary considerably by division. One respondent simply said that “the waivers need to be consolidated, and the application process simplified and consolidated and then the agency lets you decide what services you need.” People we spoke with recognized the need for people with higher needs to be served sooner, also noting that it might mean some people don’t receive services at all. Issues with funding were also apparent. One respondent said “I’d like it if we could base funding more on need, have a better system for identifying needs and making the funds stretch further. More equity, I guess, but based on need.”

As reflected in comments above, some potential drawbacks to the current structure of the state’s LTSS programs include:

- People and families find it difficult to navigate the complex system.
- People may not be able to access services that meet their needs/desires or their service delivery preferences.
- Providers find it difficult to provide services across such a complex system.
- Inefficient resource allocation may constrain access.
- There is substantial administrative burden for DHHS staff in operating such a complex system.

Based on our research, the state should consider simplifying its 1915(c) HCBS waiver structure to address these concerns and remediate potential drawbacks of its current structure to better achieve its policy priorities.

In this section, we provide background for understanding our recommendations and our specific recommendations to restructure the HCBS waivers within the Utah LTSS system.

## Background for Restructuring HCBS Waivers

To understand Utah's options for restructuring its HCBS service system, it is important to review the totality of the Medicaid program. What follows is an overview of the Medicaid program. We provide an overview of how other states have structured their HCBS systems into dual or tiered waiver systems and describe the basis and purpose for equitable resource allocation. Additionally, we provide a detailed comparative analysis of key provisions across Utah's existing HCBS waivers to identify similarities and differences.

### Overview of Medicaid

Broadly, states provide Medicaid LTSS under state plan authority, waiver authority, and other program-specific authorities. Medicaid provides health coverage to millions of Americans, including elderly adults and people with disabilities—individuals who often need long-term services and supports.<sup>123</sup> Medicaid is administered by states and is jointly funded by the states and the federal government.<sup>124</sup> To operate and receive federal funding for its Medicaid programs, a state must comply with all applicable federal Medicaid statutes and regulations.

The basis of each state's Medicaid program is its Medicaid state plan. A Medicaid state plan is an agreement between a state and the federal government describing how that state administers its Medicaid programs.<sup>125</sup> The state plan identifies (among other things):

- groups of individuals to be covered,
- services (or benefits) to be provided,
- methodologies for providers to be reimbursed, and
- administrative activities to be performed by the state.<sup>126</sup>

Under Medicaid state plan authority, states must cover some populations within the state and may choose to offer eligibility to additional groups of individuals.<sup>127</sup> Similarly, states must offer a specific set of services (mandatory benefits) and may choose to offer additional services (optional benefits) to their beneficiaries.<sup>128</sup>

States may request a waiver of certain requirements under the Medicaid state plan authority to obtain additional flexibility to design and improve their programs. Except for the waived requirement(s), all other pertinent Medicaid statutory requirements continue to apply to the operation of a waiver program. Key waiver authorities are contained in Section 1915 (HCBS options) and Section 1115 (demonstration options) of the Social Security Act. Through an approved waiver program, states may obtain flexibility to:

- Target specific groups of individuals to receive select services (including targeting based on geographic location)
- Expand eligibility to individuals who are not otherwise Medicaid eligible
- Provide services that are not otherwise available under the Medicaid state plan

- Limit the provider pool from which individuals can receive services
- Operate experimental, pilot, or demonstration projects that promote the objectives of the Medicaid program and identify approaches to better serve the Medicaid population

## Medicaid LTSS Structure and Funding Authorities

A range of structure and funding authorities are available to state Medicaid programs to deliver LTSS to people with disabilities and older adults. Under most of these authorities, states have broad flexibility to design and implement unique LTSS programs to achieve their desired policy outcomes. Each Medicaid authority has a distinct purpose and specific requirements.

Mandatory state plan LTSS benefits include services like nursing facility services and home health services, while optional state plan LTSS benefits include services like private duty nursing services, personal care services, and services provided in an ICF-IID.

Medicaid waiver authorities that can be used to provide LTSS include:

- Section 1915(c) HCBS Waivers
- Section 1915(i) State Plan HCBS Benefit
- Section 1915(j) Self-Directed Personal Assistance Services (PAS) Program
- Section 1915(k) Community First Choice Option
- Section 1115 Research and Demonstration Waivers
- Section 1915(b) Waivers

Medicaid program-specific authorities that can be used to provide LTSS include:

- Money Follows the Person
- Program of All-Inclusive Care for the Elderly
- Health Homes
- In Lieu of Services Under Managed Care Programs

Except for Section 1915(c) HCBS waivers, which are discussed below, details regarding all other listed LTSS authorities are provided in [Appendix E: Medicaid LTSS Authorities](#).

## Section 1915(c) HCBS Waivers

Prior to 1981, the Medicaid program had an institutional bias given that Medicaid reimbursement for long-term services and supports was available only in skilled nursing facilities and intermediate care facilities, and Medicaid reimbursement was not available to support community alternatives.

Advocates pushed to rectify this imbalance and their efforts succeeded when Section 1915(c) was added to the Social Security Act in 1981.<sup>129</sup> Section 1915(c) authorized the Medicaid Home and Community-Based Services waiver program, which allows states to provide services and supports to individuals in their own homes or communities rather than institutions or other isolated settings.<sup>130</sup>

Section 1915(c) permits the Secretary of Health and Human Services to grant waivers of three provisions of the Medicaid statute (Title XIX of Social Security Act):

- Section 1902(a)(10)(B) (Comparability). Waiver of this provision permits a state to offer HCBS (which are not otherwise available under the Medicaid state plan) to limited groups of individuals as an alternative to institutional care.<sup>131</sup>
- Section 1902(a)(1) (State-wideness). Waiver of this provision permits a state to offer HCBS in a limited geographic area.<sup>132</sup>
- Section 1902(a)(10)(C)(i)(III) (Income and Resources). Waiver of this provision permits a state to exclude a spouse’s income to keep medically needy individuals eligible for Medicaid and enrolled in HCBS, without requiring institutionalization.<sup>133</sup>

Section 1915(c) does not give the Secretary the authority to waive any other provisions of the Act.<sup>134</sup> Therefore, all other pertinent Medicaid statutory requirements apply to the operation of a waiver.<sup>135</sup>

Nearly all states and the District of Columbia offer services through 1915(c) HCBS waivers. States can and typically do operate multiple 1915(c) waivers at one time that may vary in terms of service menu and funding caps. More than 250 HCBS waiver programs are active nationwide.

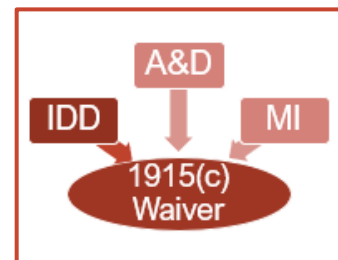
### **Notable Features of a 1915(c) HCBS Waiver**

#### **Targeted Populations**

States are permitted to limit eligibility to specific populations, including older adults, people with physical and other disabilities, people with intellectual or developmental disabilities, and/or people with mental health and substance use disorders.<sup>136</sup> Additionally, more discrete targeting criteria may be used, such as (a) nature or type of disability, (b) specific diseases or conditions, and (c) functional limitations—for example, the extent of assistance required in activities of daily (ADLs) and/or instrumental activities of daily living (IADLs).<sup>137</sup>

Prior to 2014, a state could only target one population per waiver. With the promulgation of the 2014 HCBS Final Settings Rule, the Centers for Medicare and Medicaid Services (CMS) allowed states to combine waivers for multiple target groups under one waiver authority.<sup>138</sup> Now states may design HCBS programs that meet the needs of multiple target groups (see Figure 6), a benefit to states that seek to further person-centered approaches to service delivery by ensuring individuals, regardless of a particular diagnosis, receive the services they need. Additionally, serving multiple target groups under a single waiver program maximizes administrative simplicity.

*Figure 6. Target Groups*



#### **Financial Eligibility**

To be eligible to receive waiver services, individuals must be a member of a “financial” eligibility group (e.g., SSI beneficiaries) covered under the Medicaid state plan and that the state has decided to also cover in the waiver.<sup>139</sup> For the “special HCBS waiver group,” states may extend eligibility to individuals with income up to 300% of the SSI federal benefit rate (FBR).<sup>140</sup>

## **Additional Characteristics of a 1915(c) HCBS Waiver**

In addition to the notable features discussed above, 1915(c) HCBS waivers have the following additional characteristics that shape how services are designed, administered, and delivered:

- **Number of Individuals Served.** States can limit the number of individuals served and waiting lists are allowed.<sup>141</sup>
- **Geographic Areas Served.** States can limit geographic areas served.<sup>142</sup>
- **Functional Eligibility.** Individuals must be determined to require the level of care furnished in a hospital, nursing facility, or ICF-IID.<sup>143</sup>
- **Cost Limits.** State may restrict enrollment into, and ongoing participation in, a waiver based on the expected cost of HCBS that would be furnished to a person.<sup>144</sup>
- **Reserved Capacity.** A state may reserve a portion of a waiver's capacity for specified purposes.<sup>145</sup>
- **Service Offerings.** States have flexibility to set the number and types of included services.<sup>146</sup> Settings where individuals receive support must comport with the settings regulatory rules.<sup>147</sup>
- **Availability of Self-Direction.** States may permit individuals to direct and manage some or all of their waiver services.<sup>148</sup>
- **Resource Allocation/Budgets.** States may establish dollar limits on a service, set of services, or all authorized waiver services.<sup>149</sup>
- **Hiring of Relatives.** States may authorize and set the policies for legally responsible individuals, legal guardians, and/or other relatives to furnish waiver services.<sup>150</sup>
- **Quality Assurance.** States must design a quality improvement strategy.<sup>151</sup>
- **Financial Tests/Requirements.** States must demonstrate the waiver is cost neutral.<sup>152</sup>
- **Reporting and Evaluation.** States must submit evidence of ongoing quality and cost neutrality on an annual basis.<sup>153</sup> Additionally, states must submit evidence of compliance with waiver assurances 24 months prior to renewal. Beginning in July 2027, states with waiting lists will be required to submit annual waiting list data.<sup>154</sup>
- **Federal Financial Participation.** States receive regular Federal Medical Assistance Percentage (FMAP) for the cost of HCBS waiver services.<sup>155</sup>

## **Dual/Tiered Waiver Structures**

Using a dual or tiered approach, an increasing number of states operate two or more Medicaid HCBS waivers to offer various levels/types of support to a targeted population.

There are several policy rationales for states electing to operate or restructure their waivers using a dual or tiered approach. These policy rationales include:

- reducing the high per-person costs of HCBS by avoiding the high costs of furnishing 24/7 residential services and focusing on delivering services and supports in the family home;
- leveraging and complementing the supports that are furnished by family caregivers;
- achieving broad policy goals such as encouraging CIE, or supporting individuals to transition from institutional settings to their community;

- complying with the requirements set forth by CMS State Medicaid Director Letter #01-006 (aka Olmstead Letter #4); and
- expanding services to more economically serve people with disabilities who have been wait-listed for services, sometimes in response to a lawsuit.<sup>156</sup>

When states administer dual or tiered waivers, these waivers are typically structured around distinct policy goals (purpose) and/or differentiated by the level of support offered. When structured around distinct policy goals, a waiver may target more specific groups of people—like only children or only youth transitioning from childhood to adulthood.

When differentiated by the level of support offered, waivers operated using a dual waiver structure are commonly called “supports” waivers and “comprehensive” waivers.<sup>157</sup> In a tiered waiver structure, the third waiver is often known as a “mid-tier” waiver. Supports waivers are typically characterized by individual cost limits/budget limits and curated service offerings, while comprehensive waivers are typically characterized by higher individual costs and more extensive service offerings. As its name suggests, costs and service offerings for mid-tier waivers often fall somewhere between a supports waiver and a comprehensive waiver.

Despite these differences, all HCBS waivers must set service plan development expectations, specify whether individuals may self-direct their services, describe individuals’ rights in connection with receiving services, require a quality assurance and system improvement strategy, and ensure financial accountability.

### ***Characteristics of a Supports Waiver***

Supports waivers are typically characterized by cost/budget limits and curated service offerings.

#### **Cost/Budget Limits**

The first defining characteristic of supports waivers is an overall dollar limitation on the amount of services that may be authorized for individual waiver participants.<sup>158</sup> The per person cost in supports waivers is typically less than the per person cost in comprehensive waivers.<sup>159</sup> A state may limit or cap the maximum dollar amount it expects to authorize for each person by setting an individual cost limit and/or a budget limit in their approved waiver application.

An individual cost limit is a “limitation on the entrance of individuals to a waiver [and ongoing participation in the waiver] that is based on the comparison of the expected costs of HCBS waiver and state plan services to the expected costs of institutional and State plan services that the person would receive in lieu of participation in the waiver.”<sup>160</sup> “When a state adopts an individual cost limit, the state denies entrance to the waiver when the expected cost of HCBS waiver and State plan services required by an individual exceeds the limit established by the state.”<sup>161</sup> Information on individual cost limits is found in Appendix B-2 of approved §1915(c) waiver applications.

A budget limit is a limitation on the maximum dollar amount that the state makes available for the provision of waiver services to an individual.<sup>162</sup> Budget limits may be set using an amount that is uniquely assigned to each individual, graduated amounts based on level of support need, or another

method such as “baseline” budget allocations that apply to all individuals.<sup>163</sup> Information on individual budget limits is found in Appendix C-4 of approved §1915(c) waiver applications.

### **Curated Service Offerings**

The second defining characteristic of supports waivers is a curated or limited-service offering. Supports waivers are often designed to complement the unpaid supports provided by family caregivers and other community resources.<sup>164</sup> Because there is an expectation that family members will provide significant support to waiver participants,<sup>165</sup> service arrays in supports waivers often offer “limited” in-home habilitation supports and often do not offer 24-hour residential services. These services may also be uniquely targeted toward people living independently or with families that match services to these settings such as benefits counseling to support people who are employed or family training to help families provide effective support.

For supports waivers, in-home habilitation supports are typically “limited” in the following ways:

- Limited by Duration (e.g., less than 24 hours per day)
- Limited by Cost (e.g., less than specified dollar amount per year)
- Limited by Delivery Method (e.g., remote instead of face-to-face delivery)
- Limited by Grouping (e.g., provided to a group of people instead of on a one-to-one basis)

Information on services offered and per person limits for specified services is found in Appendix C-1 of approved §1915(c) waiver applications.

### ***Characteristics of a Comprehensive Waiver***

Comprehensive waivers are typically characterized by higher individual costs and more extensive service offerings.

#### **Higher Costs/Budget Limits**

Comprehensive waivers typically do not employ a cost limit barring entrance to the waiver. Some comprehensive waivers set budget limits while others do not. When comprehensive waivers set a budget limit, the limit is typically higher than the cost limit/budget limit used in supports waivers.

#### **More Extensive Service Offerings**

Comprehensive waivers usually provide more extensive services than supports waivers, including 24-hour in-home habilitation supports and/or services furnished in a licensed residential facility outside the family home.

## Spotlight on Georgia's Dual Waiver Structure

The state of Georgia operates the Comprehensive Supports Waiver Program (see Georgia waiver number GA.0323) and its New Options Waiver Program (see Georgia waiver number GA.0175). Its supports waiver (GA.0175) utilizes a cost limit lower than institutional costs at \$65,000.

Individual budget amounts under this supports waiver are determined by an algorithm up to the individual cost limit. The supports waiver does not offer an out-of-home residential service option but does provide natural support training and community guide services that are not offered on the corresponding comprehensive waiver.

The comprehensive waiver (GA.0323) does not utilize a cost limit but does set budget limits on sets of services. This comprehensive waiver does offer an out-of-home residential service option and additional residential staffing supports.

## Outliers

While we have identified the defining characteristics of supports waivers and comprehensive waivers, there are outliers. Some supports waivers do not set an individual cost limit or have an individual budget limit. Instead, these waivers substantially limit their service array by not offering any high-cost in-home habilitation supports or by setting a low-value maximum dollar amount per person for a single high-cost service or a combination of high-cost services (typically in-home habilitation supports).

## Pathways for Waiver Entrance

A state may establish pathways for waiver entrance using reserved capacity and/or waiting lists. In a supports/comprehensive waiver structure, reserved capacity may also be used to ensure an individual's timely transition from a supports waiver to a comprehensive waiver when their needs change.

### Reserved Capacity on Comprehensive Waivers

A state may reserve a portion of a waiver's capacity for specified purposes.<sup>166</sup> Reserving waiver capacity means that some waiver openings (aka "slots") are set aside for people who will be admitted to the waiver on a priority basis for the purpose(s) identified by the state.<sup>167</sup> Capacity may be reserved for more than one purpose.<sup>168</sup>

Two categories of reserve capacity often used by states include the transition category and the emergency category.

- **Transition Category.** In a supports/comprehensive waiver structure, where the supports waiver includes a cost limit or a budget limit, states are required to safeguard people's health and safety when the amount of the limit is insufficient to meet the person's needs.<sup>169</sup> In this case, reserved capacity may be used to ensure the person's timely transition from a supports waiver to a comprehensive waiver where more resources may be available.<sup>170</sup> Typical

“transition” category language may include (excerpt from Alaska waiver number AK.0260): The state reserves capacity (10 slots) in its comprehensive waiver for people on the Individualized Supports Waiver if their health and safety can no longer be supported on that waiver.

- **Emergency Category.** Typical “emergency” category language includes (excerpt from Alabama waiver number AL.0001): New admissions to the waiver who would otherwise be homeless or subject to abuse or neglect, or in significant danger of harm from other sources and require immediate intervention.

Other categories of reserve capacity that may be of interest include reserve capacity for (a) children (18–21) transitioning from out-of-state residential placements (see Maryland waiver number MD.0159), (b) individuals transitioning from VR supported employment to waiver supported employment services (see North Dakota waiver number ND.0037), (c) individuals transitioning from educational services (see Maryland waiver number MD.0023) and (d) individuals transitioning from the MFP program or qualified institutions to an HCBS waiver (see Indiana waiver number IN.0210).

### Waiting Lists for Supports Waivers and Comprehensive Waivers

A state may limit the number of individuals who participate in a waiver, and establish a waiting list for waiver services (e.g., entrance to the waiver of otherwise eligible applicants must be deferred until slots become available as a result of turnover or the appropriation of additional funding by the legislature).<sup>171</sup> If it is necessary to defer entrance to the waiver, a state must have policies that govern the selection of individuals when capacity becomes available.<sup>172</sup>

Based on HSRI’s review of waiting list policies, states typically use one or a combination of the following three methods to govern selection of individuals for entrance into a comprehensive waiver:

- **Application Date** — Entry to the waiver is offered to individuals based on the date of their application for the waiver services (first come, first served).
- **Health & Safety Emergency** — Entry to the waiver is prioritized based on the imminent need for services.
- **Level of Need** — Entry to the waiver is prioritized based on assessed need.

### Equitable Resource Allocation Models

Under the 1915(c) waiver authority, states may establish limits on the maximum dollar amount of waiver goods and services that are authorized in a person’s service plan. Sometimes such limits are termed “budgets,” “budget allocations,” or “supports budgets.”<sup>173</sup> The overarching principles and methodologies used to establish these budgets are known as a resource allocation model.

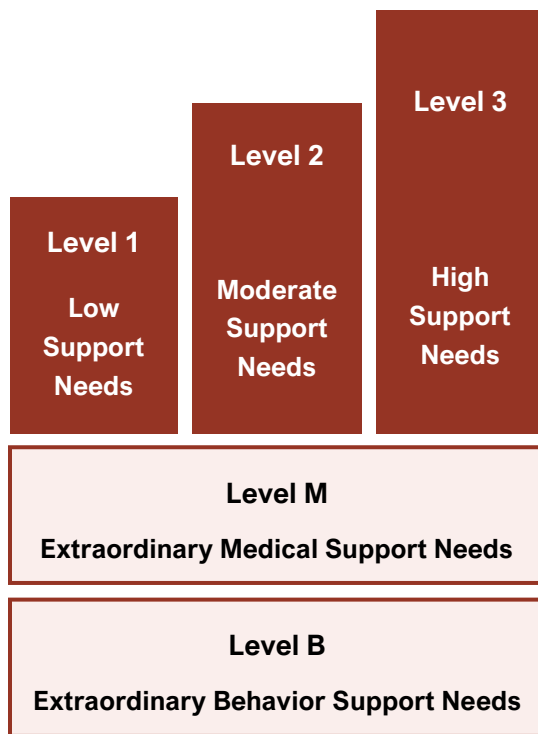
When budgets are used, we recommend an equitable resource allocation model that develops and implements budget limits by level of support.

## Description of Resource Allocation Model Using Supports Budgets and a Level-Based Framework

A supports budget is an individually based, prospectively determined amount of funds that is made available to waiver participants to plan for the services and supports they need and prefer.

Supports budgets are assigned to an individual according to a support level framework. Under a support level framework, states group people who share similar characteristics and/or assessed support needs into support levels and then assign budget amounts to each level based on anticipated cost of services. Typically, budget amounts increase as assessed support need increases.

Figure 7. Example Level-Based Framework Waiver Structure



A person is assigned to one support level based on their responses to a support needs assessment. Each level is associated with a budget amount that is commensurate with the needs of people in that level. Supports budgets are made known to individuals prior to their service planning meeting to support their decision-making about selecting services.

The number of support levels and associated budgets can vary based on a number of factors including but not limited to support needs of individuals served, available resources, state policy goals, and community input.

For illustrative purposes, if a state were to establish a five-level framework, then Levels 1, 2, and 3 may include individuals with low, moderate, and high general support needs, respectively. Level M is assigned to individuals with extraordinary medical support needs, while Level B is assigned to individuals with extraordinary behavioral support needs. Figure 7 provides a visual depiction of this framework.

Supports budgets for each level within the framework are developed using a model service mix. A model service mix is an estimate of the types and amounts of services needed by individuals in each support level and living setting. People are not required to use the specific services that are included in the model service mix. They can then use their assigned budget to purchase the combination of services that best meet their own unique needs. Additionally, a state can designate certain services as “add-on” services. People can receive additional dollars above their assigned supports budget for add-on services. Figure 8 provides a visual depiction of a model service mix and designated add-on

services. Finally, states establish processes to consider exceptions (or budget increases) for people with unique needs outside the typical needs of their assessed support level.

*Figure 8. Example Service Mix – Own Home*

Support Level	1	2	3	M	B
Companion Services	10	13	13	15	14
Day Supports - Group	10	13	13	15	14
Day Supports - Individual	5	5	5	4	5
<b>Total Hours</b>	<b>25</b>	<b>31</b>	<b>31</b>	<b>34</b>	<b>33</b>

Example Add-On Services
Supported Employment Services
Skilled Nursing Services
Specialized Medical Equipment
Home Delivered Meals
Non-Medical Transportation

A support level framework is intended to create a system of allocating resources that is fair, efficient, person-centered, and flexible. It is a data-driven, mixed-methods, and defensible means of determining budgets that also includes multiple avenues for people to seek support for unique needs not captured in the framework. Additional benefits of using a level-based framework include:

- Transparent (simple to explain and understand)
- Flexible choice of services
- Can accommodate changes (e.g., rates, new services, policies)
- Better understanding of individuals receiving (or waiting for) services
- Improved ability to predict spending based on known needs

States may choose to implement a support level framework and supports budgets to:

- Reduce crisis-driven system by offering timely support
- Promote sustainability and reduce “service only” orientation
- Efficiently allocate limited resources across increasing demands

### ***Overview of Supports Needs Assessment Instruments***

States use a standardized assessment instrument to evaluate the relative support needs of individuals and ultimately assign supports budgets by level of support. Some states develop their own support needs assessment instruments.

## Spotlight on Connecticut’s Level of Need Assessment and Screening Tool

Connecticut’s Level of Need Assessment and Screening Tool (LON) is used to assess individual need for supports and services and to allocate resources based on individual level of support need. Key areas assessed by the tool are health and medical; personal care activities; daily living activities; behavior; safety; support for waking hours, overnight support, comprehension and understanding, communication; transportation; social life, recreation, community activities; and unpaid caregiver support. A web-based data application generates a profile made up of a score in each of the various domains assessed and a composite LON score as well as an individualized risk profile that can be used to inform development of the person’s service plan.

The LON was originally created and used in Connecticut. It later came to be used in DC.

[Level of Need Assessment and Screening Tool](#)

[Level of Need Assessment and Screening Tool Manual](#)

While there may be state-developed assessments that Utah will want to consider for assigning supports budgets by level of support, DHHS may also want to consider commercially available assessment instruments. One example is the interRAI,<sup>174</sup> which is a suite of compatible tools built for a variety of populations. All the interRAI instruments are meant to be compatible with each other in terms of assessment items, language, definitions, time frames, and scoring, with the idea that each assessment can be used in conjunction with any other appropriate assessments within the suite. Common to the suite is a set of core items that include ADLs, IADLs, and cognitive performance. To allow for more state-specific information gathering, additional items that relate to a certain population can be added to the core items in these instruments, and existing items that do not apply can be eliminated. States may add an unlimited number of items, but they may only eliminate less than 5% of the existing items.

## Comparative Analysis of Utah’s Existing 1915(c) HCBS Waiver Programs

To develop informed recommendations for restructuring Utah’s 1915(c) HCBS waivers, it is essential to first understand how key provisions align or differ across DHHS’s existing waivers. This analysis can help DHHS identify opportunities for greater alignment and determine the level of complexity involved in consolidating or reconfiguring its current HCBS waiver system.

The tables in [Appendix F: Comparative Analysis of Existing 1915\(c\) HCBS Waiver Programs](#) offer a detailed comparison of key provisions across Utah’s existing waivers.

## Recommendations for Restructuring HCBS Waivers

DHHS should consider consolidating and/or reconfiguring its current HCBS waiver structure into a dual waiver structure within each of the three DHHS operating divisions—DIH, DAAS, and DSPD. Coupled with an equitable resource allocation model and sound reimbursement methodologies (including rate tiers), this waiver structure may improve the long-term sustainability of Utah’s HCBS waiver programs and help DHHS achieve its policy priorities to:

- Simplify the HCBS waiver system to make it easier to navigate
- Reduce administrative burden for DHHS staff
- Broaden service offerings to meet individuals’ unique needs and preferences
- Establish strategy for efficient and equitable resource allocation
- Expand access to HCBS to more people

In our prior research and experience, HSRI has found that states working to consolidate and/or reconfigure their HCBS waiver structures use a phased approach to implementation. They often begin by aligning system components (where feasible) and making foundational changes that will enable the broader restructuring. Once these preliminary changes are made, states move forward with broader restructuring. By using this phased approach and making incremental changes over time, states can ensure that staff responsible for the restructuring will have the time needed to perform their regular duties while also working on the restructuring. Additionally, a phased approach can disperse and reduce significant disruptions to individuals and families.

In the sections below we discuss recommendations for how Utah may effectuate a two-phased approach to restructuring. We describe the types of changes DHHS should consider, providing both broad ideas for possible changes and some specific options for interested parties to weigh and consider.

When a state considers streamlining or reconfiguring its HCBS waivers, it should give careful thought to the input from people with lived experience, families and other interested parties, the state’s policy goals and priorities, whether the state has the capacity to implement such changes, and whether the changes are financially sustainable. The information that follows does not represent a comprehensive or final restructuring plan. Additional design and implementation details will need to be determined by DHHS. Moreover, some of the potential changes outlined may not be feasible for Utah to pursue.

**These recommendations are a starting point for discussions with interested parties.** If the state elects to proceed with these changes, HSRI recommends discussing these proposed changes with interested parties early and often, and adjusting the proposed changes (as appropriate) based on the feedback received.

### Phase 1: Align Existing Waivers (Where Feasible) and Make Essential Improvements

Below we outline the recommendations for Phase 1 of the restructuring; these include updating existing waiver service arrays to better support people with complex needs, updating quality

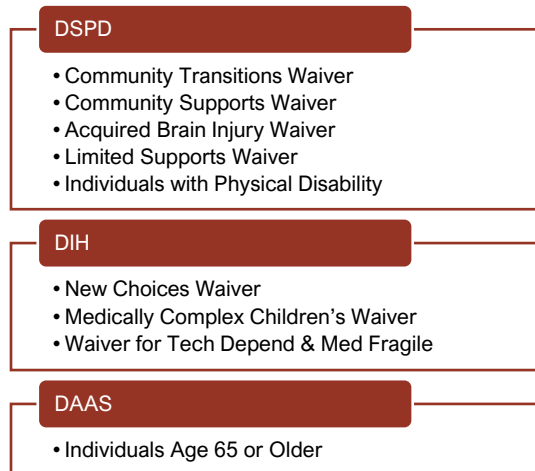


performance measures and data collection processes, and setting the foundation for developing and implementing an equitable resource allocation model.

### **Mechanism for Change**

The recommendations for Phase 1 of the proposed restructuring would require the state to prepare and submit separate amendments to CMS for each of its existing 1915(c) HCBS waivers. It is important to note that these Phase 1 recommendations do not require consolidation of any existing waivers or sunseting any existing waivers, nor do they require creating any new waivers. Figure 9 provides a visual depiction of the state’s current 1915(c) waiver structure.

*Figure 9. Current 1915(c) Waiver Structure*



### **Update Existing Waiver Service Arrays to Better Support People with Complex Needs**

Complex needs have an identifiable impact on the health, safety, and day-to-day activities of a person receiving LTSS, including people with disabilities and older adults. Individuals with the most complex needs often have both medical and behavioral support needs. Below are the specific recommendations for service changes to better support people with complex needs.

#### **Professional Nursing and Nursing Oversight Services**

Support from a nursing professional and more extensive nursing coordination/oversight can be essential to ensuring good health outcomes for individuals with a combination of complex medical and behavioral support needs.

As recommended to prioritize Community First, DHHS should make professional nursing services available in all nine of its 1915(c) HCBS waivers. Service descriptions and options are discussed in more detail in the [Prioritizing Community First](#) section and in [Appendix B](#). To ensure that the relationship between state plan nursing services and waiver nursing services is seamless, HSRI recommends offering private duty nursing services in each waiver as “Extended State Plan” services. When a state wants to enhance the amount, duration, or frequency of a state plan service but otherwise the scope of the service is the same as the state plan service, the service is considered an “extended state plan” service.<sup>175</sup> The amount chargeable as waiver services is the amount incurred after any limits in state plan services are exhausted.<sup>176</sup>

For the MCCW and TDW that serve only children under age 21, it is important to note that extended state plan nursing services may not be furnished as waiver services to children unless the waiver authorizes these services beyond what is considered medically necessary under the [Early and Periodic Screening, Diagnostic and Treatment](#) benefit.<sup>177</sup> The EPSDT benefit provides

comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid.

While private duty nursing is the provision of nursing services on a continuous or full-time basis as defined in 42 CFR § 440.80, skilled nursing is the provision of nursing services on an intermittent or part-time basis.<sup>178</sup> As an alternative to extended state plan private duty nursing, the state could consider offering a skilled nursing service in some or all of its waivers.

The table below provides a detailed description of the changes required to make professional nursing services available as extended state plan services in the state’s existing 1915(c) HCBS waivers.

*Table 25. Professional Nursing Services*

Waiver	Recommended Change	Allow SAS?	Payment to Legally Responsible Individuals	Payment to Other Relatives
<b>CSW</b>	Add extended state plan private duty nursing services	No	No	No
<b>CTW</b>	Modify existing professional nursing services to extended state plan private duty nursing services	No	No	No
<b>LSW</b>	Add extended state plan private duty nursing services	No	No	No
<b>PDW</b>	Add extended state plan private duty nursing services	No	No	No
<b>ABI</b>	Add extended state plan private duty nursing services	No	No	No
<b>NCW</b>	Add extended state plan private duty nursing services	No	No	No
<b>MCCW</b>	Add extended state plan private duty nursing services	No	No	No
<b>TDW</b>	Retain existing extended state plan private duty nursing services	No	No	No
<b>AGW</b>	Add extended state plan private duty nursing services	No	No	No

Additionally, as recommended to prioritize Community First, DHHS should make a nursing coordination/oversight service available in all nine of its 1915(c) HCBS waivers. Service descriptions and options are discussed in detail in the [Prioritizing Community First](#) section and in [Appendix B](#). The table below provides a detailed description of the changes required to make a nursing coordination/oversight service available in the state’s existing 1915(c) HCBS waivers.



Table 26. Nursing Coordination/Oversight Services

Waiver	Recommended Change	Allow SAS?	Payment to Legally Responsible Individuals	Payment to Other Relatives
<b>CSW</b>	Add nursing coordination/oversight services	No	No	No
<b>CTW</b>	Add nursing coordination/oversight services	No	No	No
<b>LSW</b>	Add nursing coordination/oversight services	No	No	No
<b>PDW</b>	Add nursing coordination/oversight services	No	No	No
<b>ABI</b>	Add nursing coordination/oversight services	No	No	No
<b>NCW</b>	Add nursing coordination/oversight services	No	No	No
<b>MCCW</b>	Add nursing coordination/oversight services	No	No	No
<b>TDW</b>	Add nursing coordination/oversight services	No	No	No
<b>AGW</b>	Add nursing coordination/oversight services	No	No	No

### Home Health Services

Similar to professional nursing services, access to home health services can be essential to ensuring good health outcomes for individuals with a combination of complex medical and behavioral support needs.

As recommended to prioritize Community First, DHHS should make home health services available in all nine of its 1915(c) HCBS waivers. Service descriptions and options are discussed in more detail in the [Prioritizing Community First](#) section above and in [Appendix B](#). To ensure that the relationship between state plan home health services and waiver home health services is seamless, HSRI recommends offering home health services in each waiver as “Extended State Plan” services.

For the MCCW and TDW waivers that serve only children under age 21, the EPSDT limitations for extended state plan private duty nursing would also apply to extended state plan home health services.<sup>179</sup>

The table below provides a detailed description of the changes required to make the [home health services](#) available in the state’s existing 1915(c) HCBS waivers.

Table 27. Home Health Aide Services

Waiver	Recommended Change	Allow SAS?	Payment to Legally Responsible Individuals	Payment to Other Relatives
<b>CSW</b>	Add extended state plan home health aide services	No	No	No
<b>CTW</b>	Add extended state plan home health aide services	No	No	No
<b>LSW</b>	Add extended state plan home health aide services	No	No	No
<b>PDW</b>	Add extended state plan home health aide services	No	No	No
<b>ABI</b>	Add extended state plan home health aide services	No	No	No
<b>NCW</b>	Retain extended state plan supportive maintenance services	No	No	No
<b>MCCW</b>	Add extended state plan home health aide services	No	No	No
<b>TDW</b>	Retain extended state plan home health aide services	No	No	No
<b>AGW</b>	Retain enhanced state plan supportive maintenance home health services	No	No	No

### Behavior Consultation

As recommended to prioritize Community First, DHHS should make behavior consultation services available in all nine of its 1915(c) HCBS waivers. Additionally, the state should allow such services to be provided via telehealth. These options are discussed in detail in the [Prioritizing Community First](#) section.

The table below provides a detailed description of the changes required to make behavior consultation services available in the state’s existing 1915(c) HCBS waivers.

Table 28. Behavior Consultation Services

Waiver	Recommended Change	Allow SAS?	Payment to Legally Responsible Individuals	Payment to Other Relatives
<b>CSW</b>	Retain/enhance behavior consultation services	No	No	No
<b>CTW</b>	Retain/enhance behavior consultation services	No	No	No
<b>LSW</b>	Replace applied behavioral analysis therapy and behavioral services with behavior consultation services	No	No	No
<b>PDW</b>	Add behavior consultation services	No	No	No
<b>ABI</b>	Retain/enhance behavior consultation services	No	No	No
<b>NCW</b>	Add behavior consultation services	No	No	No
<b>MCCW</b>	Add behavior consultation services	No	No	No
<b>TDW</b>	Add behavior consultation services	No	No	No
<b>AGW</b>	Add behavior consultation services	No	No	No

### Demonstrate Cost Neutrality

The changes recommended above would also require updates to Appendix J. Once the nature of the changes have been finalized, DHHS should consult with their financial advisors to ensure accurate updates are made to the cost neutrality demonstration of each waiver.

### Dependency on Phase 2

The service array updates proposed as part of Phase 1 of the restructuring can be implemented even if the state decides not to proceed with other Phase 1 changes or any of the Phase 2 changes.

### Update Quality Performance Measures and Data Collection Processes

As recommended in the [Improving Quality](#) section, the state should update the quality improvement performance measures and data collection and aggregation processes in each waiver to ensure compliance with the Access Rule requirements and to align/consolidate performance measures across current waivers to reduce the administrative burden and improve comparability.

Quality improvement performance measures can be found in the following waiver appendices:

*Table 29. Quality Improvement Section of 1915(c) Waiver*

<b>Appendix Number</b>	<b>Appendix Title</b>
<b>Appendix A</b>	Quality Improvement: Waiver Administration and Operation
<b>Appendix B</b>	Quality Improvement: Level of Care (LOC) Determination
<b>Appendix C</b>	Quality Improvement: Qualified Providers
<b>Appendix D</b>	Quality Improvement: Service Plan
<b>Appendix G</b>	Quality Improvement: Health and Welfare
<b>Appendix I</b>	Quality Improvement: Financial Accountability

### **Dependency on Phase 2**

The quality improvement updates proposed as part of Phase 1 of the restructuring can be implemented even if the state decides not to proceed with other Phase 1 changes or any of the Phase 2 changes.

### ***Set Foundation for Implementing Equitable Resource Allocation Model***

As discussed in the background section of these recommendations, 1915(c) waiver authority allows states to establish limits on the maximum dollar amount of waiver goods and services authorized for each person. The overarching principles and methodologies used to establish these budgets are known as a resource allocation model. When a budget is used, HSRI recommends an equitable resource allocation model that develops and implements budget limits by level of support.

Before a state can implement an equitable resource allocation model, it must first select a support needs assessment instrument. Additionally, HSRI recommends the state begin work to align its reimbursement methodologies and rates where appropriate and/or feasible.

### **Select a Support Needs Assessment Instrument**

The state will need to select a support needs assessment instrument that would be used to assess people’s level of support needs and then collect representative sample data that can be used to develop the future resource allocation model recommended in Phase 2 below. The steps outlined in this section provide an overview of the possible steps DHHS could use to select a support needs assessment instrument or instruments for use in the state’s HCBS waiver programs.

#### *Identify and Narrow Assessment Instrument Options*

The purpose of this first step is to identify assessment instruments that are generally appropriate for assigning supports budgets by level of support need and then to narrow the list to only the assessments that meet basic criteria established by the state. The idea is for the state to generate a list of assessments instruments (which are generally acceptable to the state) that can then be reviewed in detail with interested parties to obtain their feedback. State staff could then use their

expertise together with the expertise of interested parties to select the best assessment instrument for use in Utah's HCBS waiver programs.

First, to identify assessment instruments that are generally appropriate for assigning supports budgets by level of support need the state could conduct a national scan of assessment instruments used in other states for assigning supports budgets by level of support need. Next the state could establish a set of criteria it can use to determine whether each assessment instrument would be appropriate for use in Utah's HCBS waiver programs. While the state should establish criteria it deems important, some possible considerations are:

- Is the assessment statistically valid and reliable?
- Can the assessment accurately assess support needs of individuals with disabilities, and/or older adults?
- Is the assessment appropriate for use across an individual's lifespan or only a specific portion of their lifespan (e.g., appropriate for only children, adults or both)?
- How recently has the assessment been developed and/or updated?
- Does the state also want to use the assessment for other purposes such as LOC determinations? If yes, will the assessment assess the necessary LOC criteria and relevant supports needs?
- What is the cost to use the assessment instrument?

The state should then apply their criteria to each of the assessments identified in the national scan to determine which assessments are appropriate and/or feasible for use to assign supports budgets by level of support need in Utah's HCBS waiver programs. If publicly available information is not sufficient to apply the set criteria, HSRI recommends the state reach out to the authors of the assessments to obtain additional information necessary to complete this analysis.

### *Select Assessment Instrument*

The involvement of people with disabilities and their families is critical to the success of the assessment selection process. Elevating the voices of those impacted by changes to resource allocation methods allows the resulting assessment recommendation to reflect what is most important. Others who are knowledgeable about the system may also have important insights to share to improve recommendations. To this end, HSRI recommends a two-pronged approach to obtaining input and feedback from interested parties about support needs assessment instrument(s).

First, DHHS should consider establishing an advisory group to make a recommendation to DHHS about what they believe is best assessment instrument(s) for use in Utah's HCBS waiver programs. This advisory group should prioritize the voices of people and families, but its membership should represent all of the following groups of people:

- People receiving services and families
- Advocacy organizations
- Support coordination organizations
- Direct support provider organizations



- Assessment experts
- DHHS staff

This advisory group could be tasked with:

- Establishing in-depth assessment instrument evaluation criteria
- Reviewing narrowed assessment instruments and related guidelines
- Evaluating narrowed assessment instruments against in-depth criteria
- Making a recommendation for a supports needs assessment instrument(s) to DHHS

Second, the state should conduct broader engagement with interested parties throughout the assessment instrument selection process. Beyond the advisory group, the state should endeavor to engage additional individuals and families and organizations. This broader engagement could include listening sessions that provide both an opportunity to learn about supports budgets and assessments and an opportunity for people to weigh in on what is important to them in an assessment. Sessions may be tailored to accommodate specific audiences such as self-advocates, families, providers, service coordinators, and foreign language speakers. Feedback received from the listening sessions should be presented to the advisory group and DHHS staff to incorporate feedback as appropriate.

DHHS staff should then consider the recommendations provided by the advisory group and input from the broader engagement to select one or more support needs assessments to be used to assess individuals' level of support needs in Utah's HCBS waiver programs.

#### *Collect Representative Sample Assessment Data*

Once an assessment instrument is selected, DHHS will need to develop and implement a plan to assess a representative sample of waiver participants and people on the waiting list with the selected assessment instrument(s) to collect the data necessary to design the future resource allocation model.

#### **Align Reimbursement Methodologies and Rates (Where Feasible)**

When looking at consolidating services under two waivers in each division, the consolidation or reconfiguration would be easier if the rate determination methodologies in the existing waivers are aligned.

Burns & Associates, a division of Health Management Associates (HMA-Burns) was recently selected to complete a comprehensive study of payment rate methodologies for HCBS delivered through Medicaid waivers operated by DSPD. The rate study includes agency-managed services and SAS. HMA-Burns has completed its final recommendations for the waiver rate study and the final recommended rate models. HMA-Burns recommended the establishment of standardized independent rate models for most services, instead of using individual rate worksheets.

The independent rate models being developed by HMA-Burns offer the following benefits:

- Transparency and Consistency
  - Models detail the factors, values, and calculations that produce the final rate



- Providers offering the same service in the same area are paid the same rate
- Ability to Advance Policy Goals and Objectives
  - For example, improving direct care staff salaries or benefits, reducing staff-to-client ratios, incentivizing community-based services
- Efficiency In Maintaining Rates
  - For example, models can be adjusted for inflation, specific cost factors (e.g., IRS mileage rate), or to meet budget targets

For shared services such as group home and day program services, HMA-Burns recommended rates that are ‘tiered’ based on staffing levels/ratios.

DHHS should consider using similar independent rate models across all of its HCBS waivers and when establishing rates for new services. It is important to note that the state should consult with their financial advisors prior to making any rate methodology changes.

Rate methodology alignment for similar services ensures equity within a future supports budget framework (discussed below) and prevents competition between divisions for providers because providers furnishing comparable services are compensated similarly.

### **Dependency on Phase 2**

If the state decides not to proceed with implementing a resource allocation model as recommended in Phase 2, below, then it would not need to select a supports needs assessment instrument. However, the state could still complete the recommended rate alignment work across the existing nine waivers. The same benefits listed above could still be gained even if the state does not proceed to implement a new resource allocation model.

## **Phase 2: Restructure of HCBS Waivers**

After completing the Phase 1 alignment and improvement activities, DHHS should be well positioned to effectuate a broader restructuring of its HCBS waivers.

What follows is a detailed description of HSRI’s recommended approach for DHHS to restructure its HCBS waivers. This approach includes three key components: 1) reconfiguring waiver structures within each division, 2) updating waiver service offerings, and 3) developing and implementing an equitable resource allocation model.

### ***Reconfigure Waiver Structures within Each Division***

DHHS should consider consolidating and reconfiguring its current HCBS waiver structure into a dual waiver structure within each of the three DHHS operating divisions—DSPD, DIH, and DAAS. In its research and analysis, HSRI considered whether DHHS should consolidate all nine of its HCBS into two cross-disability waivers. However, HSRI determined this complete consolidation across divisions was not feasible given the variances in operational processes, the IT systems used, and the state statutes and administrative rules that govern each program.

## Division of Services for People with Disabilities: Proposed Waiver Structure

DSPD should create two new 1915(c) HCBS waivers and sunset its five existing 1915(c) HCBS waivers. The two new waivers would be organized as a comprehensive waiver and a supports waiver and serve cross-disability populations, including people with autism/developmental disabilities/intellectual disabilities, physical disabilities, and brain injuries. Serving more than one target group (and broadening the waiver service array to address both medical and behavioral support needs) can further person-centered approaches to service delivery by ensuring individuals, regardless of a particular diagnosis, receive the services they need.

The purpose of the comprehensive waiver would be to provide services to individuals who:

- require out-of-home residential support and supervision, or
- require intensive levels of in-home services, or
- have resided in an ICF-IID and desire to transition to the community.

The purpose of the supports waiver would be to provide services to individuals who live with family members or in their own home and have less intensive needs than people on the comprehensive waiver.

This proposed two-waiver structure would provide a common service array where all services are available on both waivers, except for select residential services and supports.

Entrance/enrollment into the new DSPD supports waiver would be restricted by an individual cost limit, and the amount of support an individual could access would be limited in tiers by level of support. Support levels (or tiers) will be established during the development and implementation of an equitable resource allocation model as described in the section below. The new DSPD comprehensive waiver would not have an individual cost limit, but (like the supports waiver) the amount of support an individual could access would be limited in tiers by level of support.

Depending on the funding available, both new waivers may have a waiting list. It is important to note that beginning July 2027, states with waiting lists will be required (in accordance with the Access Rule) to submit annual waiting list data to CMS.

Additional details regarding potential targeting criteria, individual cost limits, reserved waiver capacity, entrance (waiting list) criteria for the new DSPD supports waiver and the new DSPD comprehensive waiver are provided in [Appendix G](#).

After launching the new waivers, individuals in DSPD's existing waivers would transition to the new waivers over the period of approximately one year and DSPD would then sunset and terminate its prior existing waivers.

Figure 10. Proposed DSPD HCBS Waiver Reconfiguration



Reducing the number of waivers operated by DSPD from five waivers to two waivers and serving cross-disability populations within each waiver would help the state achieve its priority to simplify the HCBS waiver system. This simplification will make it easier for individuals and families to navigate the waivers and reduce the administrative burden for DSPD staff.

### Division of Integrated Healthcare: Proposed Waiver Structure

DIH should create a new 1915(c) HCBS waiver for individuals with complex needs to replace and consolidate the existing MCCW and TDW. Additionally, DIH should amend its existing New Choices Waiver to add medically fragile and technology dependent adults as target groups.

The purpose of the new DIH consolidated complex needs waiver would be to provide services to individuals who:

- are medically fragile, or
- have medically complex needs that must be supported by a nursing professional, or
- are technology dependent.

The purpose of the amended New Choices Waiver would be to provide services to individuals who:

- have resided in a nursing facility, a small health care facility, assisted living or other licensed medical institutions and desire to transition to the community, or
- are currently receiving services through the new DIH consolidated complex needs waiver and have been identified as in need of immediate (or near immediate) nursing facility admission absent enrollment into this waiver program (e.g., aging out of the consolidated complex needs waiver).

The new DIH consolidated complex needs waiver, and the amended New Choices Waiver, would not have individual cost limits, but the amount of support an individual could access would be limited in tiers by level of support. Support levels (or tiers) will be established during the development and implementation of an equitable resource allocation model as described in the section below.

Depending on the funding available, both new waivers may have a waiting list. It is important to note that beginning July 2027, states with waiting lists will be required (in accordance with the Access Rule) to submit annual waiting list data to CMS.

Additional details regarding potential targeting criteria, individual cost limits, reserved waiver capacity, entrance (waiting list) criteria for the new DIH consolidated complex needs waiver and the amended New Choices Waiver are provided in [Appendix G](#).

After launching the new waivers, individuals in DIH's existing MCCW and TDW would transition to the new DIH consolidated complex needs waiver over the period of approximately one year and DIH would then sunset and terminate those prior existing waivers.

Figure 11. Proposed DIH HCBS Waiver Reconfiguration



Reducing the number of waivers operated by DIH from three waivers to two and serving cross-disability populations within each waiver would help the state achieve its priority to simplify the HCBS waiver system. This simplification will make it easier for individuals and families to navigate the waivers and reduce the administrative burden for DIH staff.

### Division of Aging and Adult Services: Proposed Waiver Structure

DAAS should create a new 1915(c) HCBS waiver with an out-of-home residential service option for older adults to function as a comprehensive waiver and amend its existing Aging waiver to reconfigure it as a supports waiver.

The purpose of new DAAS comprehensive waiver would be to provide services to individuals who:

- require out-of-home residential support and supervision,
- require intensive levels of in-home services, or
- reside in a qualified setting and desire to transition to the community.

The purpose of amended DAAS supports waivers would be to provide services to individuals who live with family members or in their own home and have less intensive needs than people on the comprehensive waiver.

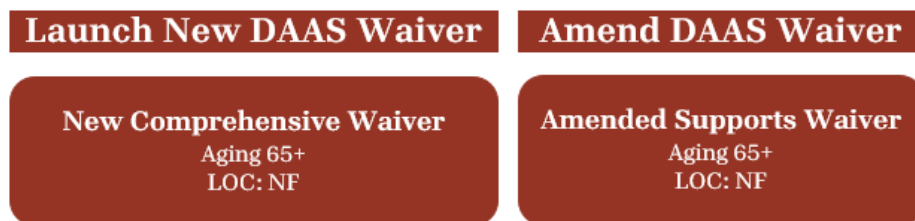
This proposed two-waiver structure would provide a common service array where all services are available on both waivers, except for select residential services and supports.

Entrance/enrollment into the new DAAS supports waiver would be restricted by an individual cost limit, and the amount of support an individual could access would be limited in tiers by level of support. Support levels (or tiers) will be established during the development and implementation of an equitable resource allocation model as described in the section below. The new DAAS comprehensive waiver would not have an individual cost limit, but (like the supports waiver) the amount of support an individual could access would be limited in tiers by level of support.

Depending on the funding available, both DAAS waivers may have a waiting list. It is important to note that beginning July 2027, states with waiting lists will be required (in accordance with the Access Rule) to submit annual waiting list data to CMS.

Additional details regarding potential targeting criteria, individual cost limits, reserved waiver capacity, entrance (waiting list) criteria for the new DAAS comprehensive waiver and the amended aging supports waiver are provided in [Appendix G](#).

*Figure 12. Proposed DAAS HCBS Waiver Reconfiguration*



Launching a new comprehensive waiver for older adults with out-of-home residential options like Assisted Living services would help the state achieve its priority to broaden service offerings to meet people’s unique needs and preferences. While this addition may add some administrative complexity for DAAS, the comprehensive and supports waiver structure will be familiar to waiver participants. This familiarity will make the DAAS waivers easier to navigate.

### Universal Waiver Application

Although the recommended restructuring approach organizes waiver programs by division, it will be important for divisions to work collaboratively to establish a universal waiver application. A shared, standardized application would provide a consistent entry point for individuals and families, regardless of division, and would support clearer understanding of available services across programs. Joint development of a universal application would also enhance the state’s ability to track applications, monitor waiting lists, and maintain consistent data across divisions. By coordinating this effort, divisions can streamline administrative processes, reduce duplication, and support a more aligned and equitable HCBS system.

### Update Waiver Service Offerings

While some of Utah’s LTSS priorities can be achieved through the structural, eligibility, and access changes discussed above, updating the waiver service offerings would build on the Phase 1 service changes and continue to help the state achieve its priority to broaden service offerings to meet people’s unique needs and preferences. Additionally, many of the changes that interested parties have requested relate to updating the waiver service offerings. In HSRI’s engagement with interested parties at the outset of this engagement, individuals and families noted that it was difficult to know what services were available and understand what supports were available.

In this section, we offer possible steps Utah could use to develop and update its waiver service offerings for its reconfigured waivers. These steps could help the state enhance the waiver service offerings and make them easier to navigate and understand.

[Appendix H](#), “Potential Waiver Service Offerings for Reconfigured Waivers,” includes a full list of the service changes offered for consideration. As with all other restructuring changes, it is important to

note that community engagement should be conducted throughout this process to increase transparency and receive feedback to improve the supports budget framework from those it will impact most.

### **Clarify and Align Service Names**

When developing and updating its waiver service offerings, the state should first review all service offerings to determine whether clearer service names would make it easier for people to find the services they are looking for. For example, “Supportive Maintenance Services” on the NCW offers home health services when such services furnished under the approved state plan limits are exhausted. The service definition specifically states that the scope and nature of supportive maintenance services do not differ from home health aide services furnished under the state plan. We would suggest changing the name of this service to “Extended Home Health Aide Services” to better speak to what the service offers.

Additionally, the state should review service names across waivers and ensure that similar services are named in the same way. Using consistent service names to describe similar services across waivers would make it easier for support coordinators to discuss service offerings with people and families and make it easier for state staff to administer. For example, when a service provides set-up expenses to help an individual establish a basic household when transitioning from an institutional setting to a community setting, the service should have the same name across all waivers. In Utah this service is most often named “Community Transition Services,” but it is named “Community Living Services” on the DAAS AGW. We would suggest changing the name of this service on the DAAS AGW to “Community Transition Services.” This name better speaks to what the service is and aligns the service name with similar services in other DHHS waivers. Similarly, the state should review the names of personal assistance services across all waivers.

### **Group and Simplify Services**

Second, the state should look to see if there are similar services that could be grouped together. To do this, the state should consider people’s experiences when selecting services. When going to a planning meeting, if a person was given a list of services to choose from, what would they think when seeing these separate services: “Respite Care – Intensive,” “Respite Care – Routine,” and “Respite Care – Session”? How would a person know which service to pick? By making these services just one item on the service list, individuals will have a shorter and simpler list to review. If they decide that Respite Care is a good service for them, they can work with their case manager to decide what kind of respite supports and payment structure is the best fit rather than having to worry about that at the start.

Another example of services that may be grouped and simplified are services that support individuals who require regular medication, such as “Professional Medication Monitoring,” “Medication Administration Assistance Services,” and “Medication Reminder Systems.” By combining these into one service and offering it across all waivers, the service may be broader and more adaptive to the changing needs of individuals served.

Changes to service groupings may also require corresponding changes to billing codes related to each service.

### **Change or Remove Services**

Third, DHHS should consider whether any services need content changes or could be removed because they were not being used or could be folded into another service. It is important to note that a service should not necessarily be removed from the waiver service offering because it is seldom used. Many services like “Environmental Accessibility Adaptations” may not be used often but could be critical for ensuring the health and safety of individuals served.

HSRI proposes the state conduct this more detailed service review with interested parties as it moves through the waiver service offering decision-making process.

### **Add New Services**

In addition to the services discussed in Phase 1, the state should consider services that may be needed to fill out the waiver service offerings—to meet the needs identified by interested parties and provide supports that are holistic, comprehensive, and individualized. Specifically, the state should consider adding an array of new employment support services and peer support services to all of its restructured waivers.

#### *Employment Support Services*

As recommended in the [Prioritizing Community First](#) section, the state should make employment support services available in all its restructured waivers. Employment support services should include:

- Prevocational Services (Time Limited)
- Career Exploration and Planning (Time/Activity Limited)
- Supported Employment Services
- Workplace Assistance Services

Service descriptions are discussed in more detail in [Appendix B](#).

Additionally, as discussed in the [Prioritizing Community First](#) section, the state should consider modifying its employment services and their respective reimbursement methodologies to include enhanced transportation options and add payment incentives to supported employment reimbursement methodology to incentivize CIE outcomes.

#### *Individual and Family Peer Support Services*

As recommended in the [Prioritizing Community First](#) section, the state should make individual and family peer support services available in all of its restructured waivers. Service descriptions are discussed in more detail in [Appendix B](#).



## Establish case management payment policies

In accordance with the 1915(c) waiver application, states are required to identify the payment authorities under which case management functions are conducted. Case management functions may be provided:

- As a waiver service
- As a Medicaid 1915(i) state plan service (HCBS as a State Plan Option)
- As a Medicaid 1915(g)(1) state plan service (Targeted Case Management)
- As an administrative activity
- As a primary care case management service under a concurrent managed care authority
- As a Medicaid 1945/1945A state plan service (Health Homes Care Management)

When case management is covered as a waiver service, functions that are performed prior to the entrance of an individual to the waiver (e.g., initial evaluation of level of care) may not be billed as a waiver service.<sup>180</sup> Alternately, when case management is provided as a Medicaid administrative activity, states must ensure that the costs are in accordance with a separately approved cost allocation plan.<sup>181</sup>

The table below provides the case management payment authorities the state should consider for each of the reconfigured waivers.

*Table 30. Proposed Case Management Payment Authorities*

Waiver	Proposed Case Management Payment Authorities
<b>New DSPD Supports Waiver</b>	Case management (known as support coordination) as a waiver service
<b>New DSPD Comprehensive Waiver</b>	Case management (known as support coordination) as a waiver service
<b>New DIH Complex Needs Waiver</b>	Case management as an administrative activity
<b>Amended DIH New Choices Waiver</b>	Case management as a waiver service
<b>Amended DAAS Supports Waiver</b>	Case management as a waiver service
<b>New DAAS Comprehensive Waiver</b>	Case management as a waiver service

Additionally, case managers must have the information, skills, and resources they need to help people navigate the reconfigured waivers. As recommended in the [Prioritizing Community First](#) section, the state should implement robust case management training and evaluation for person-centered support planning and plans.

## Establish Policies for Making Payments to Legally Responsible Individuals and Relatives

In accordance with the 1915(c) waiver application, states are required to specify their policies regarding payment for the provision of personal care or similar services by legally responsible individuals (LRIs).<sup>182</sup> States are also required to specify their policies regarding the payment for the provision of any type of waiver service by a relative or legal guardian.<sup>183</sup>

The table below provides the payment policies for LRIs and relatives that the state should consider for each of the reconfigured waivers.

*Table 31. Proposed Payment Policies for LRIs and Relatives*

Waiver	Payment Policies for LRIs	Payment Policies for Relatives
<b>New DSPD Supports Waiver</b>	Payment Authorized for LRIs to Provide: <ul style="list-style-type: none"> <li>- Supported Living</li> <li>- Personal Care Services</li> </ul> Maximum of 40 hours per week total for all services provided by each LRI.	Payment Authorized for Relatives to Provide: <ul style="list-style-type: none"> <li>- Supported Living</li> <li>- Personal Care Services</li> <li>- Homemaker</li> <li>- Chore Services</li> <li>- Companion Services</li> <li>- Respite</li> <li>- Non-Medical Transportation</li> </ul>
<b>New DSPD Comprehensive Waiver</b>	Payment Authorized for LRIs to Provide: <ul style="list-style-type: none"> <li>- Supported Living</li> <li>- Personal Care Services</li> </ul> Maximum of 40 hours per week total for all services provided by each LRI.	Payment Authorized for Relatives to Provide: <ul style="list-style-type: none"> <li>- Supported Living</li> <li>- Personal Care Services</li> <li>- Homemaker</li> <li>- Chore Services</li> <li>- Companion Services</li> <li>- Respite</li> <li>- Non-Medical Transportation</li> </ul>
<b>New DIH Complex Needs Waiver</b>	Payment Authorized for LRIs to Provide: <ul style="list-style-type: none"> <li>- Personal Care Services</li> </ul>	Payment Authorized for Relatives to Provide: <ul style="list-style-type: none"> <li>- Personal Care Services</li> <li>- Routine Respite</li> <li>- Non-Medical Transportation</li> </ul>

	<p>Maximum of 40 hours per week total for all services provided by each LRI.</p>	<ul style="list-style-type: none"> <li>- In-Home Feeding Therapy</li> </ul>
<p><b>Amended DIH New Choices Waiver</b></p>	<p>Payment Authorized for LRIs to Provide:</p> <ul style="list-style-type: none"> <li>- Personal Care Services</li> </ul> <p>Maximum of 40 hours per week total for all services provided by each LRI.</p>	<p>Payment Authorized for Relatives to Provide:</p> <ul style="list-style-type: none"> <li>- Personal Care Services</li> <li>- Homemaker</li> <li>- Chore Services</li> <li>- Companion Services</li> <li>- Respite</li> <li>- Non-Medical Transportation</li> </ul>
<p><b>Amended DAAS Supports Waiver</b></p>	<p>Payment Authorized for LRIs to Provide:</p> <ul style="list-style-type: none"> <li>- Personal Care Services</li> </ul> <p>Maximum of 40 hours per week total for all services provided by each LRI.</p>	<p>Payment Authorized for Relatives to Provide:</p> <ul style="list-style-type: none"> <li>- Personal Care Services</li> <li>- Homemaker</li> <li>- Chore Services</li> <li>- Companion Services</li> <li>- Respite</li> <li>- Non-Medical Transportation</li> </ul>
<p><b>New DAAS Comprehensive Waiver</b></p>	<p>Payment Authorized for LRIs to Provide:</p> <ul style="list-style-type: none"> <li>- Personal Care Services</li> </ul> <p>Maximum of 40 hours per week total for all services provided by each LRI.</p>	<p>Payment Authorized for Relatives to Provide:</p> <ul style="list-style-type: none"> <li>- Personal Care Services</li> <li>- Homemaker</li> <li>- Chore Services</li> <li>- Companion Services</li> <li>- Respite</li> <li>- Non-Medical Transportation</li> </ul>



## Establish Self-Administered Services Policies

Under the 1915(c) waiver authority, states may afford individuals the opportunity to direct some or all of their waiver services.<sup>184</sup> Self-administered services have been demonstrated to promote positive outcomes for individuals and families, improve satisfaction, and be a cost-effective service delivery method.<sup>185</sup> Self-administered services promote personal choice and control over the delivery of waiver services, including who provides services and how they are delivered.<sup>186</sup>

The table below provides a list of self-administered services the state should consider for each of the reconfigured waivers.

*Table 32. Proposed Self-Administered Services*

Waiver	Proposed Self-Administered (Self-Directed) Services
<b>New DSPD Supports Waiver</b>	Residential Supports Supported Living, Personal Care Services, Homemaker, Chore Services, Companion Services, and Respite Community Supports Non-Medical Transportation
<b>New DSPD Comprehensive Waiver</b>	Residential Supports Supported Living, Personal Care Services, Homemaker, Chore Services, Companion Services, and Respite Community Supports Non-Medical Transportation
<b>New DIH Complex Needs Waiver</b>	Residential Supports Personal Care Services, Skilled Nursing Respite, and Respite Community Supports Family Support Services, and Non-Medical Transportation Health and Safety Supports In-Home Feeding Therapy
<b>Amended DIH New Choices Waiver</b>	Residential Supports Personal Care Services, Homemaker, Chore Services, Companion Services, and Respite Community Supports

	Non-Medical Transportation
<b>Amended DAAS Supports Waiver</b>	Residential Supports Personal Care Services, Homemaker, Chore Services, Companion Services, and Respite Community Supports Non-Medical Transportation
<b>New DAAS Comprehensive Waiver</b>	Residential Supports Personal Care Services, Homemaker, Chore Services, Companion Services, and Respite Community Supports Non-Medical Transportation

***Develop and Implement Equitable Resource Allocation Model***

The development and implementation of an equitable resource allocation model using supports budgets and a level-based framework is a complex, multi-year process that involves a series of structured steps. The first step, to select a support needs assessment instrument, was discussed in Phase 1 above. To support the state’s understanding of this process for Phase 2, a potential approach that includes a high-level outline and description of the framework development steps is provided below. It is important to note that community engagement should be conducted throughout this process to increase transparency and receive feedback to improve the supports budget framework from those it will impact most.

**Conduct Data Collection and Analysis**

- Collect data using selected supports needs assessment instrument
- Analyze population data among waiver participants

**Design Support Level Framework**

- Analyze support needs data to explore trends in support needs
- Determine the preliminary number of levels in the framework and criteria for assignment to each level using statistical testing and create level descriptions for each level
- Develop verification process to ensure individuals are assigned to appropriate levels

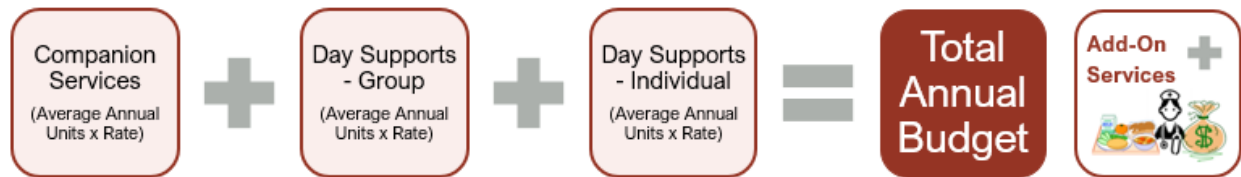
**Develop Supports Budgets Framework**

- Analyze authorization, service use, and spend data by level
- Establish waiver service arrays for future waiver structures, if needed



- Develop model service mixes. As discussed in the background information above, a model service mix is an estimate of the types and amounts of services needed by individuals in each support level and living setting.
- Determine preliminary supports budgets by calculating the annual cost of each service and adding them together. People can also request additional budget dollars for add-on services.

Figure 13. Example Budget Calculation



### Conduct Record Review

- Collect in-depth qualitative data to evaluate the effectiveness of the level-based framework for a sample of people and make adjustments as needed.

### Implement Use of Supports Budgets

- Begin using supports budgets for applicable HCBS waivers.

### Other Considerations for Restructuring

As Utah evaluates the feasibility of restructuring its HCBS waiver programs, it will need to consider the legislative, regulatory, and fiscal implications of any future changes. Specifically, the state will need to assess whether statutory or rule modifications may be necessary to support the restructuring changes; the state will also need to identify potential budget requests that could be required should it decide to move forward. Finally, federal approvals—such as waiver amendments or new waiver applications—will be required to authorize program changes and ensure continued compliance with federal requirements.

### Utah Statutory and Administrative Rule Changes

When DHHS identifies a need to establish or amend state statutes or administrative rules, the work is coordinated through the DHHS Office of Legislative Affairs.<sup>187</sup> The Office of Legislative Affairs assists DHHS staff to understand and complete the legislative process and administrative rulemaking process.<sup>188</sup>

In Utah, the process for making statutory changes begins with the development of a bill request, which is drafted by the Office of Legislative Research and General Counsel.<sup>189</sup> After drafting, the bill is numbered and receives a fiscal note and constitutional/statutory review.<sup>190</sup> The bill is then introduced and reviewed by committee.<sup>191</sup> If returned to the floor by the committee, the bill is voted on by the legislature.<sup>192</sup> If passed by both houses in the legislature and signed by the governor, most bills become effective 60 days after the legislature’s adjournment, unless a different date is specified in the bill.<sup>193</sup> This timeline means that state agencies proposing statutory changes should plan for

lead-time spanning drafting, legislative session review (Utah’s General Session begins in January and runs approximately 45 days), and the post-session waiting period until laws take effect.

When a Utah state agency intends to establish or amend administrative rules, it must proceed through a rulemaking sequence under the Utah Administrative Rulemaking Act (Title 63G, Chapter 3).<sup>194</sup> The rulemaking process includes:

- **Preproposal.** Agency identifies need for rule or amendment, drafts a proposed rule, and completes a rule analysis.
- **Proposal.** Agency files the Proposed Rule with the Division of Administrative Rules (DAR) which reviews the rule for completeness and compliance with Utah Administrative Rulemaking Act.
- **Bulletin Publication.** DAR publishes the Proposed Rule in the Utah State Bulletin.
- **Comment Period.** Agency accepts public comment for at least 30 days and may hold public hearings during the same timeframe.
- **Comment Consideration.** Agency must take at least seven days following the public comment period to consider the public comment it has received.
- **Adoption.** Agency notifies DAR of rule’s effective date and DAR publishes notice of the effective date in the next issue of the Utah State Bulletin.
- **Code Publication (Effective).** DAR codifies and publishes the effective rule in the Utah Administrative Code available at <http://www.rules.utah.gov/publicat/code.htm>.<sup>195</sup>

This process ensures rule changes are transparent, accountable, and aligned with legislative intent.

### Utah State Agency Budget Requests

The annual budget development process in Utah begins in July and continues through December each year.<sup>196</sup> The Governor’s Office of Planning and Budget (GOPB)<sup>197</sup> works with all state agencies to develop budget proposals.<sup>198</sup> Agencies are encouraged to provide comprehensive information when submitting budget request forms including paying special attention to supporting evidence, cost details, and strategic alignment questions.<sup>199</sup> Additional information regarding the process for state agency budget development can be found in the Budget Guidance document published by GOPB.

The governor must release the recommended budget at least 30 days before the legislative session begins.<sup>200</sup> During the legislative session, appropriations subcommittees and the Executive Appropriations Committee approve base budgets and prioritize funding adjustments.<sup>201</sup> Appropriation bills are then passed by the full legislature and signed by the governor.<sup>202</sup> Once signed, appropriations take effect on the dates specified in law. Agencies then implement the budget beginning July 1, the start of Utah’s fiscal year.<sup>203</sup>

### Federal Approvals Required

CMS requires states to obtain public and tribal input during the development of a new 1915(c) waiver, a renewal, and any amendment. Section 1915(c) waivers must be requested by submitting a



web-based 1915(c) waiver application to CMS.<sup>204</sup> New applications must be submitted to CMS at least 90 days prior to the anticipated effective date.<sup>205</sup> New waivers may be approved for an initial three-year or five-year period.<sup>206</sup>

A state must operate the waiver as specified in the approved application. If the state wants to change the waiver while it is in effect, it must submit an amendment to CMS for its review and approval.<sup>207</sup> Amendment applications must be submitted to CMS at least 90 days prior to the anticipated effective date.<sup>208</sup>

## **Evaluation of Restructured HCBS Waiver Programs**

If DHHS elects to move forward with restructuring all or part of its HCBS waiver programs, it will be important to evaluate the changes to understand whether they are achieving intended outcomes and effectively meeting the needs of the individuals served.

An initial comprehensive evaluation should occur one year after implementation has begun. The evaluation could be conducted in two parts: one examining eligibility, access, and services changes, and the other assessing the performance of the resource allocation model.

### ***Evaluating Eligibility, Access, and Service Changes***

An evaluation of eligibility, access, and service changes should collect both qualitative and quantitative data to understand the impact of restructuring on individuals, families, staff, and providers. Key activities may include:

- Documenting and processing reviews to examine the consistency, clarity, and efficiency of eligibility and access procedures within and across divisions.
- Conducting interviews, focus groups and surveys with individuals, families, case managers, providers, and advocacy groups to understand user experiences with the new structure.
- Analyzing the waiting list, enrollment, and service utilization data to assess whether restructuring results in improved access or unintended disparities.

Evaluation questions may focus on whether eligibility pathways are clear and equitable, whether individuals can access appropriate services in a timely manner, and whether the restructured service array meets the needs of diverse populations. Findings from this evaluation can guide revisions of eligibility criteria, access processes, and service definitions or offerings.

### ***Evaluating the Resource Allocation Model***

An evaluation of eligibility, access and service changes should collect both qualitative and quantitative data to assess how well the model reflects individual needs, whether budgets and service mixes are appropriate, and whether the model is being applied consistently. Key activities may include:

- Performing document and data process reviews to evaluate how support levels are assigned and how well data systems function.



- Conducting implementation reviews using sampled participant records to assess the appropriateness of support levels, service mixes, and budgets.
- Conducting interviews and focus groups with people receiving services, families, DHHS staff, assessors, providers, support coordinators, providers, and advocacy organizations to understand experiences with the model.
- Analyzing authorizations, exceptions and claims data to identify system-wide patterns and determine the scale of any issues detected through qualitative methods.

Evaluation questions should address whether individuals within the same level have comparable needs and whether assigned service mixes and budgets match individuals' needs.

Following this initial evaluation, the model should undergo ongoing maintenance at least every five years, including community input and periodic review of services mixes and reimbursement rate assumptions.

# Addressing and Eliminating the DSPD Waiting List

Addressing and eliminating the DSPD waiting list was not identified by DHHS as one of the initial research topics for HSRI to explore. However, early in the study, HSRI received overwhelming feedback from people waiting for services and their family members to research strategies for decreasing and potentially eliminating the DSPD waiting list. This topic was flagged as a high interest by community members due to the impact that waiting for services can have on a person and their families—who often serve as the person’s caregivers.

Many family members of people waiting for services have used their own out-of-pocket funds to pay for the services needed by their loved ones. For some, this means taking on significant debt that may never be repaid—especially given that one in four caregivers has less than \$1,000 in savings and investments (for non-caregivers, the ratio is about one in seven).<sup>209</sup> Caregiving—especially for people with highly complex needs—can also result in family members losing employment due to frequent absences at work; or physical, mental, and emotional burnout. This places family caregivers in unstable financial situations and ultimately taxes service systems with limited resources even further. If Utah does not provide adequate resources to support family caregivers, caregivers may reach crisis levels themselves. Ultimately, the person who needs services may be forced to leave their home, their community, their friends and other family and move to an institutional setting as their last resort when the care they need can no longer be fully supported by a family caregiver at home.

Through community engagement activities, people waiting for services and their families stressed the need for timely services, noting that without services, people either digress or end up in dire situations. Families noted that receiving services earlier would have helped the people they support to make more progress. As one parent said, “We are receiving services now and are very grateful, but I feel that if we have received services when my daughter was much younger, she would possibly be better functioning today.” Families noted the lost income that they experienced and the out-of-pocket costs they incurred, as well as the difficulty in finding anyone to deliver services whether paid privately or not. Sometimes families were only able to obtain support for limited time periods. People expressed a clear desire to have more information about the waiver for services. One family stated “Regular updates on waiting list status would be nice. A list of resources and out-of-pocket costs while on the waiting list would also be helpful; daughter needs services now, but I’m clueless about them.” People wanted assistance from support coordinators who knew their family and could help them piece together their support network. In the absence of support, families worried about their children’s future; as one parent aptly put it, “We have worked on our own to craft a quality of life for our adult daughter, but we are concerned about future options for her to continue a quality of life for her.” The wait for some people spanned over decades. One family member said “We were on the waiting list for 33 years. The funding my daughter is receiving now would have been very helpful

then.” Finally, while people recognized that investments were needed, they know that service providers and other infrastructure are necessary.

## Background for Addressing the DSPD Waiting List

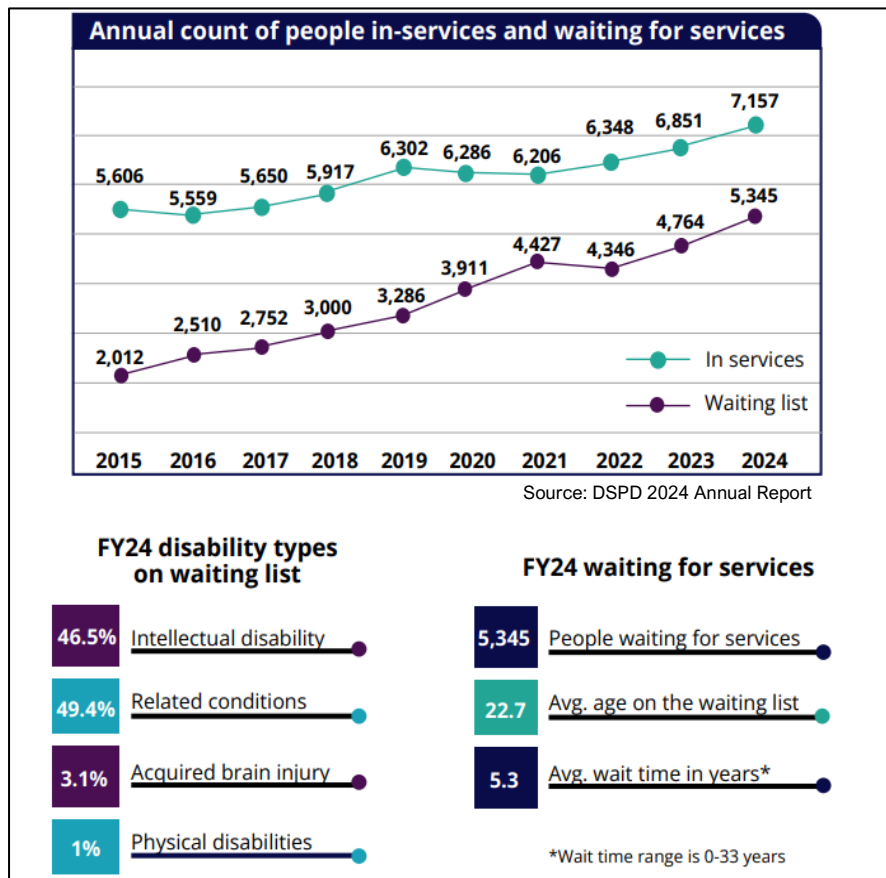
In this section, we provide background related to the DSPD waiting list and our specific recommendations to improve the Utah LTSS system.

Each state develops and has one or more HCBS waivers for targeted populations approved by CMS to offer supportive services. Each state sets the maximum number of people that may be enrolled in each waiver. Once a waiver cap is reached, new applicants are placed on a waiting list until additional funding is available, or the cap is raised.

As of 2024, the Kaiser Family Foundation (KFF) reports that 40 states have waiting lists totaling approximately 700,000 people across the country.<sup>210</sup> Most people waiting for services have intellectual or developmental disabilities and wait 3.3 years on average to access services.

In its 2024 Annual Report, the Utah DSPD reported that there are 7,157 people receiving HCBS services while 5,345 people are waiting for services with an average wait time of 5.3 years (two years longer than the national average).<sup>211</sup> From 2015-2024, the DSPD waiting list

Figure 14. Waiting List Trends



grew 165.65% while the number of people receiving services grew 27.66%. Figure 14 provides a visual depiction of Waiting List Trends published in the DSPD 2024 Annual Report.<sup>212</sup>

In contrast, as of 2024, Utah’s AGW operated by DAAS and Utah’s TDW operated by DIH both have waiting lists totaling around 100-300 people each. Therefore, when researching the “waiting list” for services for this study, we referred to the DSPD waiting list due to its significant size.

If the DSPD waiting list continues its current growth trajectory, Utah may reach a tipping point within the next decade with the number of people waiting for DSPD services surpassing the number of people in services. The Utah legislature has approved appropriations from year to year to move hundreds of people into services. However, these appropriations are not keeping pace with the significant growth of the waiting list and are only temporarily slowing some of that growth. Cutting the waiting list back down to a manageable size ultimately relies on the Utah legislature approving significant funding for DSPD to move people into services, and an ongoing investment to ensure adequate provider capacity to support an increase in people accessing HCBS.

Studies, such as one from the Brandeis Community Living Policy Center, have shown that compared to people whose HCBS needs were met, people with at least one unmet need were more likely to visit the emergency room (52% versus 34%) or stay overnight at a hospital or rehab center (36% versus 24%).<sup>213</sup> Overall, researchers found that unmet HCBS need was consistently associated with poorer health and life outcomes. This suggests that when people can't access the HCBS they need, they are likely to end up exhausting other parts of the state system and services as they reach crisis levels. While difficult to quantify the exact impact, immediate savings from not funding HCBS can be negated when people are left to rely on higher cost crisis or institutional services.

## **Level of Need for People Waiting for DSPD Services**

Since 2019, DSPD has used the Needs Assessment Questionnaire (NAQ) to evaluate the level of need for waiver applicants. The NAQ generates a numeric score that determines a person's place on the waiting list. An initial NAQ is completed after determining that an applicant is eligible for services and at least annually for each person waiting for services.

According to DSPD Directive 1.16, to decide where a person should be on the waiting list, the NAQ looks at three different areas:<sup>214</sup>

- Severity of need accounts for 50% of the person's score and identifies personal care needs, daily living needs, personal safety, behavioral issues, and specific medical needs.
- Caregiver support accounts for 30% of the person's score and measures the ability of the family or caregiver to support the person.
- Time on the waiting list accounts for 20% of the person's score and calculates how many days a person has been on the waiting list.

Urgency of need is also included in the NAQ but it does not account for a percentage of the person's score. It identifies the immediacy and criticality of the person's situation and is used for follow-up. If there is funding available and the person meets all other requirements, DSPD will make an emergency referral for one-time or ongoing services.

When reviewing DSPD data from January 2016 through November 2024, HSRI found that 10,826 people on the waiting list completed the NAQ an average of 5.64 times per person over this period (this data aligns with the average waiting time of 5.3 years reported in the 2024 DSPD Annual Report). Additionally, the data shows that people's NAQ score goes up while they wait for services, indicating that their needs may increase over time.



Table 33. NAQ Score of People on the Waiting List with More Than One NAQ (2016-2024) (n=10,826)

	Severity of Need Score (Mean)	Severity of Need Score (Median)	Caregiver Support Score (Mean)	Caregiver Support Score (Median)	Urgency of Need (Mean)	Urgency of Need (Median)	NAQ Total Score (Mean)	NAQ Total Score (Median)
<b>First NAQ Score</b>	49.61	48	5.23	5	0.09	0	58.2	58
<b>Last NAQ Score</b>	55.9	53	9.74	8	0.11	0	67.96	65
<b>Average Across All NAQ Scores</b>	55.26	53	9.08	8.29	0.07	0	66.6	65.5

Data also reveals that people placed on DSPD waivers had slightly higher scores on the NAQ for severity of need and urgency of need compared to people continuing to wait for DSPD services. This means that people with higher needs are getting into services. However, people continuing to wait for services have higher caregiver support needs compared to people entering services.

Table 34. NAQ Score of People Placed on the Waiver vs. Still Waiting for Services (2016-2024)

	Severity of Need Score (Mean)	Caregiver Support Score (Mean)	Urgency of Need Score (Mean)	Average Wait Time in Years (Mean)	NAQ Total Score (Mean)
<b>People who were placed on a DSPD waiver (n=2,951)</b>	60.85	9.08	0.25	4.14 (0-29.23)	60.47
<b>People continuing to wait for DSPD waiver services as of 2024 (n=5,692)</b>	57.28	11.09	0.03	4.93 (0-33.11)	59.62

In totality, the data indicates that people who were placed into services and people continuing to wait for services have very similar NAQ scores.

Given the growth of the waiting list and the intensifying needs of people waiting for services, the longer the Utah legislature waits to approve additional waiting list funding, the more expensive it will likely become to address the waiting list. This is because, as noted earlier and as supported by NAQ data, people’s severity of need will increase the longer their needs remain unmet. People will reach crisis levels which means it will take even more funding to adequately serve them with the potential need for more specialized providers to address complex care needs—needs exacerbated by the fact people did not get the services they need early enough.

## Reasons for People Being Removed from the Waiting List

HSRI reviewed data for 2,807 people who were removed from the waiting list from 2007-2024 for reasons other than coming into services. Primary reasons as to why people were removed included:

- DSPD being unable to contact the person/their family (1,053 people)
- Moving out of state (556 people, with 184 of those people being ineligible for services)
- Being deceased (311 people)

## Support for People Waiting for Services

While people wait for services, they may qualify for one or more limited short-term services provided by DSPD through a mixture of ongoing and one-time General Fund dollars allocated each fiscal year by the legislature. In 2024:<sup>215</sup>

- 82 people were enrolled in the SWI program (ongoing)
- 408 families were enrolled in caregiver compensation (one-time services)
- 265 families received respite services (one-time services)

While these short-term services undoubtedly help the people and families who receive them, it is important to note that many individuals on the waiting list have never received these services and likely never will, leaving them to determine how, if at all, they can obtain the services they need.

### ***Supported Work Independence Program***

The SWI program was first enacted during the Utah 2006 Legislative Session (House Bill 31) running from 2006-2008. The program provides supported employment services to individuals with disabilities who are currently on the DSPD waiting list, want to work, and cannot receive sufficient services from other agencies such as VR. To be a part of the SWI program, the person must be on the DSPD waiting list and be referred by VR. SWI recipients must start with VR and stay with them for 24 months before they can transition to SWI for ongoing support with job coaching only. SWI does not provide support for job finding. If the person needs a new job, the person must start over with VR (unless the job is similar and only requires job coaching support). The intent of the SWI program is to support people in attaining or maintaining CIE. In addition to being on the waiting list, an individual cannot receive any other services from DSPD to be eligible for SWI.<sup>216</sup> By the end of its first pilot year, 105 participants were using the SWI program. Additional data reported included 59 success stories, an average wage of \$6.87/hour (current minimum wage was \$5.85/hour), and SWI participants working an average of 21 hours per week. In 2008, the pilot transitioned to an ongoing program.<sup>217</sup> In 2010, funding cuts by the legislature resulted in the termination of the SWI program.<sup>218</sup> However, the SWI program's funding was restored the following year in 2011. As of 2024, 82 people were enrolled in SWI, but the program no longer accepts new enrollees.<sup>219</sup> As of 2025, however, the SWI program can enroll people who were previously in the SWI program but no longer are, and who need services again.

## Resource Navigation

DSPD offered a Community Broker service in the past (exact dates were difficult to determine) to help connect people on the waiting list to community resources. However, according to key informant interviews, the service ended because of lack of support coordinator availability due to low service rates. In 2023, the Utah Developmental Disabilities Council funded a two-year waiting list liaison pilot project in collaboration with DSPD and the UPC during which a support coordinator helped more than 35 families figure out supports to help stabilize their support needs.<sup>220</sup> To evaluate progress, the support coordinator conducted a strengths and needs assessment upon the family's entry into the project and ongoing every six months to evaluate the family's progress toward stabilization of life domains such as employment, transportation, and housing.<sup>221</sup> Additionally, the project collected individual impact stories.<sup>222</sup> With promising outcomes from this pilot, there was community interest and support for continuing the program. In 2025, the legislature appropriated \$971,600 for a new Family Peer Support program through DSPD.<sup>223</sup> It is anticipated that approximately 279 individuals and their families will be connected to essential resources through this program.<sup>224</sup>

## Recommendations for Addressing DSPD Waiting List

There are two distinct pathways for DHHS regarding addressing/eliminating the DSPD waiting list:

- Receive additional funding from the legislature to fund a substantial portion or the entirety of the waiting list, coupled with additional funding to ensure adequate provider capacity (such as rate increases or one-time incentives).
- Improve the support provided to people while they wait for services.

HSRI recognizes that approval of additional funding for the waiting list is not directly in DSPD's control. After DSPD submits their yearly funding request to the Utah legislature, it is ultimately up to the legislature as to whether additional funding is approved.

While fiscal estimates are provided later in this final report regarding how much it would cost to fully fund the DSPD waiting list now, in the next decade, and over time, the following set of recommendations is focused on what the state could do to continue to emphasize the importance of funding the waiting list and supporting people while they wait for services if DHHS does not choose to pursue waiver restructuring as outlined in the [Restructuring HCBS Waivers](#) section.

### Continue to Project Future Service Needs and Transparently Share Information About the Waiting List

The DSPD waiting list does not represent the full need for services in Utah. The waiting list only reflects people known to DSPD who have applied for services. In a January 2025 one-pager developed by DSPD for the Utah legislature, DSPD estimated there are 18,875 additional people in Utah who are eligible for and would likely accept DSPD support if it became available, meaning additional state funds in the range of \$237 million to \$244 million would be needed to bring the people who could benefit from services off of the waiting list.<sup>225</sup>

Currently, DSPD primarily reports waiting list data in terms of “people served” and “people waiting” in public [Annual Reports](#) and [dashboards](#); DSPD is working to make live data available so waiting list information is more current. It is important for DSPD to contextualize these numbers in terms of the broader picture of service needs in the state. HSRI recommends that DSPD continue to project future needs and publicly report estimates of how many people in the community are likely to need services in the coming years. These estimates should be included in any materials that share data about the waiting list, including the DSPD [waiting list webpage](#).

Additionally, while DSPD already provides some waiting list data publicly on different DSPD webpages, community advocates, family members, and people waiting for services expressed confusion around where to find basic data about the waiting list to support their own understanding and advocacy. Over the years, different reports and proposals about waiting list management strategies have been created. These documents are not linked directly to the DSPD website and can only be found on various other webpages.

In general, HSRI recommends that DSPD add a “Frequently Asked Questions” section or additional information about the waiting list process to the existing [waiting list webpage](#). At the time of writing this final report, there is helpful information included on the webpage regarding how people’s place on the waiting list is decided, what to do while waiting for services, how to contact waiting list workers, and what to expect when transitioning into services. However, people waiting for services and their families shared that they need more publicly available information. HSRI heard confusion from people and families waiting for services about some of the basics regarding the waiting list, such as to how find out their number on the waiting list or who their waiting list worker is. DSPD has been in the process of developing functionalities in MySteps for people to access this information. During the September 11, 2025, DSPD Provider Quarterly Meeting and October 15, 2025, DSPD Support Coordinator Quarterly Meeting, DSPD leadership expressed the intent to work on creating MySteps training for people waiting for services and families soon, along with the potential to provide dedicated Q&A meetings for people on the waiting list. HSRI is supportive of these initiatives, especially given that many people waiting for services and their families joined the community engagement sessions for this research study to try and get any information at all about what to do while waiting for services.

## **Continue to Explore and Monitor Efficacy of Initiatives to Support People While They Wait**

### ***Supported Work Independence Program***

As of 2025, people in the SWI program receive one hour of job coaching support a week. In conversations with key informants about the program, it was revealed that many people in the SWI program had expressed that they needed more support than one hour a week but were in the program because one hour was better than receiving no support at all. This raises questions regarding whether the program remains effective at its current funding level and offerings. In previous years, DSPD was able to offer 8-10 hours per week of support (hours were based on the person’s previous need with VR). If DSPD could once again provide up to 10 hours per week of job

coaching for people who need it, people could also access Employment-related Personal Assistant Services (EPAS)<sup>226</sup> to receive support with transportation. Therefore, by increasing a person's funding in the SWI program to access more hours if needed, the person would have the opportunity to receive additional services to help maintain their employment. HSRI acknowledges that increasing the hours per week of support may mean that fewer people are able to access the SWI program overall at current funding levels for the program. However, serving fewer people but ensuring they have the adequate amount of support needed would likely lead to better outcomes for people overall and potentially stabilize their severity of need for services. Additionally, HSRI would expect that while people supported through SWI would likely need more hours of support when they first enter the program, a mandatory reduction in hours could be built in over a period of time as the person is supported to work more independently. This would help free up funding to support new people coming into the program. DSPD could also explore incentivizing providers to help people be more independent at work by not reducing payment rates as people transition into working more independently.

There is very little recent information about the outcomes of people in the SWI program. Therefore, it is difficult to determine whether the program remains effective within its current structure. HSRI recommends that DSPD develop a quick tool or process for prioritizing people to receive more than one hour a week of services through SWI. Prioritization should be informed by the person's employment outcomes and attrition within the program. For example, is the person at risk of losing their job? If yes, that could be an indicator that the person should receive more than one hour of support per week. Has the person already received services through SWI multiple times over the past couple of years? If yes, this may indicate the person needs to be provided with tools for ongoing support so that they do not keep returning to the program and so that someone new can get a chance to receive support through SWI.

### ***Resource Navigation***

Community feedback revealed a major knowledge gap: people waiting for services and their families often lack information about supports outside of DSPD and which options are best suited to their needs. There have been efforts both in and outside of DSPD to try and bridge this gap as DSPD's intake and waiting list team noted that they regularly review and discuss relevant resources during interactions; and the UPC publishes their yearly [Disability Resource Book](#). 2025 legislative funding for the new DSPD Family Peer Support program is another step in the right direction that addresses a key component to successful resource navigation: providing follow-up and ongoing support to people to ensure they can access resources and that those resources are working for them. HSRI recommends that DSPD monitor the efficacy and outcomes of the program, such as through the strength and needs assessment used within the original pilot project; and identify any potential opportunities to scale the program further.

### ***Community Care Hub***

HSRI also recommends that DHHS explore the potential for developing a "Community Care Hub." Community Care Hubs (CCHs)<sup>227</sup> serve as critical connection points between community-based service providers and health care organizations. CCHs facilitate partnerships to address upstream

drivers of health and wellness for individuals by organizing and supporting networks of community-based organizations (CBOs) by centralizing administrative functions and operational infrastructure. CCH activities include, but are not limited to, contracting with health care organizations, payment operations, management of referrals, service delivery fidelity and compliance, technology, information security, data collection, and reporting. CCHs are still a relatively new and emerging concept, but “several state Medicaid programs are adopting CCH models to support more efficient contracting between the health and social sectors that coordinate service delivery and referral systems for HRSN [health-related social need] services.”<sup>228</sup> CCHs may soon be used to successfully implement waiting list management strategies. This is because a well-functioning CCH addresses the needs of local populations in a more streamlined way, connecting people to nearby resources while reducing logistical barriers to accessing programs across the network of CBOs. CCHs also present potential cost savings to states due to the containment of health care costs. For example, fall prevention programs through a CCH in Minnesota (Juniper) led to a 283% return on the CCH investment in just one year with total savings of \$8.8 million in 2023.<sup>229</sup> Developing a CCH would require the identification of a lead entity (AAAs are typically well positioned) to organize the network of CBOs in specific geographic regions. ACL has provided funding in recent years directly to CBOs interested in serving as CCHs to develop “integrated health networks that partner with health care entities.”<sup>230</sup> However, ACL funding is not necessarily needed to form CCHs and many hubs have been developed with no additional funding secured, using free and publicly available resources such as those developed through the [Partnership to Align Social Care](#) to support formation. An initial step for DHHS regarding this recommendation could be to convene CBOs from across the state to explore whether there could be value in forming a CCH structure.

## **Emphasize Need for Balancing Funding Between Limited Supports Waiver vs. Community Supports Waiver**

In the [2018 Waiting List Management Strategies Report for the Social Services Appropriations Subcommittee](#), the potential for what would become the LSW was introduced as an “ideal waiting list management tool” because:

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*“Strictly controlling resource ceilings on the most requested in-home services will meet the majority of needs and reserve money for more complex cases. Well-executed services should habilitate, thus, diffusing and preventing crises. ... Current funding methods primarily address the most critical needs on the waiting list. In FY14, the Legislature enacted section 62A-5-102 in an effort to address this preventative care need. This statute mandates that 85% of appropriations given to bring individuals off the waiting list are applied to those with the most critical needs. The remaining 15% of funds are used to bring individuals into services whose only need is respite. This statute combats crises from developing and provides preventative care to individuals with relatively low needs. DSPD recognizes the value of addressing needs as early as possible and has drafted this option in an effort to address these needs in the most efficient way possible. Providing appropriate preventative assistance could serve more people within anticipated future expenditures.”*

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Community feedback regarding the potential for the LSW was largely positive at the time, with people reporting they felt the LSW would help:

- Meet the needs of individuals prior to crisis, and emphasize preventative care
- Serve more individuals
- Give services to all individuals with disabilities, even those awaiting residential care
- Provide respite to families<sup>231</sup>

The intent of the LSW was to provide a limited amount of support to the greatest number of people waiting for services to help prevent individuals' severity of need from escalating to the point where they would need to use high-cost services. Two years after its 2022 inception, only 124 people were served by the LSW—compared to 6,168 served by the CSW.<sup>232</sup> Although it may seem counterintuitive, the goal of the LSW—to prevent people from reaching crisis—can only be achieved if funding is balanced between enrolling people with lower support needs and those who need comprehensive waivers. In 2025, DSPD sought funding for 345 people to enter services, with 214 planned to enter the CSW and 131 planned to enter the LSW.<sup>233</sup> The legislature appropriated \$6 million in response to this request.<sup>234</sup>

HSRI recommends that DSPD continue to emphasize the need for funding the LSW through ongoing conversations with the legislature on how the LSW can support management of the waiting list. Additionally, HSRI recommends that DSPD balance out funding requests to the legislature to ensure there is not too heavy of an emphasis on funding only the CSW and continue to seek funds for the LSW. HSRI also recommends that DSPD review existing statutes to ensure they emphasize offering support in more balanced ways.

If DHHS chooses to pursue a restructuring of the waivers, HSRI has additional recommendations for the LSW that may address existing concerns about its underutilization in the [Restructuring HCBS Waivers](#) section. If DHHS pursues waiver restructuring as recommended in this report, HSRI does not recommend that DHHS pursue opening up eligibility for the LSW until Phase 2, when it would make the most sense to fund the limited and comprehensive waivers at a 50/50 split.

## **Update State Plan Eligibility and Services to Provide Basic Supports to People Waiting for Services**

In the Texas Health and Human Services Commission (HHSC) Medicaid Waiver Programs Interest List Study (2020), HHSC researched nine other states taking actions to address long-standing interest lists (otherwise known as “waiting lists”) for Medicaid waivers for people with IDD. Four primary themes emerged. One of those themes was: “Enrolling individuals in non-waiver Medicaid state plan HCBS services or less expensive support waivers (often not offering 24-hour residential supports) if these services can meet the individual’s needs.” If there is a robust state plan, people don’t need to pursue higher cost waiver services as much.

In a [December 7, 2021 State Medicaid Director \(SMD\) Letter \(#21-004\)](#), CMS issued new guidance on how states can determine Medicaid eligibility for individuals on HCBS waiting lists. As described in the 1915(c) Technical Guide, Page 90:

“While not affecting any of a state’s choices or elections in Appendix B-4, states should be aware, for eligibility-related purposes, that they may target less restrictive financial methodologies at individuals in need of HCBS authorized under section 1915(c) of the Act (among other HCBS-related authorities), which may include (but is not limited to) partially or totally disregarding spousal resources. This authority is described in State Medicaid Director Letter #21-004 (December 7, 2021). A state that wishes to adopt less restrictive methodologies for individuals in need of section 1915(c) waiver services may do so by submitting a state plan amendment (SPA) pursuant to 42 CFR § 435.601(f)(2).”

As noted, on the August 16, 2022, summary of the SMD Letter #21-004 developed by DHHS for the legislature:

“Historically, individuals enrolling in HCBS waiver programs can become eligible for Medicaid using flexible financial eligibility rules. The new guidance allows states the option to use the same flexible financial rules to determine eligibility for those on HCBS waiting lists. For individuals on the waiting list who have private insurance coverage, Medicaid State Plan coverage could reduce the strain on families as Medicaid may cover certain services not covered by the primary insurance or help pay copays and coinsurance costs that can result in significant financial burden to families. CMS clarified that states could decide how to use the flexible eligibility rules; states can choose to apply the flexible eligibility rules for all HCBS waivers they operate or limit the flexibility to the waiting list of a single HCBS waiver program.”<sup>235</sup>

HSRI recommends that DSPD use this new CMS guidance to provide greater access to Medicaid to people on the DSPD waiting list, such as offering them a Medicaid card while they wait. In the DSPD *Waiting List Initiative Proposal Overview (2024)*, DSPD noted that providing greater access to Medicaid would also align with the “DLC settlement agreement that requires DSPD to continue looking into options for how to better manage the waiting list.” During the September 11, 2025, DSPD Provider Quarterly Meeting and the October 15, 2025, DSPD Support Coordinator Quarterly Meeting, DSPD leadership shared a draft of their 2026 Results-Based Accountability Strategic Plan (not yet finalized) in which estimated costs for providing Medicaid to 2,600 individuals totaled \$14.2 million.

## **Additional Waiting List Considerations**

If Utah chooses to pursue restructuring its waivers, additional recommendations regarding the waiting list are contained in the [Restructuring HCBS Waivers](#) section.

States that have requested legislative appropriations to significantly reduce or eliminate their HCBS waiting lists have also simultaneously requested funding to increase service provider capacity to support new people coming into services. As an example, SB 636 (Chapter 464 of the Acts of 2022) required the Maryland Department of Health (MDH) to develop a plan to reduce the waiting list for each of its waiver programs by 50%, along with requiring the Governor to include enough funding in the FY 2024 budget to reduce waiting lists by 50%. MDH’s plans to reduce the waiting lists by 50% by the end of FY 2028 include:



- An assessment of whether each waiver program needs to recruit and retain new providers.
- Measures to recruit and retain providers for each waiver program to expand the capacity of the programs.
- Any changes in reimbursement rates needed to ensure provider capacity to provide for services provided under the waiver programs.<sup>236</sup>

Should legislative appropriations be secured in the future to support significantly reducing or eliminating the DSPD waiting list, it is crucial that accompanying funds be secured to determine the necessary provider capacity to take on new people entering services, along with ensuring that provider reimbursement rates keep pace with inflation.

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# Implementation of Recommendations

In the preceding sections, HSRI outlined recommendations to DHHS for advancing Community First initiatives, strengthening quality oversight, restructuring the HCBS waiver system, and addressing the DSPD waiting list. The following section describes key considerations for implementing these LTSS system reforms, including a proposed high-level implementation timeline, an overview of potential fiscal impacts, and other factors the state will need to consider if it elects to move forward.

## High-Level Implementation Timeline

Implementing the recommendations in this report will require a coordinated, multi-year effort. To support Utah in planning for this work, HSRI has developed a high-level timeline that outlines major phases of activity from 2026 through 2035. This timeline is intended to help the state coordinate, sequence, and manage the complex set of changes recommended for Utah's LTSS system.

While not intended to be a detailed and executable implementation plan, this overview provides an initial framework for organizing activities, anticipating resource needs, and preparing for statewide engagement. By mapping the work over time, the state can more effectively plan across divisions, monitor progress, and adjust implementation activities as the state determines which reforms it intends to pursue.

### Timeline for Implementing Community First Recommendations

As part of Phase 1 of implementing these recommendations, HSRI recommends drafting the Community First plan, beginning improvements for person-centered planning and informed choice, and developing the support coordinator training. During this time, DHHS can continue existing efforts to transition people into the community and address critical complex care gaps by amending services to meet complex care needs.

As part of Phase 2, HSRI recommends implementing the Community First plan and developing new Community First services including employment and peer and family supports. During this time, DHHS can continue to work to transition and divert people from institutional and segregated placements, and if DHHS elects, begin a CAPABLE pilot program.

### Timeline for Implementing Quality Improvement Recommendations

As part of Phase 1 of implementing these recommendations, HSRI recommends revising and aligning waiver performance measures, updating grievance system policies and completing all steps to finalize policies and procedures related to the grievance system, including publishing it on the website in compliance with the Access Rule. During this time, DHHS should explore options to adopt the HCBS Quality Measure Set.



Starting in 2028, the Quality Measure Set will need to be reported on to CMS, the electronic management system will be developed and implemented. Once DHHS meets these initial obligations, HSRI recommends a Comprehensive Quality Improvement Strategy be developed and used to set goals, measure progress, and create plans to correct any areas identified.

## **Timeline for Implementing HCBS Waiver Restructuring**

As part of Phase 1 of implementing these recommendations, HSRI recommends updating existing waiver service arrays to better support people with complex needs, updating quality performance measures and data collection processes in existing waivers, and setting the foundation for implementing an equitable resource allocation model—including selecting a support needs assessment instrument and collecting assessment data from a representative sample.

After completing the Phase 1 alignment and improvement activities, DHHS should be well positioned to effectuate a broader restructuring of its HCBS waivers. As part of Phase 2, HSRI recommends reconfiguring waiver structures within each division, updating waiver service offerings, and developing and implementing an equitable resource allocation model.

## **Timeline for Implementing DSPD Waiting List Solutions**

As part of Phase 1 of implementing these recommendations, HSRI recommends that DSPD continue to offer strategic supports to people waiting for services through the continuation of initiatives such as the Family Peer Support Program and SWI. HSRI does not recommend any major efforts to reduce or eliminate the waiting list until Phase 2, after a new support needs assessment is selected.

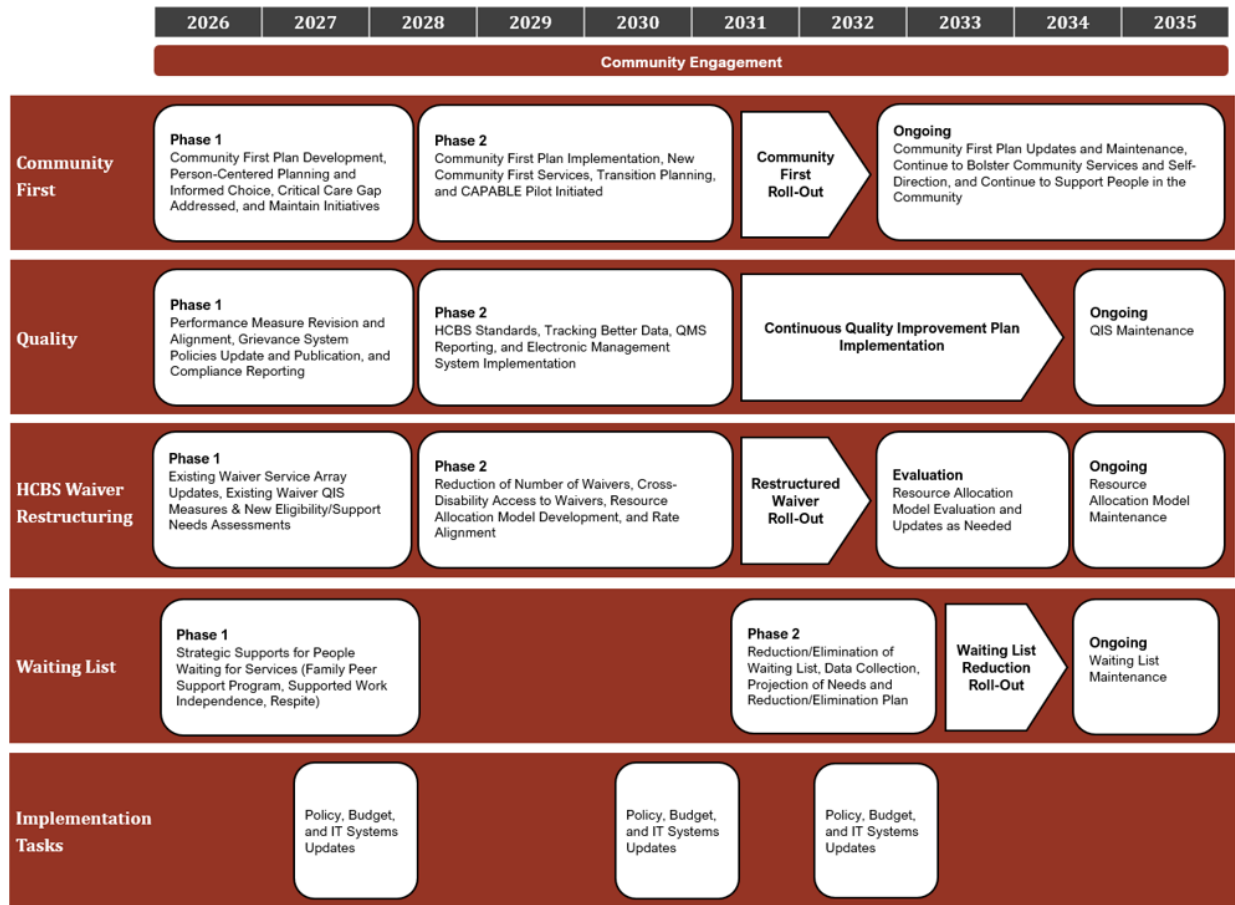
By 2030, HSRI anticipates that DSPD would have a reputable data set of people's service needs and what it would take to clear the waiting list based on the new support needs assessment and people's budgets. During 2030, HSRI would recommend that DSPD develop a funding request to the legislature using this data to reduce the waiting list. The funding request would be presented to the legislature during the 2031 budget cycle. If the legislature approves appropriations for reducing the waiting list, an overall strategic plan for how DSPD would go about bringing new people into services and ensuring adequate provider capacity would be developed in 2032. 2033 and 2034 would be used to implement the waiting list reductions. Starting in 2035, DSPD would continue ongoing waiting list maintenance depending on the extent of funding approved by the legislature.

## **Integration of Implementation Efforts**

Combining the phased approaches above brings together the major components of Utah's LTSS reform efforts into a coordinated, multi-year framework. Major rollouts are anticipated around 2031, followed by sustained evaluation, refinement, and system strengthening through 2035. Broad community engagement remains a continuous activity throughout the entire period, ensuring that system changes are informed by the experiences of individuals, families, and other interested parties.



Figure 15. High-Level Timeline



## Financial Impact

Taken together, the recommendations included in this report would represent a major evolution in the delivery of long-term services and supports for older Utahns and people with disabilities. Individually, recommendations range from relatively modest strategies to update and standardize practices—for example, improving person-centered planning and adopting consistent quality performance measures—to significant systemic overhauls such as consolidating HCBS waivers; expanding service offerings to include nursing, behavioral supports, and other services; and updating provider payment rates.

Furthermore, many of the recommendations would require that DHHS make decisions to specify the details of each initiative. For example, this report recommends that DHHS develop a resource allocation model that assigns individual budgets based on a person’s assessed needs. The financial impact of a resource allocation model depends on the individual budget amounts. Similarly, this report recommends adding several new services to existing programs. The cost of these recommendations would depend on decisions such as who would be eligible for these services and what limits would be established. Implementation costs therefore depend on both *which* recommendations are adopted and *how* they are implemented.

In the absence of such details, this section intends to provide broad estimates of the potential costs of implementing the recommendations discussed above. For the purposes of discussing potential financial impacts, recommendations have been grouped into five broad categories:

- Policy and operational changes within existing programs that represent updates to existing practices, adoption of new approaches, and/or changes in emphasis and focus.
- Strategies to deemphasize institutional placements.
- Consolidation and restructuring of the state's 1915(c) waivers.
- Provider payment rate review and alignment.
- Elimination of the DSPD waiting list.

## **Policy and Operational Changes**

As noted above, many recommendations in this report represent administrative changes intended to enhance long-term services and supports in Utah. For example, there are recommendations to improve person-centered planning, to prioritize competitive integrated employment, and to update and standardize quality systems and measures.

Many of these recommendations will require an initial focused effort from DHHS staff to determine how a given recommendation will be implemented, to engage interested parties, to establish policies and procedures, to develop communications and training, and to perform other related tasks. Given the level of effort required to effectuate meaningful change and the need for existing staff to continue to carry out their current duties, DHHS should establish an LTSS Reform Implementation Office to manage these efforts. The Implementation Office would include project managers who would be responsible for developing workplans, coordinating efforts across divisions, and managing day-to-day activities. Ultimately, DHHS and divisional leadership would remain accountable for oversight and decision-making, but the project managers would ensure there are staff responsible for advancing these initiatives, documenting progress, and identifying and elevating barriers. The size of the Implementation Office would depend on the specific recommendations adopted, but the cost would be modest in relation to the overall investment in the reform efforts.

Overall, DHHS staff have the program-specific expertise as well as responsibility for program management and should therefore lead the implementation of the recommended policy and operational changes. However, DHHS should also consider pursuing external consultant support for subject matter expertise in several areas, including:

- Updating person-centered planning and support coordination practices.
- Improving employment outcomes.
- Identifying and reviewing options for tools to assess individual needs.
- Independently evaluating the success of implementation efforts.

Based on internal expertise and capability, there may be other areas for which DHHS could seek external assistance. The cost of any consultant support would depend on the scope of work they would be assigned, but as with the recommended hiring of project managers, the expense would be

both one-time and modest in the context of overall spending in Utah’s system of long-term services and supports.

Finally, several recommendations call for specific investment:

- **CAPABLE model.** Based on the costs of Community Aging in Place – Advancing Better Living for Elders (CAPABLE) program, and the assumption that only a modest percentage of AGW enrollees would be served, the estimated cost of this initiative would be less than \$200,000. As discussed earlier, this evidence-based model has demonstrated cost savings, but these savings generally accrue to other systems (for example, reduced hospitalization costs) and so are not incorporated in this estimate.
- **Employment grants and incentives.** These grants and incentives would assist providers to transition to employment services and/or strengthen existing services. As a discretionary initiative, the state could decide how much to allocate to these payments, which could be some combination of infrastructure grants to aid in provider transformation (such as training and technical assistance) and outcome-based payments for providers achieving results, but the amounts must be meaningful to support meaningful change. For example, in fiscal year 2024, approximately 100 providers delivered a substantial amount of day and/or employment supports (defined as at least \$100,000 in billings). If DHHS targeted average payments of \$100,000 to these providers to encourage the expansion of employment services through defined grants or incentives, the total cost could be \$10,000,000.
- **Expansion of NCI.** Administering the National Core Indicators-Aging and Disabilities (NCI-AD) as recommended would cost an estimated \$25,000.
- **Implementation of an assessment instrument.** The adoption of an assessment instrument to identify and quantify individuals’ needs would incur costs related to assessment staff and instrument licensing. For example, some state contracts for assessment administration cost around \$500 per assessment. At this price, the cost of assessing 10,000 HCBS waiver enrollees would be \$5.0 million. However, states generally do not require an individual to receive a comprehensive assessment every year and instead operate on a three-to-five year cycle. The annual cost would therefore be between \$1 million and \$2 million.

## Strategies to Deemphasize Institutional Placements

Consistent with national trends, HSRI recommends that Utah gradually reduce its use of institutional placements—the USDC, other ICF-IIDs, and nursing facilities—through thoughtful and intentional person-centered planning and the development of expanded community-based supports.

### *Transitions from the Utah State Developmental Center*

In general, the cost to support an individual at USDC is significantly higher than the cost of supporting an individual in the Community Supports Waiver. Accounting records show that USDC has a \$63.7 million budget in fiscal year 2024 when it served an average of 168 individuals, translating to a cost of almost \$380,000 per person per year. In contrast, based on the highest group home rate recommended in the HMA-Burns rate study and typical utilization of non-residential supports, the annual cost of a community placement would be \$270,000.

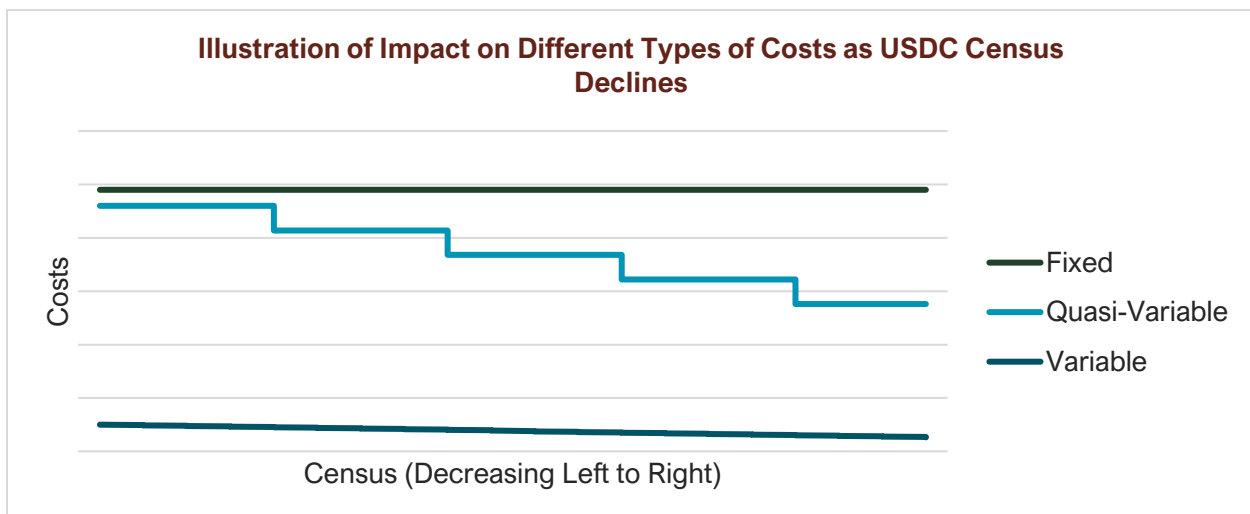


However, due to the nature of large state-run facilities such as USDC, a small reduction in the facility's census will not result in significant savings because many of its costs are fixed. Based on a high-level review of USDC's expenses:

- Almost half of the facility's costs are mostly fixed and would not change regardless of the census. For example, reducing USDC's census would not reduce the cost of the facility's administrative staff or the cost maintaining the grounds.
- Most of the remaining costs are quasi-variable, but would not change in conjunction with the census, instead requiring a critical mass of people departing. For example, a single individual transitioning from USDC probably would not allow the facility to reduce its direct support staffing, but if enough individuals transitioned, staffing could be reduced.
- Less than 5 percent of costs are truly variable, changing in concert with the number of individuals served. For example, food costs should broadly move in lockstep with any change in the census (although even in this example, there are some limitations such as bulk purchasing economies that could be lost once the census declines below some level).

The chart provides a simplified illustration of the relationship between these costs and changes in USDC's census.

Figure 16. Costs and Changes, USDC Census



As Figure 16 demonstrates, fixed costs remain the same regardless of changes in the census (although, at a certain point, these expenses would decline), the quasi-variable costs move in a stair-step pattern as a critical mass of individuals transition out, and the variable costs move in tandem with changes in the census. The fiscal impact associated with reducing the number of individuals served at USDC would therefore depend on the size of the reduction in the facility's census. For example, transitioning a single individual out of USDC would require funding the community placement without any meaningful offsetting savings at USDC, other than the minimal variable costs.

Ultimately, this report recommends that USDC's census could be approximately halved from the 183 people served in September 2024. At this level of decline, USDC would experience reductions in both variable and quasi-variable costs. The fixed costs would remain, however, to ensure the effective ongoing operation of the facility, resulting in a substantially higher per-person cost for those continuing to reside at USDC. Accounting for the cost of community services as well as decreased USDC spending (reduced variable costs), the cost of supporting these transitions would have a net annualized cost of approximately \$6 million.

### ***Transitions from Other ICF-IIDs***

This report also recommends that DHHS reduce the use of private ICF-IIDs. As of September 2024, approximately 180 individuals resided in a private ICF-IID and HSRI recommends that DHHS seek to transition the majority of these individuals to the community.

A 2025 report from Myers & Stauffer commissioned by DHHS found that the Department paid ICF-IIDs an average rate, including supplemental payments, of \$265 per day, or \$96,700 per year. This is generally less than the cost of group home services delivered through the Community Supports Waiver. DSPD's 2025 rate study conducted by HMA-Burns recommended rates ranging from \$65,700 to \$238,600 per year based on home size and staffing levels. When considering the cost of non-residential services, the total annual cost for waiver supports would range from about \$100,000 to \$270,000.

Thus, the transition from ICF-IIDs would likely increase spending. Assuming that DHHS transitions 130 individuals (roughly three-quarters of the current population) from ICF-IIDs, spending would be projected to increase by a nominal amount to as much as \$22.5 million with the total likely closer to the higher end of the range based on the needs of the individuals served.

### ***Transitions from Nursing Facilities***

In alignment with the goal of minimizing reliance on institutional care, HSRI recommends that DHHS endeavor to reduce placements in nursing facilities over time.

Based on the 2025 Myers & Stauffer report noted above, an average of nearly 3,200 Medicaid enrollees received care in a nursing facility. Including supplemental payments, Utah paid an average daily rate of about \$405, or \$148,000 per year. These costs substantially exceed the cost of waiver services. In fiscal year 2024, spending on the highest-cost individuals (the 90th percentile) receiving residential care (primarily assisted living) in the New Choices Waiver was only \$40,000 per year.

Due to these significant differences in costs, any reduction in the use of nursing facilities could result in substantial savings. For example, reducing the number of Medicaid enrollees in nursing facilities by 10 percent (320 individuals) could decrease spending by \$34.5 million, although this amount could be reduced if nursing facility rates were increased to (partly) offset the reduced census.

## Consolidation and Restructuring of DHHS’s 1915(c) Waivers

As detailed above, HSRI recommends that DHHS replace its current Section 1915(c) waivers with two waivers each for DAAS, DIH, and DSPD. Each program would have a comprehensive waiver designed to meet the needs of individuals receiving 24-hour residential services and others with significant needs and a supports waiver to support individuals in their own homes. Several aspects of the proposed redesign would impact the cost of service delivery, including:

- Adding new services and expanding other services to certain populations that do not currently have access.
- Increasing the annual spending limit for DSPD’s Limited Supports Waiver.
- Adopting a resource allocation framework that ties the amount of services that an individual may access to their assessed needs.

### *New and Expanded Services*

The recommendations for updating Utah’s 1915(c) waivers include the addition of some services not currently covered in any of the state’s existing programs as well as the expansion of some services available in some, but not all, existing programs. To estimate the potential cost of these service expansions, HSRI considered utilization rates for comparable services in other states’ waiver programs and developed potential provider payment rates based on the rate models developed as part of DSPD’s 2025 rate study. The estimated counts of individuals who may use these services and the amounts of services they may use do not represent the lowest and highest figures in other states; rather, they are intended to reflect a range that represents most states’ experiences. Table 35 details these estimates.

*Table 35. Estimated Cost of Service Additions and Expansions*

<i>Service</i>	<i>Est. Service Users</i>	<i>Est. Hours of Service per Person per Year</i>	<i>Est. Cost (total funds in millions)</i>
<b>Peer Support</b>	1% - 5% of adults not in full-time residential settings	40 - 120 hours	< \$0.1 - \$0.5
<b>Family Support</b>	1% - 5% of adults not in full-time residential settings	40 - 120 hours	< \$0.1 - \$0.7
<b>Housing Support</b>	1% - 5% of adults not in full-time residential settings	20 - 40 hours	< \$0.1 - \$0.2
<b>Direct Nursing</b>	3% - 7% of adults over 21 in AGW 1% - 5% of adults over 21 in other waivers	1,000 - 2,000 hours in AGW 500 - 1,000 hrs. in other waivers	\$4.8 - \$40.3
<b>Nursing Oversight</b>	10% - 20% of adults over 21 in AGW 3% - 8% of adults over 21 in other waivers	20 - 40 hours	\$0.2 - \$1.1
<b>Home Health Aide</b>	1% - 3% of adults not in full-time residential settings	500 - 1,000 hours	\$0.4 - \$2.4

<b>Behavioral Supports</b>	1% - 3% of individuals	20 - 40 hours	\$0.1 - \$0.4
<b>Job Discovery/ Career Planning</b>	1% - 5% of individuals 16-55 years old	40 - 80 hours	\$0.2 - \$1.6
<b>Job Development</b>	1% - 5% of individuals 16-55 years old	40 - 80 hours	< \$0.1 - \$0.3
<b>Job Coaching</b>	5% - 10% of individuals 16-55 years old	150 - 300 hours	\$0.5 - \$2.0

Overall, the table suggests the total cost of adding or expanding all of the listed services would range from more than \$6.0 million to nearly \$50 million. Notably, 80% of these costs, and the significant range of uncertainty, is associated with direct nursing services. As emphasized throughout these estimates, the actual cost will depend on the specific decisions DHHS makes with regard to each service, particularly with regard to guidelines for authorizing the service in terms of both the individuals to whom each service will be targeted and the amount of support that may be approved.

### ***Increase to Annual Spending Limit in DSPD’s Supports Waiver***

DSPD’s existing Limited Supports Waiver currently has an annual cost limit of approximately \$21,000, which is less than many (though not all) other states’ supports waivers. Based on current provider payment rates, this budget would support about 12 hours per week of Supported Living or 17 weekly hours of Day Support or 9 hours of weekly Job Coaching. The modest annual cap is one of the factors that has resulted in limited participation in the LSW.

As detailed above, HSRI recommends consolidating DSPD’s existing five waivers into two. The successor to the LSW would continue to target individuals whose present needs are comparatively modest, but the annual limit would still be increased to reflect a meaningful level of support. For example, based on current providers rates, a budget that would allow individuals to access 25 hours of week of Day Support per week and 10 hours of Supported Living would require an annual budget of about \$42,000, approximately double the current limit. This limit would need to be adjusted should provider rates be increased as recommended by DSPD’s 2025 rate study.

Given the current low enrollment in the program, the cost of doubling the annual spending limit would be modest, approximately \$1.2 million in total funds.

An increase in the annual limit could result in higher projected costs for enrolling individuals from the waiting list. However, this assumes the state would have been able to enroll more individuals into the LSW, which is uncertain given that enrollments have not met expectations.

### ***Implementation of a Resource Allocation Framework***

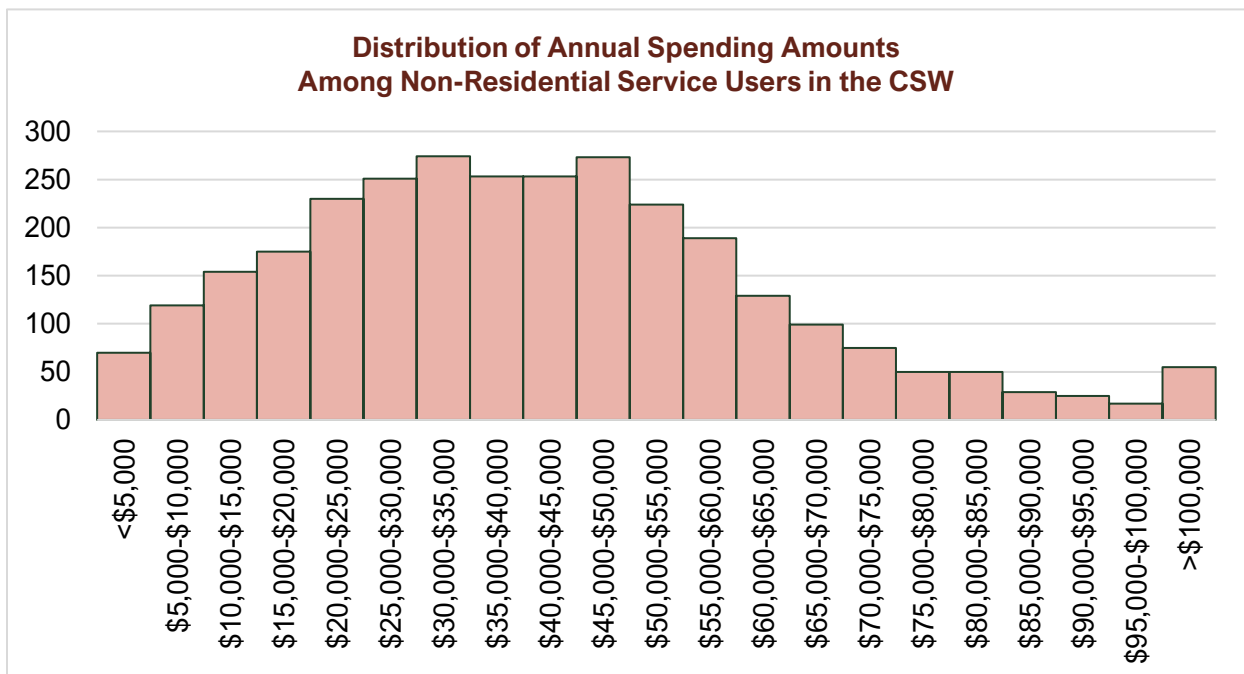
As described earlier, HSRI recommends that the redesigned Section 1915(c) waivers include a resource allocation framework that aligns the amount of support an individual may access with their assessed needs. The impact of such a framework on individuals’ services and overall spending would depend on several factors, including:



- **Existing relationships between individuals' needs and services.** Without the current ability to reliably assess an individual's needs, the extent to which services reflect their needs is unclear. Broadly, even in states without assessment-based budgets, individuals with more needs tend to receive more or more intensive services than those with fewer needs, but the strength of this correlation varies. If there is a strong existing correlation, the impacts will generally be less than if there is a weaker correlation.
- **Funding levels.** States have significant discretion in the establishment of budgets within a resource allocation framework. Impacts will therefore depend on the decisions made when constructing these budgets.
- **Exceptions processes.** No resource allocation model is designed to meet the needs of every individual within a system; there will always be a need for an exceptions process for individuals who require more services than is typical of others with similar needs. Overall impacts will be affected by the prevalence and amount of exceptions.

The chart below illustrates the distribution of spending amounts for adults in the Community Supports Waiver who do not receive residential services.

Figure 17. Distribution of Spending Amounts, Non-Residential CSW Service Users



As Figure 17 shows, there is substantial variability in current spending levels within this group. To create a resource allocation framework for this group, the key decisions would be creating the assessment levels and building the budgets for each level.

As discussed earlier, to create the assessment levels, DHHS would need to assess the needs of at least a sample of individuals and conduct statistical analyses to determine the criteria that could be applied to the assessment results to create groups of individuals with similar needs.

For each group of individuals in an assessment level (and potentially sharing other characteristics such as their living situation), DHHS would establish a model service mix based on the types and amounts of services sufficient to meet the needs of the typical individuals within the group. These model service mixes are then priced based on the applicable fee schedule to establish the budget allocation for individuals in each group.

States have wide discretion in establishing model service mixes and resulting individual budget. For example, if a group of individuals in the first quartile of spending represent an assessment level (note that this would not actually happen as support needs are not perfectly correlated with service utilization), this would cover those with current service usage between \$0 and \$25,000. When establishing the budget for this group, DHHS could opt to set a budget at the median utilization for this group of about \$16,200, which likely would produce a largely cost-neutral impact. Alternatively, DHHS could elect to create a budget that covered the current utilization of most individuals in the group, such as \$20,000, in which case there likely would be an increase in spending as some individuals with lower budgets seek to increase their service usage.

Although not necessary, when developing the service mixes, DHHS could choose to establish a specific financial target, such as not increasing overall spending by a specific amount. The potential cost of a resource allocation framework therefore depends on DHHS decisions regarding how to develop the individual budgets.

## **Provider Payment Rate Review and Alignment**

As described above, DSPD contracted with the Burns & Associates division of Health Management Associates to conduct a comprehensive study of provider payment rates. That yearlong effort included a comprehensive review of service requirements, administration of a provider survey to gather data regarding current program structures and operating costs, collection of benchmark data to ensure that payment rates reflect current market-based costs in Utah, development of rate models that detail the assumptions made to produce the overall rates, facilitation a public comment process to solicit feedback on the draft recommendations, and publication of final results.

The final DSPD rate study recommendations were published in late 2025. Due to infrequent rate adjustments, the rate study found that rates should receive significant increases to reflect current costs. Overall, the rate study recommended increasing payment rates by an average of 24%, though the actual increase varies by individual services. Based on current service levels, fully implementing the recommended rates would require an additional \$125 million in total funds.

To maintain robust provider networks, ensure parity across programs, and avoid placing some providers at a disadvantage in terms of their ability to recruit and retain staff given the overlap in HCBS workforces, HSRI has recommended that similar rate studies be conducted for all of DHHS's waiver programs.



As with the DSPD rate study, it is anticipated that updating provider payment rates for the other programs would require a significant investment. Specific estimates would depend on the outcomes of these rate studies. However, if rate increases for the DAAS and DIH programs also averaged 24%, the total funds cost would be about \$16 million.

In addition to undertaking thorough reviews of payment rates, Utah should consider a mechanism for making regular adjustments to payment rates. Such updates will help ensure that rates account for rising costs, allowing providers to continue to invest in their programs and workforces. This strategy would also avoid the very large increases that are required when rates remain stagnant for multiple years.

Because HCBS costs primarily include staff wages and benefits, which tend to grow more quickly than general inflation, annual adjustments would likely total 3% to 5%. Based on current service levels and the estimated increase required to update rates to current market costs, the cost of subsequent annual adjustments would total approximately \$25 million to \$42 million in total funds.

## **Elimination of the DSPD Waiting List**

At the end of 2024, more than 5,800 people with IDD were on the waiting list for a DSPD waiver slot. Enrolling these individuals would require a significant investment but would support the safety and well-being of these individuals and their families, help to maintain individuals in their homes, and mitigate or prevent deterioration in individuals' conditions.

To estimate the cost of eliminating the waiting list, HSRI first considered the number of individuals who would ultimately enroll as Utah's and other states' experience in attempting to contact individuals on the waiting list when new waiver slots become available has shown that not every individual will be enrolled. This is due to a number of reasons, including an inability to reach the individual, individuals who move out of state or who are ineligible for another reason, and personal decisions to decline services. Based on waiting list reduction efforts in other states, HSRI estimates that 25 percent of individuals on the waiting list will not enroll in services, suggesting that approximately 4,400 individuals would enroll.

HSRI next estimated the cost of providing services to this group. In general, individuals who are new to service typically use fewer services than individuals who have been in service for a longer period of time for a number of reasons, including new enrollees are typically younger and healthier, are less likely to reside in more costly residential placements, and often take time to get connected to service providers. After accounting for residential placement, new enrollees do tend to reach parity with longer-enrolled individuals fairly quickly. Reviewing enrollments in the New Choices Waiver (chosen because the program does not have a waiting list so the program is not enrolling only those with the greatest needs, typical spending for new enrollees who do not receive residential services was about 45 percent of the average for existing enrollees for the first six months. For the next six months, spending increased to about 65 percent of the average for existing enrollees, increasing to 85 percent for the next 12 months, and then effectively reaching parity after two years.



Based on the estimated number of enrollees and their projected service usage assuming 20 percent receive residential care and 80 percent do not, eliminating the waiting list would ultimately reach \$150 million in total funds on an annualized basis. Based on a one-year phase-in and the assumption that spending will initially be comparatively modest before increasing over time, the cost would be about \$55 million in the first year, \$130 million in the second year, before reaching about \$150 million in subsequent years.

These costs could be stretched over time through a gradual elimination of the waiting list. For example, the recommended timeline would eliminate the waiting list over a two-year period. Further, it is assumed that enrollments would be distributed across the year to ensure that support coordinators and service providers are able to absorb the population growth. Based on this schedule, total funds costs would be \$27 million in the first year of implementation, \$92 million in the second year, and \$138 million in the third.

## **Additional Considerations**

The following section describes additional considerations that will be critical to the successful implementation of Utah's LTSS system reforms, including the need to meaningfully involve individuals and families in shaping policy and practice, to develop a clear and effective communication and change management strategy, and to strengthen system data capabilities. These elements will help ensure that reforms are informed by lived experience, supported by transparent and consistent messaging, and guided by reliable information as the state moves forward.

### **Involve People Receiving Services and Families in Shaping Policy and Practice**

Individuals with disabilities and their families must play a central leadership role in shaping Utah's future LTSS system, and the state must actively create opportunities for them to help drive policy and practice decisions. This engagement cannot be limited to those already well connected to DHHS. To truly understand system needs, DHHS must reach a broad and diverse cross-section of individuals and families—including those who have been historically difficult to engage due to language, culture, limited access to technology, or distrust of government systems. Addressing these barriers is essential to achieving meaningful involvement.

Good person-centered practices are culturally responsive by definition; however, our systems have long overlooked or failed to do the work needed to make sure that is the case. While there has long been anecdotal evidence, emerging research indicates that people with disabilities from racial, ethnic, and linguistic minorities experience disparities in access, quality, and outcomes. By engaging directly with diverse individuals and families during policy development, DHHS can better understand community needs and avoid unintentionally perpetuating these disparities.

To strengthen this work, the state should begin community engagement early, involve individuals with lived experience, and use strategies such as culturally appropriate outreach, accessible communication platforms, and inclusive public meetings. DHHS should also consult national

resources, including [NCAPPS](#) and the [Georgetown University National Center for Cultural Competence](#), to inform effective engagement approaches.

Although meaningful engagement requires substantial effort, the state does not need to approach this work alone. Advocacy organizations maintain strong relationships with individuals and families, and DHHS can leverage these networks to enhance outreach. Providers, too, have regular contact with the people they serve and can help expand and strengthen engagement efforts.

## **Effective Communication and Change Management Strategy**

In our prior discussions with states that have restructured their HCBS waiver programs, state staff stressed the importance of developing an effective communication strategy. Many states described significant efforts related to statewide listening tours, meeting with key stakeholder organizations such as provider associations, disability rights, and other advocacy groups, and providing means for ongoing communication. Effective change-management planning and execution will be essential to prepare everyone involved for upcoming transitions and supporting smooth implementation as reforms are introduced. Related to this, some states provide training on new technology solutions, services, and policies and procedures for state staff at all levels, managed care organizations, service providers, and others. An effective change management strategy may bolster additional support for the proposed changes and increasing the likelihood that DHHS's plans receive support.

## **Funding, Approval, and Coordination**

Prior to engaging in the wide-ranging recommendations outlined in this report, DHHS should begin efforts to engage its legislature to share the recommendations that DHHS is pursuing to begin testing the ideas and garnering support for needed changes. Beginning conversations early with approving bodies can help to ensure a more seamless transition toward adopting the recommendations outlined in this report. Recommendations that may require approval are included in all recommendation topics noted in this report. For example, to engage in Community First planning, DHHS may want to consult its in-house legal team to ensure that forward momentum does not incur additional risks for DHHS and that the plan can propel DHHS forward. In Improving Quality, recommendations related to the grievance system will likely also need approval by DHHS in house legal team as well as approval by CMS to ensure that they comply with the requirements stated in the Access rule. Plans to restructure the HCBS waivers will require approval by CMS and the legislature as these changes will substantially shift DHHS's system and will require an overhaul of rules and statutes underpinning services. Addressing the DSPD waiting list will require additional funds that must be approved by the Utah legislature. All these efforts will require substantial coordination amongst DHHS divisions to implement changes. These partnerships should begin as soon as is feasible.

## **Monitoring Federal Landscape**

Federal landscape is shifting. Recent changes to Medicaid brought on the One Big Beautiful Bill<sup>237</sup> are expected to shift the entire Medicaid system. These changes have not been fully finalized, but once finalized, they may result in changes that limit access for some people to receive services.



DHHS should closely monitor these forthcoming changes, as there may be impacts that affect the recommendations outlined in this report. It may also require DHHS to divest resources differently than expected, limiting opportunities to invest in changes. Additionally, there are current rules, such as the Access Rule which have impending implementation dates with implementation guidance forthcoming. DHHS should monitor these dates and guidance for changes that would require DHHS to take a different approach than outlined in this report.

## **System Data Improvements**

Tasks throughout this project required HSRI to request, acquire, and analyze data across multiple sources in the state. We are able to make recommendations for system data improvements based on this work.

We recommend:

- Conducting an audit of existing data across departments, including content, uses, owners/managers, and reporting.
- Establishing and maintaining methods for accessing and sharing data sources.
- Identify methods for merging and conducting analyses across data sources, including unifying identifiers and format of data sources.
- Understand the status of the quality of data, including how data are collected, when the data are collected, and how it has been tested for validity and reliability.
- Establishing standards for collecting same/similar information from the same people (e.g., one way of collecting race and gender) and/or eliminate redundancies in data collected across sources.
- Leverage merged data sources for potential research and evaluation and/or improvements to quality measures.
- Identify ways in which data may be used in combination with non-state sources of data to better understand system needs and improvements.

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# Conclusion

DHHS commissioned this study with the aim of improving services for people with disabilities and older adults. Following the priorities of DHHS and the Steering Committee, we completed extensive research to understand Utah’s LTSS system, to learn from people receiving services and others about their experiences, to understand the barriers, and to explore opportunities for meeting DHHS’s priorities. The final recommendations included in this report are informed by this research and intended to move DHHS’s system forward.

## Summary of Final Recommendations

Throughout the project, HSRI researched 11 topics and developed a series of research briefs. To identify priority topics for the Final Report, HSRI collaborated with the Steering Committee and DHHS to narrow the focus. Through this process, the following topics were selected for further research and recommendations:

- Community First
- Improving Quality
- Restructuring HCBS Waivers
- Addressing the DSPD Waiting List

A summary of recommendations for each topic is provided below.

**Community First:** Based on what we learned, HSRI recommends that Utah prioritize community-based services over institutional care. This means creating a Community First Plan to guide community-focused policies, improving person-centered planning so people have more control over their services, and helping people move from institutions or segregated settings into homes and jobs in the community.

**Improving Quality:** HSRI also recommends strengthening quality measures to meet new federal requirements, such as improving grievance systems, aligning performance measures across programs, and expanding surveys to track outcomes for all populations.

**Restructuring HCBS Waivers:** Utah should also consider consolidating its nine Medicaid waivers within divisions to make services easier to access and more person-centered. These changes aim to promote inclusion, empower people to make choices, improve service quality, and create a more effective system. Overall, the goal is to help people live and work in their communities with the supports they need, while reducing barriers and delays that keep people from getting help.

**Addressing the DSPD Waiting list:** Another major challenge is the large waiting list for services—more than 5,000 people are waiting. HSRI suggests better communication about the waiting list, improving programs that help people while they wait, and ensuring equitable funding for waivers to help more people get the services they need.

## Impact on Priorities

We had a Steering Committee made up of more than 40 people with professional and lived experience of the Utah service system. This Committee and DHHS decided what is most important in this project, called “priorities.” These are the project priorities:

The priorities outlined four areas:

- Inclusion
- Person-Centered Support
- Service Quality
- Effective Service System

Below we address how our recommendations impact these priorities.

### Impact on Inclusion

Inclusion, as defined by DHHS and our Steering Committee, means supporting and honoring people’s choices for where they live and who they live with. Giving people options for receiving community services and participating in competitive integrated employment.

Promoting Community First through Community First planning and modifying services supports people to be included in their communities. Including input from people and families in the Comprehensive Quality Improvement Strategy will help ensure people with lived experience help shape the service system. Modifying the service arrays will give people more options for receiving community services, receiving support for complex needs, and participating in competitive integrated employment. Providing people with timely access to services can prevent them feeling like their only option is institutional services.

### Impact on Person-Centered Support

Person-Centered Support, as defined by DHHS and our Steering Committee means empowering people to maintain control over their own life and services (self-direction) by offering holistic support.

Strengthening person-centered planning and informed choice, along with supporting people to live in and receive services in their homes and communities as long as possible, supports individual choice. Compliance with the Access Rule and creating a state-level grievance system will help ensure that people receive services appropriately and that issues are addressed. Establishing cross-disability waivers will empower people to maintain control over their own life and services by offering holistic support. Providing services before someone is in crisis can help the person ease into services and prevent the negative impacts of waiting too long.

### Impact on Service Quality

Service Quality, as defined by DHHS and our Steering Committee means ensuring that people in Utah equitably receive the services that they need. Promoting high quality services and highly qualified providers.



Robust support coordinator training, along with the development of new services and provider incentives, can improve the quality of services and supports people receive. Continuous quality improvement will make sure everyone in Utah gets high-quality services offered by well-trained providers and support staff. Aligning performance measures across waivers will enhance the state's ability to analyze trends across the entire HCBS population to make system-wide improvements. Providing services before people reach crisis levels can prevent overwhelming the system's capacity which in turn negatively impacts service quality.

## **Impact on Effective Service System**

Effective Service System, as defined by DHHS and our Steering Committee means improving coordination between agencies, funding, and reimbursement of services to help more people.

Coordinating planning across departments and piloting new programs, as well as reducing unnecessary institutional placement can lead to a more effective service system. Using consistent performance measures will make reporting easier, reduce paperwork, and improve how service quality is tracked across DHHS. Reducing the number of HCBS waivers operated by DHHS will make HCBS programs easier for people and families to navigate and simplify operational burdens for DHHS staff. Coordinating between state agencies and community partners can help people get connected to additional support.

## **Final Thoughts**

DHHS has engaged in considerable efforts to improve its LTSS system for people receiving services. In recent years, DHHS and its divisions have developed initiatives to transition people from USDC and from ICF-IIDs to community supports, to reduce the number of individuals waiting for waiver services, to enhance supports to older adults, and to improve caregiver compensation. DHHS staff have participated in state and national workgroups established to promote person-centered thinking, to promote competitive integrated employment (CIE), and to address staffing shortages. Building on this momentum, DHHS is now offered an opportunity to take these efforts to the next level, following the recommendations outlined in this report, and creating a sustainable pathway to the future.

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# Appendix A: Research Background, Approach, Activities & Limitations

## Research Background

The first year of the research study (2023-2024) focused on conducting community engagement activities and topical research. This included the development of a study Steering Committee made up of people with lived and professional experience of Utah's disability and aging service system to provide feedback on opportunities for improvement. HSRI also hosted various large group listening sessions, small focus groups, one-on-one interviews, and presentations with community members to gather feedback on research topics. Initial topical research focused on topics of interest identified by DHHS and the Steering Committee. HSRI researched each of the topics to suggest possible changes for the LTSS service system.

In the second year of the research study (2024-2025), HSRI developed a method for projecting future service needs to help DHHS figure out what services may be needed and potential costs. HSRI also developed final recommendations as outlined in this final report, narrowed on three specific research topics to set Utah on a more sustainable path for the future, with an emphasis on getting people what they want and need in the community.

## HSRI's Approach

HSRI believes that our experiences and perspectives bring value to the work that we do. Central to our approach are the following three values.

### Centering the people impacted throughout the process

We believe our work is improved by including people with lived experience and those who will be impacted by recommendations throughout our work with a jurisdiction. This means having regular opportunities to conduct engagement that is inclusive and accessible. In this project, we created and led a steering committee throughout this process that is described later in this report. We also believe that the ways in which we conduct our work and share our recommendations should align with what is most important to the community. For example, we heard that it was important to prioritize taking a community-first approach to our recommendations on the future of the service system. Lastly, it is important that we always consider the intersectional identities of those in the community. We spoke to as many people as possible to understand how the service system works today and learn about the goals and priorities of the community moving forward. To the extent possible, we sought people from diverse perspectives to learn where there may be differences, commonalities, and new learnings beyond talking to those most often able to engage.



## Using a data-driven and multimethod approach

We believe that all recommendations and policy decisions should be informed by data collected and analyzed using multiple methodologies. Multiple evidence-backed perspectives allow us to better triangulate recommendations with greater confidence. In this project, this meant collecting qualitative data via interviews, analyzing claims and assessment and other existing data sources, and conducting literature reviews to supplement findings from the state of Utah with information from other states. Whenever possible, we make recommendations for how to bolster knowledge and support for recommendations with additional data, analyses, or new perspectives.

## Maintaining transparency with project partners and the community

Lastly, HSRI values honesty and transparency among our staff, state and other partners, and the community. Relationships depend on forthright ongoing exchange of information, which increases community trust, collection of ideas that improve recommendations, and easier knowledge exchange among all people invested in the work.

## Research Activities

This subsection describes HSRI's research activities, including the steering committee engagement, community engagement, topical research, and other related activities.

### Steering Committee Engagement

HSRI established the study Steering Committee to provide expertise on Utah's current LTSS programs, practices, and policies. The Steering Committee helped develop broad objectives, goals for the LTSS system, and action items needed to move toward the recommendations created through this research study. HSRI recruited 40 members with specialized knowledge and lived experience of the disability and aging network in Utah. Along with state representatives from DHHS, people in services, families, and independent service providers, Steering Committee members represented the following organizations:

- American Association of Retired Persons (AARP)
- Brain Injury Alliance of Utah (BIAU)
- Disability Law Center (DLC)
- Home Care and Hospice Association of Utah (HHAU)
- Utah Association of Area Agencies on Aging (U4A)
- Utah Association of Community Services (UACS)
- Utah Commission on Aging (UCOA)
- Utah Developmental Disabilities Council (UDDC)
- Utah Health Care Association (UHCA)
- Utah Independent Support Coordination Association (ISCA)
- Utah Parent Center (UPC)
- Utah State University Institute for Disability Research, Policy & Practice (IDRPP)
- Utah Statewide Independent Living Council (USILC)

Through the research study, HSRI met with the Steering Committee on a quarterly basis (10 times in total) to review research findings and explore opportunities for improving the LTSS system. Feedback from the Steering Committee informed the research briefs and final recommendations.

## **Community Engagement**

To connect with the greatest number of people across Utah, HSRI facilitated listening sessions, one-on-one interviews, focus groups, presentations, and gathered feedback through a public feedback form.

HSRI conducted community engagement activities both virtually and in-person. While internet access may be limited in some rural areas, virtual opportunities allowed HSRI to connect with community members in more isolated parts of the state we may not have heard from otherwise. Additionally, HSRI conducted in-person interviews with a focus on speaking to people in more secluded, institutional settings who may not have been reached through the virtual engagement sessions.

HSRI hosted six virtual community listening sessions in January, May, and August 2024. A total of 200 people attended the sessions including people with disabilities, older adults, family members, and professionals supporting people with disabilities and older adults (service providers, support coordinators, direct support professionals, etc.) Throughout community listening sessions, HSRI sought to ensure confidentiality of the information provided by allowing participants to provide anonymous feedback through Mentimeter, a web-based platform that collects real-time audience input. During the listening sessions, HSRI asked targeted questions regarding the research topics and participants provided feedback through Mentimeter, chat, and live spoken comments.

HSRI also conducted virtual one-on-one interviews with 22 key informants, including DHHS staff. HSRI facilitated 46 additional interviews during in-person site visits in November 2024 (institutional settings) and May 2025 (14(c) employment programs). HSRI held focus groups with 27 total participants on research topics related to natural supports and quality DSPs.

Early in the research study, HSRI developed a feedback form where people could provide anonymous feedback on the LTSS system. 89 people provided input through the feedback form.

Additionally, HSRI shared information and gathered community feedback on the research study at 25 presentations at both DHHS and community-led events. This included the DSPD quarterly meetings (self-advocates, families, case managers, and service providers), the UDDC 2025 conference, and meetings with individual organizations. Attendance numbers for each presentation were not always able to be easily tracked (especially for those in-person) but ranged from 20-100 participants (approximately 700 participants in total).

Therefore, HSRI estimates that in total, approximately 1,000 people were reached through community engagement activities for this research study.

## **Topical Research**

HSRI developed and researched the following LTSS topics:



- Recruitment and Retention of Quality Direct Support Professionals (DSPs)
- Strengthening Natural Supports
- Addressing/Eliminating the DSPD Waiting List
- Pursuing a Medicaid Training and Technical Assistance Center
- HCBS Payment Models
- Supports for Complex Medical/Behavioral Needs
- Supports for People with IDD and Mental Health Needs
- Institutional Settings vs. HCBS Settings
- Quality of Care in LTSS
- LTSS Service Arrays
- Medicaid LTSS Programs - Structure and Funding Options

To inform our understanding of each topic, the research team (i) reviewed relevant Utah statutes and rules, Utah DHHS and divisional websites, claims and utilization data (when applicable), and relevant program operational documents; (ii) conducted focus groups and informational interviews to learn from people in services, family members, providers, advocacy organizations, and field experts, (iii) reviewed Section 1915(c) waivers and HCBS programs in other states; and (iv) researched and analyzed a wide variety of expert field literature.

Based on this research HSRI identified key opportunities for DHHS to consider for each brief topic.

Our initial research findings were presented to the Project Steering Committee and the committee's feedback has been incorporated into this research brief. Then presented to DHHS staff for feedback and incorporation of feedback into briefs. For each brief, we noted HSRI's recommendations may change as we collect more information on this and other research topics and explore their feasibility. Some opportunities may not be possible for DHHS now or in the future. Our final recommendations will take all research topics into consideration holistically to come up with the right plan for Utah.

## Other Activities

In addition to the activities listed above, in the second year of this LTSS project, HSRI conducted detailed quality improvement analysis, utilization and cost analysis, and a projection of needs analysis.

## Limitations of LTSS Project Research and Final Report

In this report, we provide recommendations based on our current understanding of Utah's service system. It is important to note that, as with all research studies, there are limitations that HSRI experienced which must be considered in interpreting our recommendations. Our research was limited by access to people, information, and data.

Utah, like all state systems, has limitations on the data it has available and is able to collect. Our initial data request was broad in effort to ask for all data sources that could potentially answer particular questions related to these research topics. Some data sources in our request were available, while others were not. Therefore, the research and recommendations included in this report are informed



by and limited to the data that we have available. We made every attempt to secure data in a timely manner in order to support our research, however collecting data across three disparate state divisions proved difficult and took considerably more time than anticipated, limiting some of our earlier research efforts. That is, briefs produced early in this project were unable to include relevant datapoints from Utah's service system. There were also inconsistencies noted in the data by DHHS staff that we attempted to resolve, however, some inconsistencies may remain.

It is also worth noting that any data elements we are reporting carry forth any issues within the data itself. For example, in our recommendation pertaining to Quality (see [Improving Quality](#) above), we are reliant on the quality data provided to us. That data may be missing elements, collected across a sample that is not representative, or have other issues within that compromise its overall integrity. The same may be true for any other data sources that we reference in this report. For instance, within the data sets received for assessment data there was some missingness of data as well as a lack of demographic data associated with the assessment data. This led to difficulty in looking at trends and inequities within the population being assessed. We recommend including consistent identifiers to allow for merging data across multiple sources. Another option would be to include demographic data as part of collecting assessment responses to allow for further analysis.

Due to the way that the service system is operated for older adults, with regional entities managing the bulk of services, we were unable to request and receive certain types of data that would have greatly benefited this project and our understanding of how older adults access and use services.

We had a robust community engagement plan and attempted to be as inclusive as possible to reach the greatest number of people across disabilities and regions (see [Community Engagement](#)). We worked with various community organizations to coordinate and share information about the different opportunities for providing feedback. We did, however, have trouble recruiting some groups for participation. For example, we held specific sessions to hear from older adults about the problems that they experience in accessing and using support services. Compared to other community engagement sessions, these were not well attended. We also attempted to connect with organizations serving communities with Limited English Proficiency (LEP), to hear from diverse populations, but these efforts were not fruitful. The lack of diversity in whom we were able to connect should be considered in any interpretation of the research and recommendations that we share in this report.

Finally, our research was significantly enhanced by a review of publicly available information about other states and programs and interviews with people who were familiar with these innovations. In some cases, we were unable to connect with people who could speak more to specific initiatives of interest to our team, and were unable to gather more details, or were reliant on only reporting on the public information available, no matter how limited. If DHS is interested in taking recommendations further, it may explore additional means to understand from other states or programs the effort entailed in implementing different innovations.

# Appendix B: Service Examples

## Employment First Policies in Day Services Examples

State / Waiver	Service Title	Service Definition
<p><b>Delaware /</b>  <a href="#"><u>DDDS Lifespan Waiver</u></a></p>	<p>Prevocational Services</p>	<p>Per Delaware's Employment First Law, H.B. 319, signed into law in July 2012, and in accordance with H.B. 319 (codified in Delaware Code Title 19. 740) and in accordance with federal guidelines governing employment for persons with disabilities, agencies that provide services to persons with disabilities are required to consider competitive and integrated employment (CIE), including self-employment, as the first option when serving people with disabilities who are of working age. Prevocational services provide learning and work experiences, including volunteer work and/or internships, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services are expected to produce specific outcomes to be achieved, as determined by the individual and his/her services and supports planning team through an ongoing person-centered planning process evaluated annually. Initial referrals for prevocational services must also include a referral to the Division of Vocational Rehabilitation in order to determine eligibility for Vocational Rehabilitation services and to arrange for a formal community-based employment assessment. The results of the initial community-based employment assessment must support the outcome of integrated, competitive employment and include specific strategies to be achieved by participating in prevocational services that will ultimately enable the individual to obtain integrated, competitive employment. In order to continue to be eligible for prevocational services, service recipients must, at minimum, be assessed annually for the continued need for prevocational services. Reviewing individual progress toward the previously identified specific strategies shall be included as part of the annual assessment. Individuals receiving prevocational services must have employment-related outcomes in their person-centered services and supports plan; the general habilitation strategies must be designed to support such employment outcomes. Individuals will be eligible for and can choose to participate in prevocational services while engaging in job development or job search activities in order to expand employability skills. The optimal outcome for prevocational services is CIE in the community for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Prevocational services should enable each individual to attain the highest level of work in the most integrated setting and with the job matched to the</p>

individual's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines. Services are intended to develop and teach general skills; examples include, but are not limited to: ability to communicate effectively with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem-solving skills and strategies; general workplace safety and mobility training. Personal care is a component of this service but may not comprise the entirety of the service. Meals are not provided as part of this service. Prevocational facility-based services are the provision of regularly scheduled employment related activities that may be furnished at a fixed-site facility, in the general community, or any combination of service locations, provided that the activities take place in a non-residential setting that is separate from the participant's private residence or other residential living arrangement. Prevocational non-facility-based services may be furnished in the general community, or any combination of service locations, provided that the activities take place in a non-residential setting that is separate from the participant's private residence or other residential living arrangement. Individuals may gather at the beginning and end of the day at a "hub" before embarking on their employment-related activities of the day but may not spend any more than 1 hour in total at the hub during the scheduled program delivery day. Other than the brief period at the beginning or end of the day, prevocational non-facility-based services cannot be delivered in a provider-owned or managed setting. The provider must actively promote and be capable of providing opportunities for full access to participate in the greater community for those waiver participants that express a desire for such access and for whom it would not be contrary to their health and safety needs as articulated in their person-centered plan. The provider must demonstrate that they support individuals to exercise their option to achieve their desired level of participation in the community. To the greatest extent possible, individuals should be exposed to a broad array of community experiences so that they can make informed choices about what they like and what they don't like. When it is clearly documented in the person-centered plan that the service recipient uses sign language to communicate, DDDS may authorize a higher rate for prevocational services when the provider employs ASL fluent or certified staff to directly support the service recipient and their communication needs. When it is clearly documented in the person-centered plan that the service recipient has an increased behavioral support need, DDDS may authorize a higher rate for prevocational services when the provider employs Registered Behavior Technicians (RBTs) to directly support the service recipient in order to meet their behavioral support needs. The provider must also employ a Board-Certified Behavior Analyst (BCBA) to oversee the RBTs. Transportation to and from the service location may be billed as a component of the service for days when it is provided. Documentation is maintained that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or IDEA (20 U.S.C. 1401 et seq.).

<p><b>Colorado / <u>Developmental Disabilities</u></b></p>	<p>Workplace Assistance (find under Supported Employment)</p>	<p>Workplace Assistance services provide support at a member’s place of employment for members with elevated supervision needs who, because of valid safety concerns, may need assistance from a paid caregiver to maintain an individual job in an integrated work setting for which the member is compensated at or above minimum wage. The aim of Workplace Assistance is to support members who have been identified as having specific needs that are above and beyond what could be regularly supported by the workplace supervisor or co-workers and are outside the scope of intermittent Job Coaching support. The degree to which the member must be supported by a paid caregiver directly (as opposed to natural supports), should be based on actual needs related to the member, and the nature and specific details of their position and work location. The goal of the Workplace Assistance service is to address the safety-related needs of the member in order to maintain/sustain community employment or self-employment while promoting the member’s independence and integration at the worksite. Workplace Assistance services should encourage members to maximize their independence through the development of safety skills and the engagement of natural supports (e.g., supervisors and co-workers). Workplace Assistance is provided on a one-on-one basis and may be delivered intermittently or regularly throughout the member’s shift; or at times adjacent to the shift. Workplace Assistance supports the member by promoting integration, furthering natural support relationships, reinforcing/modeling safety skills, assisting with behavioral support needs (including implementation of behavioral support plans), redirecting, and reminders to follow work-related protocols/strategies. Workplace Assistance can also support the member with activities that are beyond job-related tasks that ensure they are integrated and successful at work, such as: assisting, if necessary, during breaks, lunches, occasional informal employee gatherings, and employer-sponsored events. Prior to Workplace Assistance being utilized, efforts have been made to promote the member’s independence with job tasks and minimize the need for the consistent presence of a paid caregiver by ensuring adequate job training, advocating for appropriate accommodations, leveraging natural supports, integrating technology, and using systematic instruction techniques.</p>
<p><b>Hawaii / <u>HCB Services for People with Intellectual and Developmental Disabilities (I/DD Waiver)</u></b></p>	<p>Discovery and Career Planning</p>	<p>Discovery &amp; Career Planning (DCP) combines elements of traditional prevocational services with career planning to provide supports that are ongoing throughout the participant’s work career. DCP is based on the belief that all individuals with intellectual and developmental disabilities can work when given the opportunity, training, and supports that build on their strengths, abilities, and interests. Based on the employment goals in the participant’s Individualized Service Plan (ISP), this service is designed to assist participants to: 1) acquire skills to achieve underlying habilitative goals that are associated with building skills necessary to perform work in integrated community employment; 2) explore possibilities/impact of work; and 3) develop career goals through career exploration and learning about personal interests, skills, and abilities. The outcome of DCP services is to complete or revise a career plan and develop the knowledge and skills needed to get a job in a competitive, integrated workplace. This is defined as a</p>



		<p>work place in the community or self-employment where the participant receives at least minimum wage or the prevailing wage for that work, where the majority of individuals do not have disabilities, and which provides opportunities to interact with non-disabled individuals to the same extent that individuals employed in comparable positions would interact. Services are time-limited. Participation in DCP is not a prerequisite for receiving individual employment supports. Personal care/assistance may be a component of DCP services but may not comprise the entirety of the service. DCP services include: 1) exploring employment goals and interests to identify a career direction; 2) community-based formal or informal situational assessments; 3) task analysis; 4) mobility training to be able to use fixed route and/or paratransit public transportation as independently as possible; 5) skills training/mentoring, work trials, apprenticeships, internships, and volunteer experiences; 6) training in communication with supervisors, co-workers and customers; generally accepted workplace conduct and attire; ability to follow directions; ability to attend to tasks; workplace problem-solving skills and strategies; general workplace safety and other skills as identified through the person-centered planning process; 7) broad career exploration and self-discovery resulting in targeted employment opportunities including job shadowing, information interviews, and other integrated worksite-based opportunities; 8) interviewing, video resumes, and other job-seeking activities; 9) transitioning the participant into employment supports for individualized competitive integrated employment or self-employment from: a) volunteer work, apprenticeships, internships or work trials; b) from a job the participant is currently in that pays less than minimum wage; and c) from a more segregated setting or group employment situation; 10) financial literacy, money management, and budgeting; and 11) when assisting a participant who is already employed, activities to support the participant in exploring other careers or opportunities. DCP is not intended to teach the participant task-specific skills to perform a particular job. This is provided through Individual Employment Supports. Transportation to and from activities will be provided or arranged by the provider and is included in the rate paid for the service. Any newly approved DCP provider must be in full compliance with the CMS HCBS Settings Final Settings Rule and be able to demonstrate the provision of services in fully integrated community settings. For settings that were operating prior to March 2014 as prevocational service providers, the setting must be in compliance, or working toward compliance, as part of the My Choice My Way state transition plan. DCP services are limited to a maximum of 24 cumulative months with an expectation that the participant is working at the end of this period in a competitive integrated job or is self-employed. An extension of the authorization may be made for a second 24-month interval if the participant has experienced a major gap in employment due to health or other issues. Services will not duplicate or replace services available to a participant under a program funded through section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401) but may complement those services beyond any program limitations. DCP excludes: 1) vocational services where participants are supervised for the primary purpose of producing goods or performing services, including services provided in sheltered</p>
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		<p>workshops and contract work at less than minimum wage; 2) payments that are passed through to participants, including payments of wages or stipends for internships or work experience; 3) paying employers incentives to encourage or subsidize the employer’s participation in internships or apprenticeships; 4) supporting participants to volunteer at for-profit organizations or businesses or to independently perform services without pay (“volunteering”) that benefit the waiver service provider or its staff and which would otherwise require the provider or staff to pay to have that service completed; 5) supporting any activities that involve payment of subminimum wage except for the purpose of assisting the participant to move into a job paying at or above minimum wage.</p>
<p><b><u>Indiana / Community Integration and Habilitation Waiver</u></b></p>	<p>Career Exploration and Planning</p>	<p>Career exploration is a targeted service designed to help an individual make an informed choice about whether they wish to pursue competitive integrated employment, (CIE), including self-employment, obtain information to dissuade myths around or hesitation about CIE, and to identify the career path they would like to pursue either independently or with other available supports. This service is ideal for individuals newly transitioning from school-based services who are unsure as to their path toward CIE and may be used to gather information in preparation for a referral to Vocational Rehabilitation Services, an American Jobs Center, or other employment supports. If the individual is employed, career exploration may be used to explore advancement opportunities in their chosen career, or to explore other CIE career objectives which are more consistent with their skills and interests. Career exploration is not appropriate for individuals who have determined their desired career path and are already actively seeking CIE in that career path, either independently or with employment supports. Individuals with identified career outcomes documented in the PCISP should be referred to Vocational Rehabilitation Services, American Job Centers, or other employment supports. This service also includes, when applicable, introductory education on the numerous work incentives for individuals receiving publicly funded benefits (e.g., SSI, SSDI, Medicaid, Medicare, etc.), and how Supported Employment services work (including Vocational Rehabilitation services). Educational information is provided to the individual and the legal guardian and/or most involved family member(s), if applicable, to ensure legal guardian/family support for the individual’s choice to pursue CIE. The educational aspects of this service shall include addressing any concerns, hesitations, or objections of the individual and the legal guardian/family, if applicable. Services may be provided on an individual basis or in groups dependent on participant choice. When group services are offered, the group shall not exceed 4 persons and must be formed based on shared CIE interests of the group members. Services must be provided in community settings.</p> <p>Reimbursable Activities: • Activities to identify an individual’s specific interests and aptitudes for CIE, including experience and skills transferable to CIE. • Exploration of CIE opportunities in the local area that are specifically related to the individual’s identified interests, experiences, and/or skills can include: - business tours - informational interviews - job shadows - work experiences. • Set-up, preparation for,</p>

		<p>and debriefing of each exploration opportunity. • Introductory education on available employment supports, work incentives, supported employment services, and benefits of working in CIE settings. • Development of documentation around individual’s interests and aptitudes, stated career objectives, and development of a strengths-based career profile for use and guidance when seeking individual employment support. This profile must include the individual’s determined career path and outcome documented in the PCISP. Career profiles may also be used to develop an individual’s resume and inform outreach to local employers. • When applicable, career profiles should include: - dreams, goals, and interests, - talents, skills, and knowledge, - learning styles, - positive personality traits and values, - workplace and environmental preferences, - dislikes and situations/careers to avoid, - previous work experiences, - support system and community resources, - specific challenges and possible solutions (including benefits considerations and accommodation needs), - career opportunities (including preferred career paths and potential contributions to community employers).</p>
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## Employment Transportation in Day Services Examples

State / Waiver	Service Title	Service Definition
<b>Delaware / <u>DDDS Waiver</u></b>	Supported Employment	... “Transportation between the participant’s place of residence and the employment site is a component of individual supported employment services and the cost of this transportation is included in the rate paid to providers of individual supported employment but may not compromise the entirety of the service.”
<b>Connecticut / <u>Employment and Day Supports Waiver</u></b>	Transportation	Services offered in order to enable individuals to get to their place of employment or their community-based day supports. These can include pre-purchased bus tickets or bus passes. Payment per mile is made for a maximum of one round trip daily. Wheelchair accessible transportation is paid at a higher rate only if the individual requires the use of a wheelchair accessible vehicle.
<b>Hawaii / <u>HCB Services for People with Intellectual and Developmental</u></b>	Individual Employment Supports	... “The job coach may transport the participant to and from the workplace on a temporary, transitional basis to assist the participant to retain employment while learning how to arrange and use transportation on an ongoing basis.”

<u>Disabilities (I/DD Waiver)</u>		
<u>Maryland / Community Pathways Waiver</u>	Supported Employment	<p>A. Supported Employment services include a variety of supports to help an individual identify career and employment interests, as well as to find and keep a job.</p> <p>Supported Employment activities include: 1. Individualized job development and placement; 2. On-the-job training in work and work-related skills; 3. Facilitation of natural supports in the workplace; 4. Ongoing support and monitoring of the individual's performance on the job; 5. Training in related skills needed to obtain and retain employment such as using community resources and public transportation; 6. Negotiation with prospective employers; and 7. Self-employment supports.</p> <p>C. Supported Employment services include: 1. Direct support services that enable the participant to gain and maintain CIE, as provided in Sections A-B above; 2. The following services provided in combination with, and incidental to, the provision of this waiver program service: a. Transportation to, from, and within this waiver program service; b. Delegated nursing tasks, based on the participant's assessed need; c. Personal care assistance, based on the participant's assessed need; and 3. Nursing Support Services. The scope of the Nursing Support Services is defined under the stand-alone service in Appendix C.</p>

## Complex Care Service Examples

State / Waiver	Service Title	Service Definition
<u>Alaska / Children with Complex Medical Conditions</u>	Nursing Oversight and Care Management	<p>“Nursing Oversight and Care Management (NOCM) services may be authorized for a recipient who needs extraordinary supervision and observation because of a medical condition. NOCM services are provided by a registered nurse employed by a certified NOCM provider agency. The NOCM nurse develops a nursing plan for inclusion in a participant's Support Plan if the participant is dependent on medical care or technology to maintain health; periodically experiences acute exacerbation of a severe medical condition that requires frequent or life-saving administration of specialized treatment; or is dependent on mechanical support devices. In addition, the NOCM nurse develops and implements a plan to train the participant and the participant's caregivers regarding how to perform the medical care tasks necessary to meet the recipient's needs. NOCM is different from state plan Private Duty Nursing and Home Health Nursing Services because the NOCM service allows a nurse to train and supervise family or service providers, delegate nursing tasks to those providers, and monitor the provision of those services and does not provide direct care nursing, unlike state plan services. NOCM services under this waiver are not otherwise covered under the</p>

		state plan, including EPSDT, and are consistent with waiver objectives of avoiding institutionalization.”
<b><u>Alaska / People with IDD</u></b>	Nursing Oversight and Care Management	“Nursing Oversight and Care Management (NOCM) services may be authorized for a recipient who needs extraordinary supervision and observation because of a medical condition. NOCM services are provided by a registered nurse employed by a certified NOCM provider agency. The NOCM nurse develops a nursing plan for inclusion in a participant’s Support Plan if the participant is dependent on medical care or technology to maintain health; periodically experiences acute exacerbation of a severe medical condition that requires frequent or life-saving administration of specialized treatment; or is dependent on mechanical support devices. In addition, the NOCM nurse develops and implements a plan to train the participant and the participant’s caregivers regarding how to perform the medical care tasks necessary to meet the recipient’s needs. NOCM is different from state plan Private Duty Nursing and Home Health Nursing Services because NOCM services allows a nurse to train and supervise family or service providers, delegate nursing tasks to those providers, and monitor the provision of those services and does not provide direct care nursing, unlike state plan services. NOCM services under this waiver are not otherwise covered under the state plan, including EPSDT, and are consistent with waiver objectives of avoiding institutionalization.”
<b><u>Colorado / Supported Living Services (SLS)</u></b>	Health Maintenance Activities	“Health maintenance activities include routine and repetitive health-related tasks furnished to an eligible member in the community or in the member’s home, which are necessary for health and normal bodily functioning that a person with a disability is physically unable to carry out.”
<b><u>Connecticut / Comprehensive Supports Waiver</u></b>	Health Care Coordination	“Assessment, education and assistance provided by a registered nurse to those waiver participants with identified health risks living in their own homes with less than 24 hour supports, and who, as a result of their intellectual disability, have limited ability to identify changes in their health status or to manage their complex medical conditions. These participants have medical needs that require more healthcare coordination than is available through their primary healthcare providers to ensure their health, safety and well-being. This service will ensure that there is communication between primary care physicians, medical specialists, and behavioral health practitioners, and will provide a resource person to communicate to consumers and direct support staff (if utilized by the participant) and train them to follow through on medical recommendations. The RN Healthcare Coordinator will complete a comprehensive nursing assessment on each participant and develop an integrated healthcare management plan for the participant and his/her support staff (if utilized by the participant) to implement. This service shall provide the clinical and technical guidance necessary to support the participant in managing complex health care services and supports to improve health outcomes and

		prevent admission to a nursing facility. Support provided includes, but is not limited to, the following: train/retrain staff (if utilized by the participant) on interventions; monitor the effectiveness of interventions, coordinate specialists, evaluate treatment recommendations, review lab results; monitor, coordinate tests/results; and review diets. This service is only available to individuals with identified health risks who receive less than 24-hour supports in their own home. The RN Healthcare Coordinator does not provide skilled nursing services that are available under the Medicaid State plan.”
<b><u>Connecticut / Individual and Family Support Waiver</u></b>	Health Care Coordination	“Assessment, education and assistance provided by a registered nurse to those waiver participants with identified health risks living in their own homes with less than 24-hour supports, and who, as a result of their intellectual disability, have limited ability to identify changes in their health status or to manage their complex medical conditions. These participants have medical needs that require more healthcare coordination than is available through their primary healthcare providers to ensure their health, safety and well-being. This service will ensure that there is communication between primary care physicians, medical specialists, and behavioral health practitioners, and will provide a resource person to communicate to consumers and direct support staff (if utilized by the participant) and train them to follow through on medical recommendations. The RN Healthcare Coordinator will complete a comprehensive nursing assessment on each participant and develop an integrated healthcare management plan for the participant and his/her support staff (if utilized by the participant) to implement. This service shall provide the clinical and technical guidance necessary to support the participant in managing complex health care services and supports to improve health outcomes and prevent admission to a nursing facility. Support provided includes, but is not limited to, the following: train/retrain staff (if utilized by the participant) on interventions; monitor the effectiveness of interventions; coordinate specialists; evaluate treatment recommendations; review lab results; monitor, coordinate tests/results; and review diets. This service is only available to individuals with identified health risks who receive less than 24-hour supports in their own home. The RN Healthcare Coordinator does not provide skilled nursing services that are available under the Medicaid State plan.”
<b><u>Georgia / Independent Care Waiver Program (ICWP)</u></b>	Enhanced Case Management	“Definition of Enhanced Case Management: A collaborative process which includes assessing, implementing, coordinating, monitoring, evaluating options and services required to meet an individual’s needs and making referrals as needed. Enhanced Case Management service provides focused attention on high-risk waiver members with complex medical or behavioral/brain injury needs. Nurses must be registered nurses (Nurse Practice Act. O.C.G.A. 43-26-1) certified in rehabilitation or case management to ensure that waiver consumers residing in the community maintain maximum control possible over daily decisions and health. The process will use all available resources for cost-effective outcomes with a focus on waiver participant education in self-care and



		<p>self-management. The case manager serves as the pivotal core for service planning and delivery for the ICWP and in the case of the member who requires enhanced case management, serves as the coordinator of specialized supplies, equipment, acute care and rehabilitative care. Case managers authorize services for the member within the budget set by DCH.”</p>
<p><b><u>Indiana / Pathways for Aging Waiver</u></b></p>	<p>Integrated Health Care Coordination</p>	<p>“Integrated Health Care Coordination is to promote improved health status and quality of life, delay/prevent deterioration of health status, manage chronic conditions in collaboration with the participant's provider and circle of support, and integrate medical and social services. Allowable activities: development and oversight of a healthcare support plan which includes coordination of medical care and proactive care management of both chronic diseases and complex conditions such as falls, depression, and dementia; skilled nursing services provided within the scope of the Indiana State Nurse Practice Act; collaboration across all service providers: waiver, state plan, mental health, dental, medical; collaboration across social supports: housing, food, Medicare/Medicaid system navigation, finances, transportation; medication review; transitional support from hospital or nursing facility to home/assisted living; and advanced care planning. C. Provider standards: current Indiana RN license for each nurse; current Indiana license for each LPN; Indiana license for social worker (LSW) with master’s degree in social work with additional documentation of at least two years of experience providing health care coordination; weekly consultations or reviews; face-to-face visits with the participant, including a minimum of one face-to-face visit per month, not to exceed 16 hours of Health Care Coordination per month, including travel time. Service Coordinator/Care Manager Standards: service coordinator/care manager is expected to coordinate and collaborate with the participant’s integrated health care coordination provider; review any and all updates about the participant from the health care coordination provider, including interventions and follow up with the participant about changes in medical and social services as well as interventions implemented by the health care coordinator provider to ensure the member’s needs are being met.; the service coordinator/care manager shall communicate information learned in these follow-up meetings with the integrated health care coordination provider and shall work together to resolve any unmet needs identified. Documentation standards: evidence of a consultation including complete date and signature; consultation can be with the participant, informal caregivers, other staff, other professionals, as well as health care professionals; weekly consultations or reviews; minimum of one face-to-face visit/month. IHCC is not to exceed 16 hours per month. Services must address needs identified in the service plan as determined by the person-centered planning process. The provider will provide a written report to pertinent parties at least quarterly. Pertinent parties include the participant, guardian, waiver service coordinator/care manager and all waiver service providers, including mental health providers, state plan services, and physicians.”</p>

<p><b><u>Indiana / Traumatic Brain Injury Waiver</u></b></p>	<p>Integrated Health Care Coordination</p>	<p>“Integrated Health Care Coordination is to promote improved health status and quality of life, delay/prevent deterioration of health status, manage chronic conditions in collaboration with the participant’s provider and circle of support, and integrate medical and social services. Allowable activities: development and oversight of a healthcare support plan which includes coordination of medical care and proactive care management of both chronic diseases and complex conditions such as falls, depression, and dementia; skilled nursing services that are provided within the scope of the Indiana State Nurse Practice Act; collaboration across all service providers: waiver, state plan, mental health, dental, medical; collaboration across social supports: housing, food, Medicare/Medicaid system navigation, finances, transportation; medication review; transitional support from hospital or nursing facility to home/assisted living; and advanced care planning. Provider standards: a current Indiana RN license for each nurse; current Indiana license for each LPN; Indiana license for social worker (LSW) with master’s degree in social work with additional documentation of at least two years of experience providing health care coordination; weekly consultations or reviews; face-to-face visits with the participant, including a minimum of one face-to-face visit per month, not to exceed 16 hours of health care coordination per month, including travel time. Service Coordinator/Care Manager Standards: service coordinator/care manager is expected to coordinate and collaborate with the participant’s integrated health care coordination provider; review any and all updates about the participant from the health care coordination provider, including interventions and follow up with the participant about changes in medical and social services as well as interventions implemented by the health care coordinator provider to ensure the member’s needs are being met. The service coordinator/care manager shall communicate information learned in these follow-up meetings with the integrated health care coordination provider and shall work together to resolve any unmet needs identified. Documentation standards: evidence of a consultation including complete date and signature; consultation can be with the participant, informal caregivers, other staff, other professionals, as well as health care professionals; weekly consultations or reviews; minimum of one face-to-face visit/month. IHCC is not to exceed 16 hours per month. Services must address needs identified in the service plan as determined by the person-centered planning process. The provider will provide a written report to pertinent parties at least quarterly. Pertinent parties include the participant, guardian, waiver service coordinator/care manager; all waiver service providers including mental health providers, state plan services, and physicians.”</p>
<p><b><u>Kansas / Technology Assisted Waiver</u></b></p>	<p>Health Maintenance Monitoring</p>	<p>“This service is provided in conjunction with agency-directed or self-directed attendant care services to provide ongoing evaluation and oversight of the participant’s health and welfare status. This service is intended to assure the participant that medical needs are being met when his/her healthcare is being managed by a non-licensed agency or self-directed attendant. Specifically, the</p>



		<p>services to be provided include the following: 1. General healthcare assessment; 2. Assess vital signs; 3. Assessing proper healthcare management activities; 4. Assessing for appropriate medication administration; 5. Consultation with the participant/ parent/ legal guardian regarding assessment and participant's general healthcare status; 6. Report assessment findings to MCO Care Coordinator; 7. May include delegation or supervision of KDAD'S approved health maintenance activities. The participant may select his/her provider of choice. Health Maintenance Activities provided through the Personal Care Service and through Health Maintenance Monitoring service cannot be billed at the same time or time of day.”</p>
<p><b>Massachusetts / <u>Frail Elder Waiver</u></b></p>	<p>Complex Care Training and Oversight</p>	<p>“Complex Care Training and Oversight is a periodic, episodic service that includes medication management, filling medication cassettes, as well as development and ongoing management and evaluation of the participant’s Home Health Aide Plan of Care, for purposes of monitoring the participant’s underlying conditions or complications to ensure the unskilled care is successfully addressing the participant’s needs. Complex Care Training and Oversight includes the provision of education and services requiring specialized skills related to the participant’s health conditions promoting health and welfare. Complex Care Training and Oversight services listed in the service plan that are within the scope of the State’s Nurse Practice Act and are provided by a Registered Nurse or a Licensed Practical Nurse with a valid Massachusetts license. Agencies that provide Complex Care Training and Oversight services under the waiver do not need to meet the requirements for participation in Medicare, as provided in 42 CFR §489.28.”</p>
<p><b>Maryland / <u>Community Pathways Waiver</u></b></p>	<p>Nursing Support Services</p>	<p>“A. Nursing Support Services provides a registered nurse (RN), licensed in the state of Maryland, to perform Nursing Consultation, Health Case Management, and Delegation services, based on the participant’s assessed need. B. At a minimum, the RN must perform an initial nursing assessment. 1. This initial nursing assessment must include: a. Review of the participant’s health needs, including: i. Health care services and supports that the participant currently receives; and ii. The participant’s health records, including any physician orders; b. Performance of a comprehensive nursing assessment; c. Clinical review of the participant’s HRST, in accordance with department policy; and d. Completion of the Medication Administration Screening Tool, in accordance with department policy. 2. The purpose of this initial nursing assessment is to determine the participant’s assessed needs, particularly whether: a. The participant’s health needs require performance of nursing tasks, including administration of medication, b. The participant’s nursing tasks are delegable in accordance with the MBON’s regulations, and c. The participant’s nursing tasks are Exempt from delegation in accordance with the MBON’s regulations. C. Based on the initial nursing assessment, if the participant requires, and meets criteria to receive, Nursing Consultation services, then the RN providing Nurse Consultation services must: 1. Provide recommendations to the participant on how to have the participant’s health needs met in the community, including accessing health services</p>

	<p>available in the community and other community resources; 2. Develop or review health care protocols, including emergency protocols, for the participant and the participant's uncompensated caregivers for use in training the participant's direct support staff; and 3. Develop or review communication systems the participant may need to communicate effectively with: a. The participant's health care providers, direct support staff, and uncompensated caregivers who work to ensure the health of the participant; and b. Resources in the community that may be needed to support the participant's health needs, such as notifying the electrical company if the participant has medical equipment that requires prompt restoration of power in the event of a power outage. 1. Provide recommendations to the provider and direct support staff on how to have the participant's health needs met in the community, including accessing health services available in the community and other community resources; 2. Develop a Nursing Care Plan and protocols regarding the participant's specific health needs; and 3. Provide training to the provider's direct support staff on how to address the participant's specific health needs, in accordance with the health care plans and protocols developed. E. Health case management services ... does not include delegation of nursing tasks to the direct support staff and, therefore, does not require continuous nursing assessments of the participant or monitoring of the provision of services by the direct support staff. F. Based on the initial nursing assessment, if the participant requires, and meets criteria to receive Delegation services then the RN providing delegation services must: 1. Provide recommendations to the participant, the direct support staff, and, if applicable, the participant's providers on how to have the participant's health needs met in the community, including accessing health services available in the community and other community resources; 2. Develop a Nursing Care Plan and health care plans and protocols regarding the participant's specific health needs in accordance with applicable regulations and standards of nursing care; 3. Provide training to direct support staff on how to address the participant's specific health needs and to perform the delegated nursing tasks, in accordance with the Nursing Care Plan and health care plans and protocols developed; 4. Monitor the direct support staff's performance of delegated nursing tasks, including reviewing applicable documentation that must be maintained in accordance with applicable regulations and standards of nursing care; 5. Continually monitor the participant's health by conducting nursing assessments and reviewing health data documented and reported by direct support staff, in accordance with applicable regulations and standards of nursing care; 6. Ensure availability on a 24/7 basis, or provide qualified back-up, to address the participant's health needs as may arise emergently; and 7. Collaborate with the participant enrolled in the SDS delivery model or the provider to develop policies and procedures governing delegation of nursing tasks in accordance with COMAR 10.27.11 and other applicable regulations. G. Nursing Support Services (i.e., nurse consultation, health case management and delegation services) do not include provision of any direct nursing care services to a participant. Service requirements:: A. The DDA will authorize the amount, duration, and types of</p>
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services under this waiver program service. Based on the initial nursing assessment, if the participant requires, and meets criteria to receive, Health Case Management services, then the RN providing Health Case Management services must: assess participants' level of service need and in accordance with other applicable requirements. If the participant's health needs change, the participant may submit a new request for additional hours or different services, with applicable supporting documentation, to the DDA. B. Based on the initial nursing assessment, the participant may be eligible for Nursing Support Services if the participant meets the criteria below. 1. A participant is eligible to receive Nurse Consultation services if: a. The participant's health needs require performance of nursing tasks, including administration of medication, b. The participant is enrolled in the SDS delivery model, c. The participant receives a waiver program service for which the participant has employer authority, as provided d. The participant directly employs, or contracts with, direct support staff under that employer authority and, therefore, is responsible for directing and managing direct support staff in provision of that waiver program service, and e. The participant's health needs are exempt from delegation of nursing tasks in accordance with applicable Maryland regulations. 2. A participant is eligible to receive Health Case Management services if: a. The participant's health needs require performance of nursing tasks, including administration of medication, b. The participant either: i. Is enrolled in the traditional services delivery model; or ii. Is enrolled in the SDS delivery model and receives a waiver program service for which the participant does not have employer authority, as provided in Appendix E; c. A provider, and not the participant, directly employs, or contracts with, direct support staff under the provider's employer authority and, therefore, is responsible for directing and managing direct support staff in provision of that waiver program service; and d. The participant's health needs are exempt from delegation of nursing tasks in accordance with applicable Maryland regulations. 3. A participant is eligible to receive Delegation services if: a. The participant's health needs require performance of nursing tasks, including administration of medication, b. The participant is enrolled in either service delivery model; c. Direct support staff provide the participant with a waiver program service, whether employed by, or contracted with, a provider or the participant; d. During provision of that waiver program service, the direct support staff needs to perform nursing tasks for the participant to maintain the participant's health and safety, e. The nursing tasks are delegable to the direct support staff in accordance with applicable Maryland regulations, and f. The participant's health needs are not exempt from delegation of nursing tasks in accordance with applicable Maryland regulations. 4. A participant is not eligible to receive any of these additional nursing services beyond the initial assessment (i.e., Nurse Consultation, Health Case Management, or Delegation services) if: Appendix E; a. The participant's health needs do not require performance of any nursing tasks or administration of any medication, b. The nursing tasks are not delegable in accordance with applicable Maryland regulations, or c. The participant does not have any direct support staff paid, to

provide any Waiver program service either under the traditional services delivery model or SDS delivery model, or any uncompensated caregivers. C. The RN must complete and maintain documentation of delivery of these waiver program services, including any nursing assessments, nursing care plans, health care plans and protocols, training of participant, direct support staff, and/or uncompensated caregivers, and any other documentation of services, in accordance with applicable Maryland laws and regulations, Department policies, and standards of nursing care. D. The RN must comply with all applicable laws, regulations, and department policies governing delivery of these waiver program services, including but not limited to MBON's regulations, and the standards of nursing care. If there is a conflict: E. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including those services offered by Maryland Medicaid State Plan, MSDE, DORS, and DHS or any other federal or State government funding program must be explored and exhausted to the extent applicable. 1. These efforts must be documented in the participant's file. 2. If these services are deemed by the participant's person-centered planning team to be inappropriate to meet the specific needs of the participant, the exploration efforts and reasons that these services do not meet the participant's needs shall be documented in the participant's PCP. The DDA has authority to determine if further efforts must be made, and documented, prior to authorization of funding for the service under the Waiver program. F. A participant cannot qualify, or receive funding from the Waiver program, for this Waiver program service if the participant: 1. Requires provision of direct nursing care services provided by a licensed nurse; or 2. Currently receives, or is eligible to receive, nursing services in another health care program paid for by the Maryland Medicaid Program or the department, such as hospital services, skilled nursing or rehabilitation facility services, or Medicaid Program's Rare and Expensive Case Management Program's private duty nursing services. G. To the extent that any listed services are covered under the Medicaid State Plan, the services under the waiver would be limited to additional services as allowed and not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization. Between this waiver program service and applicable MBON regulations, the applicable MBON regulations will control. H. Children have access to any medically necessary preventive, diagnostic, and treatment services under EPSDT services to help meet children's health and developmental needs. This includes age appropriate medical, dental, vision, and hearing screening services and diagnostic and treatment services to correct or ameliorate identified conditions. Supports provided by this waiver service is to improve and maintain the ability of the child to remain in and engage in community activities. I. A legally responsible person, legal guardian, or relative (that is not a spouse) cannot be paid by the waiver program, either directly or indirectly, to provide this waiver program service unless otherwise approved by the DDA due to extraordinary circumstances in accordance with the applicable requirements set forth in Section C-2. J. For participants enrolled in the SDS delivery model, this waiver program service

		<p>includes: 1. The reasonable and customary costs of training the participant’s direct support staff, including First Aid and CPR certifications; 2. Travel reimbursement, benefits, and leave time for the participant’s direct support staff, subject to the following requirements: a. The reimbursement, benefits and leave time requested are i. Within applicable reasonable and customary standards as established by DDA policy; or ii. Required for the participant’s compliance, as the employer of record, with applicable federal, State, or local laws; and b. Any reimbursement (e.g., mileage), benefit and leave time requested by the participant must comply with applicable federal, State, or local laws. c. Mileage reimbursement, under the SDS delivery model, to the owner of a specialized, modified, or accessible vehicle driven by an employee of the participant and for the purpose of the participant engaging in activities specified in the recipient’s PCP. 3. Cost for training, mileage, benefits, and leave time are allocated from the participant’s total budget allocation.”</p>
<p><b><u>Maryland / Community Supports Waiver</u></b></p>	<p>Nursing Support Services</p>	<p>“A. Nursing Support Services provides a registered nurse (RN), licensed in the state of Maryland, to perform Nursing Consultation, Health Case Management, and Delegation services, based on the participant’s assessed need. B. At a minimum, the RN must perform an initial nursing assessment. 1. This initial nursing assessment must include: a. Review of the participant’s health needs, including: i. Health care services and supports that the participant currently receives; and ii. The participant’s health records, including any physician orders; b. Performance of a comprehensive nursing assessment; c. Clinical review of the participant’s HRST, in accordance with department policy; and d. Completion of the Medication Administration Screening Tool, in accordance with department policy. 2. The purpose of this initial nursing assessment is to determine the participant’s assessed needs, particularly whether: a. The participant’s health needs require performance of nursing tasks, including administration of medication, b. The participant’s nursing tasks are delegable in accordance with the MBON’s regulations, and c. The participant’s nursing tasks are exempt from delegation in accordance with the MBON’s regulations. C. Based on the initial nursing assessment, if the participant requires, and meets criteria to receive, Nursing Consultation services, then the RN providing Nurse Consultation services must: 1. Provide recommendations to the participant on how to have the participant’s health needs met in the community, including accessing health services available in the community and other community resources; 2. Develop or review health care protocols, including emergency protocols, for the participant and the participant’s uncompensated caregivers for use in training the participant’s direct support staff; and 3. Develop or review communication systems the participant may need to communicate effectively with: a. The participant’s health care providers, direct support staff, and uncompensated caregivers who work to ensure the health of the participant; and b. Resources in the community that may be needed to support the participant’s health needs, such as notifying the electrical company if the participant has medical equipment that requires prompt restoration of power in the event of a power outage. 1.</p>

	<p>Provide recommendations to the provider and direct support staff on how to have the participant's health needs met in the community, including accessing health services available in the community and other community resources; 2. Develop a Nursing Care Plan and protocols regarding the participant's specific health needs; and 3. Provide training to the provider's direct support staff on how to address the participant's specific health needs, in accordance with the health care plans and protocols developed. E. Health Case Management services, as provided in Section D above, does not include delegation of nursing tasks to the direct support staff and, therefore, does not require continuous nursing assessments of the participant or monitoring of the provision of services by the direct support staff. F. Based on the initial nursing assessment, if the participant requires, and meets criteria to receive Delegation services then the RN providing Delegation services must: 1. Provide recommendations to the participant, the direct support staff, and, if applicable, the participant's providers on how to have the participant's health needs met in the community, including accessing health services available in the community and other community resources; 2. Develop a Nursing Care Plan and health care plans and protocols regarding the participant's specific health needs in accordance with applicable regulations and standards of nursing care; 3. Provide training to direct support staff on how to address the participant's specific health needs and to perform the delegated nursing tasks, in accordance with the Nursing Care Plan and health care plans and protocols developed; 4. Monitor the direct support staff's performance of delegated nursing tasks, including reviewing applicable documentation that must be maintained in accordance with applicable regulations and standards of nursing care; 5. Continually monitor the participant's health by conducting nursing assessments and reviewing health data documented and reported by direct support staff, in accordance with applicable regulations and standards of nursing care; 6. Ensure available on a 24/7 basis, or provide qualified back-up, to address the participant's health needs as may arise emergently; and 7. Collaborate with the participant enrolled in the SDS delivery model or the provider to develop policies and procedures governing delegation of nursing tasks in accordance with COMAR 10.27.11 and other applicable regulations. G. Nursing Support Services (i.e., Nurse Consultation, Health Case Management and Delegation services) do not include provision of any direct nursing care services to a participant. Service Requirements: A. The DDA will authorize the amount, duration, and types of services under this Waiver program service based on the D. Based on the initial nursing assessment, if the participant requires, and meets criteria to receive, Health Case Management services, then the RN providing Health Case Management services must: participant's assessed level of service need and in accordance with other applicable requirements. If the participant's health needs change, the participant may submit a new request for additional hours or different services, with applicable supporting documentation, to the DDA. B. Based on the initial nursing assessment, the participant may be eligible for Nursing Support Services if the participant meets the criteria below. 1. A participant is eligible to receive Nurse Consultation</p>
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services if: a. The participant's health needs require performance of nursing tasks, including administration of medication, b. The participant is enrolled in the SDS delivery model, c. The participant receives a waiver program service for which the participant has employer authority, as provided in d. The participant directly employs, or contracts with, direct support staff under that employer authority and, therefore, is responsible for directing and managing direct support staff in provision of that waiver program service, and e. The participant's health needs are exempt from delegation of nursing tasks in accordance with applicable Maryland regulations. 2. A participant is eligible to receive Health Case Management services if: a. The participant's health needs require performance of nursing tasks, including administration of medication, b. The participant either: i. Is enrolled in the traditional services delivery model; or ii. Is enrolled in the SDS delivery model and receives a waiver program service for which the participant does not have employer authority, as provided in Appendix E; c. A provider, and not the participant, directly employs, or contracts with, direct support staff under the provider's employer authority and, therefore, is responsible for directing and managing direct support staff in provision of that waiver program service; and d. The participant's health needs are exempt from delegation of nursing tasks in accordance with applicable Maryland regulations. 3. A participant is eligible to receive Delegation services if: a. The participant's health needs require performance of nursing tasks, including administration of medication, b. The participant is enrolled in either service delivery model; c. Direct support staff provide the participant with a waiver program service, whether employed by, or contracted with, a provider or the participant; d. During provision of that Waiver program service, the direct support staff needs to perform nursing tasks for the participant to maintain the participant's health and safety, e. The nursing tasks are delegable to the direct support staff in accordance with applicable Maryland regulations, and f. The participant's health needs are not exempt from delegation of nursing tasks in accordance with applicable Maryland regulations. 4. A participant is not eligible to receive any of these additional nursing services beyond the initial assessment (i.e., Nurse Consultation, Health Case Management, or Delegation services) if: Appendix E; a. The participant's health needs do not require performance of any nursing tasks or administration of any medication, b. The nursing tasks are not delegable in accordance with applicable Maryland regulations, or c. The participant does not have any direct support staff paid, to provide any waiver program service either under the traditional services delivery model or SDS delivery model, or any uncompensated caregivers. C. The RN must complete and maintain documentation of delivery of these waiver program services, including any nursing assessments, nursing care plans, health care plans and protocols, training of participant, direct support staff, and/or uncompensated caregivers, and any other documentation of services, in accordance with applicable Maryland laws and regulations, Department policies, and standards of nursing care. D. The RN must comply with all applicable laws, regulations, and Department policies governing delivery of these Waiver program services, including

but not limited to MBON's regulations, and the standards of nursing care. If there is a conflict E. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including those services offered by Maryland Medicaid State Plan, MSDE, DORS, and DHS or any other federal, or State government funding program must be explored and exhausted to the extent applicable. 1. These efforts must be documented in the participant's file. 2. If these services are deemed by the participant's person-centered planning team to be inappropriate to meet the specific needs of the participant, the exploration efforts and reasons that these services do not meet the participant's needs shall be documented in the participant's PCP. The DDA has authority to determine if further efforts must be made, and documented, prior to authorization of funding for the service under the Waiver program. F. A participant cannot qualify, or receive funding from the Waiver program, for this Waiver program service if the participant: 1. Requires provision of direct nursing care services provided by a licensed nurse; or 2. Currently receives, or is eligible to receive, nursing services in another health care program paid for by the Maryland Medicaid Program or the Department, such as hospital services, skilled nursing or rehabilitation facility services, or Medicaid Program's Rare and Expensive Case Management Program's private duty nursing services. G. To the extent that any listed services are covered under the Medicaid State Plan, the services under the waiver would be limited to additional services as allowed and not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization. Between this Waiver program service and applicable MBON regulations, the applicable MBON regulations will control. H. Children have access to any medically necessary preventive, diagnostic, and treatment services under EPSDT services to help meet children's health and developmental needs. This includes age appropriate medical, dental, vision, and hearing screening services and diagnostic and treatment services to correct or ameliorate identified conditions. Supports provided by this waiver service is to improve and maintain the ability of the child to remain in and engage in community activities. I. A legally responsible person, legal guardian, or relative (that is not a spouse) cannot be paid by the waiver program, either directly or indirectly, to provide this waiver program service unless otherwise approved by the DDA due to extraordinary circumstances in accordance with the applicable requirements set forth in Section C-2. J. For participants enrolled in the SDS delivery model, this waiver program service includes: 1. The reasonable and customary costs of training the participant's direct support staff, including First Aid and CPR certifications; 2. Travel reimbursement, benefits and leave time for the participant's direct support staff, subject to the following requirements: a. The reimbursement, benefits and leave time requested are i. Within applicable reasonable and customary standards as established by DDA policy; or ii. Required for the participant's compliance, as the employer of record, with applicable federal, State, or local laws; and b. Any reimbursement (e.g., mileage), benefit and leave time requested by the participant must comply with applicable federal, State, or local laws. c. Mileage reimbursement, under the SDS

		<p>delivery model, to the owner of a specialized, modified, or accessible vehicle driven by an employee of the participant and for the purpose of the participant engaging in activities specified in the recipient's PCP. 3. Cost for training, mileage, benefits, and leave time are allocated from the participant's total budget allocation."</p>
<p><b>Maryland / Family Supports Waiver</b></p>	<p>Nursing Support Services</p>	<p>1. Provide recommendations to the provider and direct support staff on how to have the participant's health needs met in the community, including accessing health services available in the community and other community resources; 2. Develop a Nursing Care Plan and protocols regarding the participant's specific health needs; and 3. Provide training to the provider's direct support staff on how to address the participant's specific health needs, in accordance with the health care plans and protocols developed. E. Health Case Management services, as provided in Section D above, does not include delegation of nursing tasks to the direct support staff and, therefore, does not require continuous nursing assessments of the participant or monitoring of the provision of services by the direct support staff. F. Based on the initial nursing assessment, if the participant requires, and meets criteria to receive Delegation services, then the RN providing Delegation services must: 1. Provide recommendations to the participant, the direct support staff, and, if applicable, the participant's providers on how to have the participant's health needs met in the community, including accessing health services available in the community and other community resources; 2. Develop a Nursing Care Plan and health care plans and protocols regarding the participant's specific health needs in accordance with applicable regulations and standards of nursing care; 3. Provide training to direct support staff on how to address the participant's specific health needs and to perform the delegated nursing tasks, in accordance with the Nursing Care Plan and health care plans and protocols developed; 4. Monitor the direct support staff's performance of delegated nursing tasks, including reviewing applicable documentation that must be maintained in accordance with applicable regulations and standards of nursing care; 5. Continually monitor the participant's health by conducting nursing assessments and reviewing health data documented and reported by direct support staff, in accordance with applicable regulations and standards of nursing care; 6. Ensure available on a 24/7 basis, or provide qualified back-up, to address the participant's health needs as may arise emergently; and 7. Collaborate with the participant enrolled in the SDS delivery model or the provider to develop policies and procedures governing delegation of nursing tasks in accordance with COMAR 10.27.11 and other applicable regulations. G. Nursing Support Services (i.e., Nurse Consultation, Health Case Management and Delegation services) do not include provision of any direct nursing care services to a participant. Service Requirements: A. The DDA will authorize the amount, duration, and types of services under this waiver program service based on the D. Based on the initial nursing assessment, if the participant requires, and meets criteria to receive, Health Case Management services, then the RN providing Health Case Management</p>



services must: participant's assessed level of service need and in accordance with other applicable requirements. If the participant's health needs change, the participant may submit a new request for additional hours or different services, with applicable supporting documentation, to the DDA. B. Based on the initial nursing assessment, the participant may be eligible for Nursing Support Services if the participant meets the criteria below. 1. A participant is eligible to receive Nurse Consultation services if: a. The participant's health needs require performance of nursing tasks, including administration of medication, b. The participant is enrolled in the SDS delivery model, c. The participant receives a waiver program service for which the participant has employer authority, as provided in

"A. Nursing Support Services provides a registered nurse (RN), licensed in the State of Maryland, to perform Nursing Consultation, Health Case Management, and Delegation services, based on the participant's assessed need. B. At a minimum, the RN must perform an initial nursing assessment. 1. This initial nursing assessment must include: a. Review of the participant's health needs, including: i. Health care services and supports that the participant currently receives; and ii. The participant's health records, including any physician orders; b. Performance of a comprehensive nursing assessment; c. Clinical review of the participant's HRST, in accordance with Department policy; and d. Completion of the Medication Administration Screening Tool, in accordance with Department policy. 2. The purpose of this initial nursing assessment is to determine the participant's assessed needs, particularly whether: a. The participant's health needs require performance of nursing tasks, including administration of medication, b. The participant's nursing tasks are delegable in accordance with the MBON's regulations, and c. The participant's nursing tasks are Exempt from delegation in accordance with the MBON's regulations. C. Based on the initial nursing assessment, if the participant requires, and meets criteria to receive, Nursing Consultation services, then the RN providing Nurse Consultation services must: 1. Provide recommendations to the participant on how to have the participant's health needs met in the community, including accessing health services available in the community and other community resources; 2. Develop or review health care protocols, including emergency protocols, for the participant and the participant's uncompensated caregivers for use in training the participant's direct support staff; and 3. Develop or review communication systems the participant may need to communicate effectively with: a. The participant's health care providers, direct support staff, and uncompensated caregivers who work to ensure the health of the participant; and b. Resources in the community that may be needed to support the participant's health needs, such as notifying the electrical company if the participant has medical equipment that requires prompt restoration of power in the event of a power outage. d. The participant directly employs, or contracts with, direct support staff under that employer authority and, therefore, is responsible for directing and managing direct support staff in provision of that waiver program service, and e. The participant's health needs are exempt from delegation of nursing

tasks in accordance with applicable Maryland regulations. 2. A participant is eligible to receive Health Case Management services if: a. The participant's health needs require performance of nursing tasks, including administration of medication, b. The participant either: i. Is enrolled in the traditional services delivery model; or ii. Is enrolled in the SDS delivery model and receives a waiver program service for which the participant does not have employer authority, as provided in Appendix E; c. A provider, and not the participant, directly employs, or contracts with, direct support staff under the provider's employer authority and, therefore, is responsible for directing and managing direct support staff in provision of that waiver program service; and d. The participant's health needs are exempt from delegation of nursing tasks in accordance with applicable Maryland regulations. 3. A participant is eligible to receive Delegation services if: a. The participant's health needs require performance of nursing tasks, including administration of medication, b. The participant is enrolled in either service delivery model; c. Direct support staff provide the participant with a waiver program service, whether employed by, or contracted with, a provider or the participant; d. During provision of that Waiver program service, the direct support staff needs to perform nursing tasks for the participant to maintain the participant's health and safety, e. The nursing tasks are delegable to the direct support staff in accordance with applicable Maryland regulations, and f. The participant's health needs are not exempt from delegation of nursing tasks in accordance with applicable Maryland regulations. 4. A participant is not eligible to receive any of these additional nursing services beyond the initial assessment (i.e., Nurse Consultation, Health Case Management, or Delegation services) if: Appendix E; a. The participant's health needs do not require performance of any nursing tasks or administration of any medication, b. The nursing tasks are not delegable in accordance with applicable Maryland regulations, or c. The participant does not have any direct support staff paid, to provide any waiver program service either under the traditional services delivery model or SDS delivery model, or any uncompensated caregivers. C. The RN must complete and maintain documentation of delivery of these waiver program services, including any nursing assessments, nursing care plans, health care plans and protocols, training of participant, direct support staff, and/or uncompensated caregivers, and any other documentation of services, in accordance with applicable Maryland laws and regulations, Department policies, and standards of nursing care. D. The RN must comply with all applicable laws, regulations, and Department policies governing delivery of these waiver program services, including but not limited to MBON's regulations, and the standards of nursing care. If there is a conflict: E. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including those services offered by Maryland Medicaid State Plan, MSDE, DORS, and DHS or any other federal, or State government funding program must be explored and exhausted to the extent applicable. 1. These efforts must be documented in the participant's file. 2. If these services are deemed by the participant's person-centered planning team to be inappropriate to meet the specific needs of the

participant, the exploration efforts and reasons that these services do not meet the participant's needs shall be documented in the participant's PCP. The DDA has authority to determine if further efforts must be made, and documented, prior to authorization of funding for the service under the waiver program. F. A participant cannot qualify, or receive funding from the waiver program, for this waiver program service if the participant: 1. Requires provision of direct nursing care services provided by a licensed nurse; or 2. Currently receives, or is eligible to receive, nursing services in another health care program paid for by the Maryland Medicaid Program or the Department, such as hospital services, skilled nursing or rehabilitation facility services, or Medicaid Program's Rare and Expensive Case Management Program's private duty nursing services. G. To the extent that any listed services are covered under the Medicaid State Plan, the services under the waiver would be limited to additional services as allowed and not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization. Between this waiver program service and applicable MBON regulations, the applicable MBON regulations will control. H. Children have access to any medically necessary preventive, diagnostic, and treatment services under EPSDT services to help meet children's health and developmental needs. This includes age appropriate medical, dental, vision, and hearing screening services and diagnostic and treatment services to correct or ameliorate identified conditions. Supports provided by this waiver service is to improve and maintain the ability of the child to remain in and engage in community activities. I. A legally responsible person, legal guardian, or relative (that is not a spouse) cannot be paid by the waiver program, either directly or indirectly, to provide this waiver program service unless otherwise approved by the DDA due to extraordinary circumstances in accordance with the applicable requirements set forth in Section C-2. J. For participants enrolled in the SDS delivery model, this waiver program service includes: 1. The reasonable and customary costs of training the participant's direct support staff, including First Aid and CPR certifications; 2. Travel reimbursement, benefits and leave time for the participant's direct support staff, subject to the following requirements: a. The reimbursement, benefits and leave time requested are i. Within applicable reasonable and customary standards as established by DDA policy; or ii. Required for the participant's compliance, as the employer of record, with applicable federal, State, or local laws; and b. Any reimbursement (e.g., mileage), benefit and leave time requested by the participant must comply with applicable federal, State, or local laws. c. Mileage reimbursement, under the SDS delivery model, to the owner of a specialized, modified, or accessible vehicle driven by an employee of the participant and for the purpose of the participant engaging in activities specified in the recipient's PCP. 3. Cost for training, mileage, benefits, and leave time are allocated from the participant's total budget allocation."

<p><b><u>Michigan / MI Health Link HCBS</u></b></p>	<p>Preventive Nursing Services</p>	<p>“Preventive Nursing Services are covered on a part-time, intermittent (separated intervals of time) basis for an enrollee who generally requires nursing services for the management of a chronic illness or physical disorder in the enrollee’s home and are provided by a registered nurse (RN) or a licensed practical nurse (LPN) under the supervision of a RN. Nursing services are for enrollees who require more periodic or intermittent nursing than otherwise available for the purpose of preventative interventions to reduce the occurrence of adverse outcomes for the enrollee such as hospitalizations and nursing facility admissions. An enrollee using this service must demonstrate a need for observation and evaluation. In addition to the observation and evaluation, a nursing visit may also include, but is not limited to, one or more nursing services. Observation and evaluation of skin integrity, blood sugar levels, prescribed range of motion exercises, and physical status. Additional nursing services include medication set-up, administration and monitoring, dressing changes, range of motion assistance and/or monitoring, refresher training to the beneficiary and/or caregivers to assure the use of proper techniques for health-related tasks such as diet, exercise regimens, body positioning, taking medications according to physician’s orders, proper use of medical equipment, performing activities of daily living, or safe ambulation within the home.”</p>
<p><b><u>Missouri / Children with DD (MOCDD) Waiver</u></b></p>	<p>Health Assessment and Coordination Services</p>	<p>“These telemedicine Services are designed for individuals with I/DD receiving Home and Community Based (HCBS) waiver services to coordinate care with local emergency departments, urgent cares, and primary care physicians to enable real-time support, consultation and coordination on health issues and to assist individuals, families and support providers to understand presenting health symptoms and to identify the most appropriate next steps. The service is consultative in nature related specifically to the presence of an intellectual disability and seeks to provide disability-specific advice on when best to seek additional or in-person medical treatment. This service is a supportive service that can occur while the person is in their home to help assess the need for medical attention; this unique service is otherwise unavailable through any other service. The service serves as an I/DD conduit to, rather than a duplication of medical services covered under the state plan. available to the case managers. The services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. Telehealth Platform Requirements, inclusive of the specifics of state file acceptance, HIPAA compliance, access timeliness and secure communication to individuals, families/caregivers and providers will be outlined and binding in provider contracts and manuals. Furthermore, in addition to assisting to help assess the need for medical attention specific to individuals with developmental and intellectual disabilities, the service includes support and consultation to families and direct support professionals (DSPs) otherwise unavailable in any other service. This component of the service seeks to build the capacity of families and DSPs (who do not possess medical credentials) to better understand the best approaches for supporting the individual</p>

depending on their symptom presentation. This support to caregivers, informed with a strong expertise in I/DD, is an absolutely essential component that is not available elsewhere within Medicaid state plan or other waiver services. This service is available 24 hours a day, 7 days a week and includes immediate evaluations, video-assisted examinations, treatment plans and discussion and coordination with individuals and/or caregivers by professionals with extensive specialized expertise supporting individuals with I/DD. The goal of this service is to provide a right-on-time health assessment to determine the best clinical course of action, often avoiding unnecessary emergency room visits. If a hospital visit is clinically necessary, this service allows the HAC provider to communicate with the emergency department directly, ensuring advance preparation for the ED and decreasing the chances of admission. The service includes follow-up consultations with the individual or family and/or caregiver of the individual within 18 hours of the initial call. Health Assessment and Coordination Services is unique in both provider qualifications and coverage within Medicaid and does not duplicate (but complements and links to) those services available in the state plan. The combination of required medical experience AND extensive expertise with intellectual and developmental disabilities is not included in state plan services and the consultative nature of the service distinguishes this service from other state plan benefits. While the provider qualifications included do require medical acumen, they are not limited to medical credentials, nor does the service duplicate physician services or other services covered under the state plan. This service works in close contact with but does not duplicate any of the functions of case management. The care coordination facilitated by this service becomes a part of rather than duplicating the person-centered plan. Furthermore, this service provides clinically informed, disability specific advice and counseling to caregivers that is entirely distinct from any information provided by or Telehealth Platform Training Requirements composed of timely, accessible initial and ongoing training for individuals, family/caregivers and providers, help line capacity and ongoing health education modules, with for those working with individuals enrolled with the provider to increase health care knowledge will be specific and binding in provider manuals and contracts. Reporting and Recordkeeping Requirements outlining timelines and contacts of reporting to the state, reports to be sent to individuals, families/caregivers and providers, HIPAA compliance, elements to be included in the reports and records retention will be specified in provider manuals and contracts. Missouri reimburses using a monthly unit of service derived from a market-based rate. The state's four waivers do not provide a 24/7 physician driven right on time assessment service for waiver participants. The Health Assessment & Coordination service is not a nursing service. This service works in close contact with but does not duplicate any of the functions of case management. The care coordination facilitated by this service becomes a part of rather than duplicating the person-centered plan. Furthermore, this service provides clinically informed, disability specific advice and

		counseling to caregivers that is entirely distinct from any information provided by or available to the case managers.”
<b>Missouri / DD Comprehensive Waiver</b>	Health Assessment and Coordination Services	<p>“These telemedicine Services are designed for individuals with I/DD receiving Home and Community Based (HCBS) waiver services to coordinate care with local emergency departments, urgent cares, and primary care physicians to enable real time support, consultation and coordination on health issues and to assist individuals, families and support providers to understand presenting health symptoms and to identify the most appropriate next steps. The service is consultative in nature related specifically to the presence of an intellectual disability and seeks to provide disability-specific advice on when best to seek additional or in-person medical treatment. This service is a supportive service that can occur while the person is in their home to help assess the need for medical attention; this unique service is otherwise unavailable through any other service. The service serves as an I/DD conduit to, rather than a duplication of medical services covered under the state plan. available to the case managers. The services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. Telehealth Platform Requirements, inclusive of the specifics of state file acceptance, HIPAA compliance, access timeliness and secure communication to individuals, families/caregivers and providers will be outlined and binding in provider contracts and manuals. Furthermore, in addition to assisting to help assess the need for medical attention specific to individuals with developmental and intellectual disabilities, the service includes support and consultation to families and direct support professionals (DSPs) otherwise unavailable in any other service. This component of the service seeks to build the capacity of families and DSPs (who do not possess medical credentials) to better understand the best approaches for supporting the individual depending on their symptom presentation. This support to caregivers, informed with a strong expertise in I/DD, is an absolutely essential component that is not available elsewhere within Medicaid state plan or other waiver services. This service is available 24 hours a day, 7 days a week and includes immediate evaluations, video-assisted examinations, treatment plans and discussion and coordination with individuals and/or caregivers by professionals with extensive specialized expertise supporting individuals with I/DD. The goal of this service is to provide a right-on-time health assessment to determine the best clinical course of action, often avoiding unnecessary emergency room visits. If a hospital visit is clinically necessary, this service allows the HAC provider to communicate with the emergency department directly, ensuring advance preparation for the ED and decreasing the chances of admission. The service includes follow-up consultations with the individual or family and/or caregiver of the individual within 18 hours of the initial call. Health Assessment and Coordination Services is unique in both provider qualifications and coverage within Medicaid and does not duplicate (but complements and links to) those services available in the state</p>

		<p>plan. The combination of required medical experience AND extensive expertise with intellectual and developmental disabilities is not included in state plan services and the consultative nature of the service distinguishes this service from other state plan benefits. While the provider qualifications included do require medical acumen, they are not limited to medical credentials, nor does the service duplicate physician services or other services covered under the state plan. This service works in close contact with but does not duplicate any of the functions of case management. The care coordination facilitated by this service becomes a part of rather than duplicating the person-centered plan. Furthermore, this service provides clinically informed, disability specific advice and counseling to caregivers that is entirely distinct from any information provided by or Telehealth Platform Training Requirements composed of timely, accessible initial and ongoing training for individuals, family/caregivers and providers, help line capacity and ongoing health education modules, with for those working with individuals enrolled with the provider to increase health care knowledge will be specific and binding in provider manuals and contracts. Reporting and Recordkeeping Requirements outlining timelines and contacts of reporting to the state, reports to be sent to individuals, families/caregivers and providers, HIPAA compliance, elements to be included in the reports and records retention will be specified in provider manuals and contracts. Missouri reimburses using a monthly unit of service derived from a market-based rate. The state’s four waivers do not provide a 24/7 physician driven right on time assessment service for waiver participants. The Health Assessment &amp; Coordination service is not a nursing service. This service works in close contact with but does not duplicate any of the functions of case management. The care coordination facilitated by this service becomes a part of rather than duplicating the person-centered plan. Furthermore, this service provides clinically informed, disability specific advice and counseling to caregivers that is entirely distinct from any information provided by or available to the case managers.”</p>
<p><b>Missouri / DD Comprehensive Waiver</b></p>	<p>Professional Assessment and Monitoring</p>	<p>“Professional Assessment and Monitoring (PAM) is intended to promote and support an optimal level of health and well-being. A prescribing practitioner must prescribe an identified need for the PAM service. PAM is a consultative service by a licensed health care professional that may be utilized to assess, examine, evaluate, and/or treat an individual’s identified condition(s) or healthcare needs and planning and may include instruction and training when identified as needed for the care of the individual. PAM services maintain, restore, and / or improve an individual’s functional status. PAM may include ancillary, management, and / or instructional strategies. PAM providers are to coordinate and communicate with the individual, their caregivers, and the support team. All changes in health status are to be communicated to the physician and the support coordinator. Written reports of the visit will be provided to the support coordinator. All services must be documented in the individual record. Any changes in health status are to be reported to the physician and support</p>

		<p>coordinator as needed. Written reports of the visit are required to be sent to the support coordinator. This service may be provided by an RN, or an LPN under the supervision of an RN, or a licensed dietitian to the extent allowed by their respective scope of practice in the state of Missouri. This service must not supplant Medicaid State plan services or Medicare services for which an individual is eligible. Excluded services include Diabetes Self-Management Training available under the state plan and medical nutrition therapy services prescribed by a physician for Medicare eligibles who have diabetes or renal diseases. PAM is not continuous care. PAM service providers must have a valid DMH contract and/or provide services through an OHCDs for the provision of PAM services. Service Documentation: Providers of PAM must maintain an individualized plan of treatment and detailed record of intervention activities by unit of service.”</p>
<p><b>Missouri / Partnership for Hope</b></p>	<p>Health Assessment and Coordination Services</p>	<p>“These telemedicine Services are designed for individuals with I/DD receiving Home and Community Based (HCBS) waiver services to coordinate care with local emergency departments, urgent cares, and primary care physicians to enable real time support, consultation and coordination on health issues and to assist individuals, families and support providers to understand presenting health symptoms and to identify the most appropriate next steps. The service is consultative in nature related specifically to the presence of an intellectual disability and seeks to provide disability-specific advice on when best to seek additional or in-person medical treatment. This service is a supportive service that can occur while the person is in their home to help assess the need for medical attention; this unique service is otherwise unavailable through any other service. The service serves as an I/DD conduit to, rather than a duplication of, medical services covered under the state plan. available to the case managers. The services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. Telehealth Platform Requirements, inclusive of the specifics of state file acceptance, HIPAA compliance, access timeliness and secure communication to individuals, families/caregivers and providers will be outlined and binding in provider contracts and manuals. Furthermore, in addition to assisting to help assess the need for medical attention specific to individuals with developmental and intellectual disabilities, the service includes support and consultation to families and direct support professionals (DSPs) otherwise unavailable in any other service. This component of the service seeks to build the capacity of families and DSPs (who do not possess medical credentials) to better understand the best approaches for supporting the individual depending on their symptom presentation. This support to caregivers, informed with a strong expertise in I/DD, is an absolutely essential component that is not available elsewhere within Medicaid state plan or other waiver services. This service is available 24 hours a day, 7 days a week and includes immediate evaluations, video-assisted examinations, treatment plans and discussion and coordination with individuals and/or caregivers by professionals with extensive specialized</p>

		<p>expertise supporting individuals with I/DD. The goal of this service is to provide a right-on-time health assessment to determine the best clinical course of action, often avoiding unnecessary emergency room visits. If a hospital visit is clinically necessary, this service allows the HAC provider to communicate with the emergency department directly, ensuring advance preparation for the ED and decreasing the chances of admission. The service includes follow-up consultations with the individual or family and/or caregiver of the individual within 18 hours of the initial call. Health Assessment and Coordination Services is unique in both provider qualifications and coverage within Medicaid and does not duplicate (but complements and links to) those services available in the state plan. The combination of required medical experience AND extensive expertise with intellectual and developmental disabilities is not included in state plan services and the consultative nature of the service distinguishes this service from other state plan benefits. While the provider qualifications included do require medical acumen, they are not limited to medical credentials, nor does the service duplicate physician services or other services covered under the state plan. This service works in close contact with but does not duplicate any of the functions of case management. The care coordination facilitated by this service becomes a part of rather than duplicating the person-centered plan. Furthermore, this service provides clinically informed, disability specific advice and counseling to caregivers that is entirely distinct from any information provided by or Telehealth Platform Training Requirements composed of timely, accessible initial and ongoing training for individuals, family/caregivers and providers, help line capacity and ongoing health education modules, with for those working with individuals enrolled with the provider to increase health care knowledge will be specific and binding in provider manuals and contracts. Reporting and Recordkeeping Requirements outlining timelines and contacts of reporting to the state, reports to be sent to individuals, families/caregivers and providers, HIPAA compliance, elements to be included in the reports and records retention will be specified in provider manuals and contracts. Missouri reimburses using a monthly unit of service derived from a market-based rate. The state's four waivers do not provide a 24/7 physician driven right on time assessment service for waiver participants. The Health Assessment &amp; Coordination service is not a nursing service. This service works in close contact with but does not duplicate any of the functions of case management. The care coordination facilitated by this service becomes a part of rather than duplicating the person-centered plan. Furthermore, this service provides clinically informed, disability specific advice and counseling to caregivers that is entirely distinct from any information provided by or available to the case managers."</p>
<p><b>Missouri / Partnership for Hope</b></p>	<p>Professional Assessment and Monitoring</p>	<p>"Professional Assessment and Monitoring (PAM) is intended to promote and support an optimal level of health and well-being. A prescribing practitioner must prescribe an identified need for the PAM service. PAM is a consultative service by a licensed health care professional that may be</p>



		<p>utilized to assess, examine, evaluate, and/or treat an individual’s identified condition(s) or healthcare needs and planning and may include instruction and training when identified as needed for the care of the individual. PAM services maintain, restore, and / or improve an individual’s functional status. PAM may include ancillary, management, and / or instructional strategies. PAM providers are to coordinate and communicate with the individual, their caregivers, and the support team. All changes in health status are to be communicated to the physician and the support coordinator. Written reports of the visit will be provided to the support coordinator. All services must be documented in the individual record. Any changes in health status are to be reported to the physician and support coordinator as needed. Written reports of the visit are required to be sent to the support coordinator. This service may be provided by an RN, or an LPN under the supervision of a RN, or a licensed dietitian to the extent allowed by their respective scope of practice in the State of Missouri. This service must not supplant Medicaid State plan services or Medicare services for which an individual is eligible. Excluded services include Diabetes Self-Management Training available under the state plan and medical nutrition therapy services prescribed by a physician for Medicare eligibles who have diabetes or renal diseases. PAM is not continuous care. PAM service providers must have a valid DMH contract and/or provide services through an OHCDs for the provision of PAM services. Service Documentation: Providers of PAM must maintain an individualized plan of treatment and detailed record of intervention activities by unit of service.”</p>
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## Remote Supports Service Examples

State / Waiver	Service Title	Service Definition
Ohio	Remote Supports	<p>Remote Supports is the provision of supports by staff at a remote location who are engaged with the individual through technology/devices with the capability for live two-way communication. Equipment used to meet this requirement must include one or more of the following systems: motion sensing system, radio frequency identification, live video feed, live audio feed, GPS tracking, web-based monitoring system, or a device that otherwise meets the requirement for two-way communication. Individual interaction with the staff person may be scheduled, on-demand, or in response to an alert from a device in the remote support equipment system. Per Ohio Administrative Code (OAC) rule 5123-9-35: “When remote support involves the use of audio and/or video equipment that permits remote support staff to view activities and/or listen to conversations in the residence, the individual who receives the service and each person who lives with the individual shall consent in writing after being fully informed of what remote support entails including, but not limited to, that the remote</p>

		<p>support staff will observe their activities and/or listen to their conversations in the residence, where in the residence the remote support will take place, and whether or not recordings will be made. If the individual or a person who lives with the individual has a guardian, the guardian shall consent in writing. The individual’s service and support administrator shall keep a copy of each signed consent form with the individual service plan.” Individuals and/or guardians who consent to the use of remote supports use this service in lieu of in-person caregiving, most typically provisioned through Ohio’s Homemaker/Personal Care (HPC) service. As an example, a remote support device can be used to set reminders for medication administration for an individual who can self-administer. Remote supports allow for an individual to choose the method of supportive caregiving which best suits their needs. In this way, remote supports help ensure an individual’s rights of privacy, dignity, and respect, as well as freedom from coercion in that individuals now have a different method of receiving care.</p>
<p><b>Washington</b></p>	<p>Remote Supports</p>	<p>Remote Support is supervision, coaching, and consultation from a contracted Remote Support provider to a DDA waiver participant from a distant, HIPPA-compliant location that allows an HCBS waiver participant to increase their independence and safety in their home and community when not engaged in other HCBS services or informal supports that offer similar supports (personal care, etc.). Remote support allows an individual to live in their home without the intrusive presence of a caregiver when the individual’s needs can be met without a caregiver being in-person. They are receiving their support in the setting they choose, by the providers they choose. This support not only allows the individual to be more independent and have increased autonomy, but directly supports community integration, rather than institutionalization, since the participant receives their needed supports in their chosen community and in a person-centered way.</p> <p>Remote support will allow an individual more autonomy to move around their living space without the presence of someone right beside them, often doing things for them. Individuals will be given the opportunity to complete tasks on their own and have the ability to ask for help, if and when they need it. It allows the person the ability to ask for the presence of in-person support when they want it, as opposed to always having someone there. Remote support allows an individual to go out into their community on their own if they wish, with the support of remote support devices. Clients are informed of the device capabilities and what the device can support them with in the community, and when they may need to call the remote support provider for assistance through the device. In another way, remote support allows for the participant to have the independence to live in their home, and to engage in other waiver services as intended with other providers or staff who are available to support them. The state will finalize policy around remote support and informed consent. Clients and their representatives will acknowledge the risks of using technology in any setting. When remote support is added to a client’s home where there is family living (and not providing informal</p>

support) the client can choose an area within the home to video call or video chat their remote support provider.

When an individual elects to receive remote support, the person-centered service plan will reflect how many hours/days per week an individual will receive this support. Policy will direct case managers to ensure that there is an identified backup plan for an individual who is receiving remote support and this information will be added to the client's person-centered service plan, and the evaluation plan the provider creates. Additionally, case managers are already required to check in with clients and their representatives every 6 months to review service delivery and follow-up on any issues or concerns raised.

The remote support vendor is responsible for following through with the client and other identified individuals identified on the client's person-centered service plan when a device fails or when the technology is not working. They are responsible for replacing the item and delivering it to the client in a timely manner. Individuals the client has identified in their person-centered service plan will be notified and the backup system will be put into motion so support is consistently in place. There is not an in-person component like other waiver services offering teleservice. The only component that would be in person is the initial installation of the devices and if the client chooses, the initial evaluation with the provider to determine what kind of devices would meet the client's need. This is usually done remotely, but some vendors may have the ability to conduct these in person, in which the state will leave that up to the client to decide.

Radio frequency identification (RFID) is a wireless system that uses tags and readers. Information is passed between a tag and the reader through radio waves at different frequencies. For use in remote support, this would look like out of bed detection/fall detection, monitoring the individual (through sensors) and equipment tracking. Remote Support is intended to be a less-intrusive way of supporting an individual in their home. Live audio feed is referring to client or provider-initiated video calls. The client can initiate a video call anytime with their remote support provider, and the provider can initiate a video call if they have not heard from the client or monitoring data suggests there is a problem. Calls initiated by the provider must be answered by the client- the provider cannot just turn on the video call. If the client chooses to include video monitoring in their remote support plan, they can turn the camera on or off at any time.

Because this service is strengths-based and takes a very person-centered approach to what the client wants in their life, individual plans will look differently. The state requires identification of when the remote support provider will be expected to provide support to the client as well as what that is for (reminders for ADLs, medication reminders, check in, etc.). The client can contact or initiate calls to their remote support provider at any time. In addition, the remote support provider is available

24/7 to the client but will only bill the state for approved schedule. Remote support providers must be available to the client 24/7. Backup plans will be individualized and include identification of who will respond in-person to an individual when there is an emergency or simply if a client needs an in-person support for a specific task. DDA policy will direct case managers to ensure a solid backup plan is in place with documentation in the client's PCSP before authorizing services. Service may be received via teleservice as identified in the person-centered service plan. The waiver participant selects whether they want to receive service in person, via teleservice, or a combination of both. Providers engage with an individual through technology equipment with the capability for live two-way communication. Based on the person-centered plan and client choice, there may be consistent monitoring through the use of non-video sensors that can capture movement and baseline movements of a client to ensure safety for the client in their home. If the client chooses to include video monitoring, there will be an exception to policy process to request that, and additional documentation will be required to move forward with such a request. Equipment used to meet this requirement shall include one or more of the following components:

1. Motion-sensing system
2. Radio frequency identification
3. Video calling via assistive technology
4. Live audio feed
5. Web-based monitoring systems

All necessary equipment to deliver Remote Supports is the responsibility of the Remote Supports provider and that the cost for this equipment is built into the rate for Remote Supports. Any technology equipment that must be purchased separately would be the property of the client and purchased through the Assistive Technology service. Need for service is based on the person-centered planning process and requested by the waiver participant.

Assurances:

The well-developed person-centered service plan will document the participant's specific health and welfare needs and how each service selected by the participant contributes to meeting the participant's needs and does not duplicate supports. The PCSP is the first resource that will ensure the health and safety of that participant. The PCSP identifies supervision and physical assistance support needs that inform the decision making of whether teleservice is appropriate for the client. The service authorization system (ProviderOne) has distinct and separate service codes for each waiver service and has built-in system logic that prevents duplication of services. DDA policies and

procedures provide guidance to Case Resource Managers on developing effective person-centered service plans that identify services and service delivery methods that best meet their unique health and welfare needs without any duplication of services.

Teleservice will be the service delivery method for a particular service at the direction of the participant, not by the preference of the service provider. A teleservice agreement form will be required prior to authorization of teleservice delivery. This form will document the client's desired level of in person to teleservice delivery and will remind clients that they can change their mind about frequency of teleservice delivery at any time. This agreement is intended to assist in clear and documented communication between the client, DDA, and the provider (in addition to the person-centered service plan) to ensure the client is the driver of the method of service delivery they receive. Case/Resource Managers will consult with their participants and family members, if appropriate, to develop the PCSP that includes the specific services and service delivery methods that best meet the participant's unique health and welfare needs. Participants will document in their PCSPs what approximate percentage of service delivery they desire to receive via teleservice. The State is not mandating what percentage of time teleservice can be utilized, to ensure person-centered service planning and promote client choice. Participants who need hands on assistance/physical assistance will require careful person-centered planning coordinated by their Case/Resource Manager to determine if teleservice delivery is a practical or feasible option for the successful delivery of services. Voice-activated communication devices may be an option that some participants select to ensure that remote service delivery will work for them. Other clients may require in-person service delivery only to ensure safety and successful service delivery.

State will permit recording of live interactions with the participant via audio or video technology only at the request of the participant. Policy will include specific language around bathrooms and bedrooms. Video cameras are not permissible in bathrooms. If a client requests a video camera in their bedroom, there must be an approved exception to policy in place and the device must be situated in a way that does not compromise client privacy. Live 2-way interactions are always initiated by the participant. The participant can initiate the service when needed and turn off the equipment when not needed.

The state believes teleservice will be an important component in a well-developed and balanced PCSP that focuses on the specific wants and health and welfare needs of the participant. Experience during the COVID-19 pandemic has shown that teleservice can facilitate community integration in a person-centered way. Washingtonians in the broader community utilize both technology-supported remote and in-person community service environments, and the proposed change in waiver services give waiver clients the same opportunity to participate in their community as everyone else.

	<p>Providers employing teleservice delivery will be guided by policy and will continue to follow all service protocols and report any concerns they have to the case/resource manager and make any appropriate incident reports.</p> <p>The provider delivering services remotely will be responsible for using an approved delivery platform that the client is able and willing to use and will provide basic technical assistance as necessary during their service delivery (device on and off, volume control, etc.). If a client is unable to use technology for teleservice delivery, then in person service delivery would be the appropriate service delivery mechanism for the client, and this would be discussed during the person-centered planning meeting. The participant utilizing the services remote support and each person who shares a residence with that participant will be fully informed of what remote service delivery entails including, but not limited to: (A) that remote staff may observe their activities if they are within the view of the participant's video communication device; (B) that the participant decides where in the residence the remote support will occur; (C) whether or not recordings of sessions will be made (the participant's case/resource manager will document in the PCSP); (D) that the participant will control the operation of the communication device, when it is turned on and when it is turned off. Please note that this service is not approved for clients receiving residential habilitation services.</p> <p>The state will use the CARE assessment to determine client need for technology and remote support through the person-centered planning process. If a client requests that a video camera be placed in their home to use in the provision of remote support, there must be an exception to policy (ETP) in place with justification as to why the camera is needed instead of a simple sensor. The ETP must be approved and documented in the client's file before the device is installed and prior to the service being authorized. Adds that services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to or receives from the Department of Children, Youth, and Families (DYYF) or from a Tribe in Washington State or from Title IV-E of the Social Security Act or from other sources. Please clarify whether individuals will not lose access to this service.</p>
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# Appendix C: QIS Waiver Performance Measure Comparison

Due to size constraints, this appendix is hosted externally to ensure accessibility and ease of use. The document can be accessed via the following link: [HSRI Waiver Performance Measure Comparison](#).

# Appendix D: Sample HCBS QMS Tool

## Background on the QIS Performance Measures

There is caveat about the performance measures cited below. We identified the most consistent performance measures across waivers that most closely aligned with the Quality Measure Set sub-assurances. In some cases, there are standalone performance measures that we identified as inconsistent with the other performance measures. In those cases, we recommend that DHHS consider aligning and consolidating the performance measure across as many waivers as possible.

### Service Plan

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants. Sub-assurances for this area are indicated below:

***Sub-Assurance 1: Service plans address all members’ assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Source	Applicable Waivers (If Any)	Item	2022-2023 Outcome	2023-2024 Outcome
NCI	N/A	Does your service plan include things that are important to you?	94%	97%
NCI	N/A	Did you help make your service plan? For example, did you get to set your own goals?	87%	89%
NCI	N/A	If you want to change something about your services, do you know who to talk to?	84%	93%
<b>Appendix D, Sub-Assurance A, Line 399</b>	CSW, ABI, PD, CTW, LSW, MCCW, TDW	Number and percentage of PCSPs that address all participants’ assessed needs including health needs, safety risks, and personal goals either by the provision of waiver services or other funding sources including state plan, generic and natural supports. The numerator is the number of PCSPs in compliance; the denominator is the total number of PCSPs reviewed.		
<b>Appendix D, Sub-Assurance A, Line 419</b>	NCW, AGW	Number and percentage of care plans which address all needs, personal goals and health and safety factors that are identified in the full assessment. Numerator is the number of care plans addressing all needs identified; denominator is the total number of care plans reviewed.		

**Sub-Assurance 2: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant’s needs.**

Source	Applicable Waivers (If Any)	Item	2022-2023 Outcome	2023-2024 Outcome
NCI	N/A	Does your case manager review your service plan with you throughout the year?	78%*	77% *
Appendix D, Sub-Assurance C, Line 449	CSW, ABI, PDW, CTW, LSW, NCW, MCCW, TDW	Number and percentage of PCSPs which are updated/revised when warranted by changes in the participant’s needs. The numerator is the number of PCSPs which were updated/revised when warranted by changes in the participant's needs; the denominator is the total number of PCSPs which required updates/revision due to a change in need.		
Appendix D, Sub-Assurance C, Line 459	CSW, ABI, PDW, CTW, LSW, NCW, MCCW, TDW	Number and percentage of PCSPs reviewed and updated annually, completed during the calendar month in which it is due. The numerator is the number of reviewed PCSPs for which a review shows it was updated annually, completed during the calendar month in which it is due; the denominator is the total number of PCSPs reviewed.		

\*Significantly lower than national

\* There were no performance measures around updated/revised service plans for the Aging Waiver.

\*\* While similar, the performance measures for the NCW, MCCW, and TDMFW on line 459 are slightly different than the other waivers’ performance measures.

**Sub-Assurance 3: Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.**

Source	Applicable Waivers (If Any)	Item	2022-2023 Outcome	2023-2024 Outcome
NCI	N/A	Do your staff come and leave when they are supposed to?	92%	86%
Appendix D, Sub-Assurance D, Line 469	CSW, ABI, PDW, CTW, LSW, NCW, MCCW, TDW	Number and percentage of PCSPs identifying the amount, frequency, duration, type and scope for each service authorized. The numerator is the total number of PCSPs in the review that clearly identify the amount, frequency, duration, type and scope for each waiver service authorized; the denominator is the total number of PCSPs reviewed.		



<b>Appendix D, Sub-Assurance D, Line 479</b>	CSW, ABI, CTW, LSW*	Number and percentage of support coordinator monthly summary reports indicating that services are being delivered in accordance with the PCSP (Type, scope, amount, duration, and frequency). The numerator is the total number of PCSPs reviewed for which monthly summary reports indicate that services are being delivered in accordance with the PCSP; the denominator is the total number of PCSPs reviewed.		
<b>Appendix D, Sub-Assurance D, Line 489</b>	PDW, AGW, NCW	The number and percentage of participants 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. Numerator is the number of cases where evidence of monthly contact occurred; denominator is the total number of cases reviewed.		

\*Some performance measures mentioned “support coordinator monthly summary” and “provider monthly summary.”

***Sub-Assurance 4: Participants are afforded choice between/among waiver services and providers.***

Source	Applicable Waivers (If Any)	Item	2022-2023 Outcome	2023-2024 Outcome
NCI	N/A	Do you choose (or pick) your staff?	63%	80%
NCI	N/A	Can you change your case manager/service coordinator if you want to?	82%	91%
NCI	N/A	Who chose (or picked) your day program or workshop?	58%	68%
NCI	N/A	If you want to change something about your services, do you know who to talk to?	84%	93%
<b>Appendix D, Sub-Assurance E, Line 499</b>	All waivers	Number and percentage of participants who are offered choice among providers when more than one is available. The numerator is the total number of participants reviewed who sign or have their legal representative sign the Choice of Services section of the PCSP when more than one provider is available; the denominator is the total number of participants in the sample that have more than one provider available.		



<b>Appendix D, Sub-Assurance E, Line 509</b>	CSW, ABI, PDW, CTW, LSW, NCW	Number and percentage of participants who are made aware of all services available on the CSW Waiver. The numerator is the total number of participants reviewed who were made aware of all services available on the CSW Waiver as indicated by their or their legal representative's signature on the Choice of Services section of the PCSP; the denominator is the total number of participants reviewed.		
<b>Appendix D, Sub-Assurance E, Line 519</b>	AGW, MCCW, TDW	Number and percentage of participants who are offered the choice between nursing facility care/institutional care and [specific waiver services]. Numerator is the number of participants where choice of service delivery was documented; denominator is the total number of participants reviewed.		

## Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. The sub-assurances for this area are indicated below:

***Sub-Assurance 1: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.***

Source	Applicable Waivers (If Any)	Item	2022-2023 Outcome	2023-2024 Outcome
NCI	N/A	If you ever feel afraid, is there someone you can talk to?	93%	94%
NCI	N/A	Do your staff treat you with respect?	90%	88%
NCI	N/A	Are there any places where you feel afraid or scared?	32%	21%
<b>Appendix G, Sub-Assurance A, Line 540</b>	All waivers	Number and percentage of incidents involving abuse, neglect, exploitation, and unexpected death of waiver participants where recommended actions to protect health and welfare were implemented. The numerator is the total number of reported incidents where recommended actions to protect health and welfare were implemented; the denominator is the total number of incidents requiring safeguards.*		
<b>Appendix G, Sub-</b>	All waivers	Number and percentage of suspected abuse, neglect, exploitation, and unexpected death		

<b>Assurance A, Line 550</b>		incidents referred to Adult Protective Services and/or law enforcement/Child Protective Services as required by State law. The numerator is the total number of incidents reported correctly; the denominator is the total number of reported incidents reviewed involving suspected abuse, neglect, exploitation, and/or unexpected death.		
<b>Appendix G, Sub-Assurance A, Line 560</b>	CSW, ABI, PD, CTW, LSW, Aging, MCCW, TDW	Number and percentage of abuse, neglect, exploitation, and unexpected death incidents reported to DSPD within 24 hours [(or the required timeframe)] of discovery of occurrence. Numerator is total number of abuse, neglect, exploitation, and unexpected death incidents reviewed reported to DSPD within 24 hours of the discovery of occurrence; denominator is the total number of abuse, neglect, exploitation, and unexpected death incidents reviewed.		
<b>Appendix G, Sub-Assurance A, Line 570</b>	CSW, ABI, PDW, CTW, LSW	Number and percentage of abuse, neglect, exploitation & unexpected death incidents for which providers submit incident report in 5 business days of discovery of incident. Numerator is total number of incidents reviewed for which providers submit incident report in 5 business days of discovery of incident; denominator is total number of abuse, neglect, exploitation, and unexpected death incidents reviewed.		
<b>Appendix G, Sub-Assurance A, Line 580</b>	CSW, ABI, PDW, CTW, LSW	Number and percentage of waiver participant deaths for which the Department of Human Services' Fatality Review Committee process was followed. The numerator is the total number of waiver participant deaths for which the Department of Human Services' Fatality Review Committee process was followed; the denominator is the total number of waiver participant deaths.		

\*Note that the NCW references Level I and II Criteria that other waivers do not.

In this section, there is wide variation between performance measures in how and when they review and investigate claims of abuse, neglect, exploitation, and unexpected death incidents. DSPD waivers seemingly have a more robust reporting system than waivers operated by DIH and DAAS when it comes to reviewing and investigating these claims. We recommend a consolidation of existing performance measures that could apply across divisions when reviewing and investigating these claims against health and welfare and specifying a timeline for when these incidents should be reported and reviewed.

**Sub-Assurance 2: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.**

Source	Applicable Waivers (If Any)	NCI Item	2022-2023 Outcome	2023-2024 Outcome
NCI	N/A	None		
Appendix G, Sub-Assurance B, Line 620	All waivers*	Number and percentage of critical incident trends identified for systemic intervention that were implemented. The numerator is the number of trends where systemic intervention was implemented; the denominator is the total number of critical incident trends.		
Appendix G, Sub-Assurance B, Line 630	CSW, PDW, CTW, LSW	Number and percentage of quarterly critical incident reports submitted to the SMA which demonstrate how incident data are collected, compiled, and used to prevent re-occurrence. The numerator is the number of reports which demonstrate how incident data are collected, compiled, and used to prevent re-occurrence; the denominator is the total number of reports required.		

\*Note that there is some slight variation in the wording for the performance measure for the New Choices Waiver.

**Sub-Assurance 3: State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.**

Source	Applicable Waivers (If Any)	NCI Item	2022-2023 Outcome	2023-2024 Outcome
NCI	N/A	None		
Appendix G, Sub-Assurance C, Line 682	All waivers	Number and percentage incidents identifying unauthorized use of restrictive interventions (including restraints/seclusion) appropriately reported, investigated and for which recommended follow-up was completed. Numerator is total number of these types of incidents reviewed that were appropriately reported, investigated, and had recommended follow-up; denominator is total number of these types of incidents.		



**Sub-Assurance 4: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.**

Source	Applicable Waivers (If Any)	NCI Item	2022-2023 Outcome	2023-2024 Outcome
NCI	N/A	None		
<b>Appendix G, Sub-Assurance D, Line 670</b>	CSW, ABI, PDW, CTW, LSW, AGW	Number and percent of participants whose [Person Centered Support Plan/Care Plan (PCSP)] addresses their health needs. Numerator is the number of participants whose PCP addresses their health needs. Denominator is the number of PCSPs reviewed.		

In this section, we observed that the New Choices, Medically Complex Children’s, and Tech Dependent and Medically Fragile waivers do not have a performance measure that identifies or addresses health care needs. They instead have performance measures that identify whether participants have an emergency/natural disaster preparedness plan (for the New Choices waiver, this PM is directed toward SAS participants only). We recommend that these waivers include a performance measure that identifies and addresses health care needs.

**Access**

The level to which the beneficiary/family caregiver/natural support is aware of and able to access resources (e.g., peer support, respite, crisis support, information, and referral) that support overall well-being. The measures for this area are indicated below:

Source	Applicable Waivers (If Any)	NCI Item	2022-2023 Outcome	2023-2024 Outcome
NCI	N/A	Do you have a way to get places you need to go?	90%	89%
NCI	N/A	Are you able to get places when you want to do something outside your home, like going out to see friends, for entertainment, or to do something fun?	76%	79%
NCI	N/A	Can you talk or communicate with your staff in your preferred language?	96%	98%

There are no waiver performance measures that measure access to resources.



## Rebalancing

Achieving a more equitable balance between the share of spending and use of services and supports delivered in home and community-based settings relative to institutional care. The measures for this area are indicated below:

Source	Applicable Waivers (If Any)	NCI Items	2022-2023 Outcome	2023-2024 Outcome
NCI	N/A	Does your case manager/service coordinator know what is important to you?	87%	88%
NCI	N/A	Does your service plan include things that are important to you?	94%	97%

## Community Integration

Focused on ensuring self-determination, independence, empowerment, and full inclusion of children and adults with disabilities and older adults in all parts of society. The measures for this area are indicated below:

Source	Applicable Waivers (If Any)	NCI Items	2022-2023 Outcome	2023-2024 Outcome
NCI	N/A	Do you ever feel lonely?	8%	8%
NCI	N/A	Are you able to get places when you want to do something outside your home, like going out to see friends, for entertainment, or to do something fun?	71%	79%
NCI	N/A	When people in your house go somewhere, do you have to go too, or can you stay at home if you want to?	57% **	50%
NCI	N/A	Are there people who do not have disabilities who are also members of [the groups, organizations, or communities the person takes part in]?	62%	32% *
NCI	N/A	Do people ask you before coming into your bedroom?	79%	60% *
NCI	N/A	Do you like how you usually spend your time during the day?	75%	63% *
NCI	N/A	Can you meet up with your friends in-person when you want to?	71%	76%
NCI	N/A	Do you do [things person likes to do outside home] with the people you want?	80%	89% **
Appendix D, Sub-assurance E, Line 519	AGW	Number and percentage of participants who were offered the choice between institutional care and home and community-based waiver services as documented on the “Documentation of LTC Program Choice and Right to Fair Hearing” form. (Numerator = # of participants where choice of service delivery was documented; Denominator = total # of participants reviewed)		

\*Significantly lower than national

\*\*Significantly higher than national



# Appendix E: Medicaid LTSS Authorities

## LTSS Waiver Authorities

Medicaid waiver authorities that can be used to provide LTSS include:

**1915(c) HCBS Waivers.** Section 1915(c) authorized the Medicaid Home and Community-Based Services (HCBS) waiver program, which allows states to provide services and supports to individuals in their own homes or communities rather than institutions or other isolated settings.<sup>238</sup> Additional details regarding this authority are discussed in the body of the main report.

**Section 1915(i) State Plan HCBS Benefit.** The 1915(i) State Plan HCBS benefit is an optional Medicaid program that allows states to offer HCBS to individuals who meet state-defined needs-based criteria (which are less stringent than institutional criteria) through their state plan instead of requiring a separate waiver agreement (e.g., 1915(c) waiver).<sup>239</sup> Under 1915(i) authority, a state can request a waiver of comparability requirements (Section 1902(a)(10)(B) of the SSA) and/or certain income and resource requirements (Section 1902(a)(10)(C)(i)(III) of the SSA).<sup>240</sup> States are permitted to limit eligibility to one or more targeted populations.<sup>241</sup> To be eligible to receive 1915(i) state plan HCBS benefits, an individual must meet the state-determined needs-based criteria.<sup>242</sup> These 1915(i) needs-based criteria must be less stringent than institutional (and therefore, waiver) level of care.<sup>243</sup> Additionally, to be eligible to receive 1915(i) state plan HCBS benefits, individuals must be a member of a “financial” eligibility group covered under the Medicaid state plan, except that the individual may have incomes up to 150% of federal poverty level.<sup>244</sup> In addition, states may elect to include a special income group for individuals with income up to 300% SSI; to qualify under this group, individuals must be eligible for HCBS under a §1915(c) waiver or an 1115 demonstration program.<sup>245</sup>

**Section 1915(j) Self-Directed Personal Assistance Services (PAS) Program.** The 1915(j) Self-Directed PAS program is an optional Medicaid program that allows states to provide individuals with the option to self-direct their personal assistance services under its Medicaid state plan and/or 1915(c) waiver.<sup>246</sup> Under 1915(j) authority, a state can request a waiver of comparability requirements (Section 1902(a)(10)(B) of the SSA) and/or certain income and resource requirements (Section 1902(a)(10)(C)(i)(III) of the SSA).<sup>247</sup> At the state’s option, people enrolled in 1915(j) can (1) purchase goods, supports, services, or supplies that increase their independence or substitute for human help (to the extent they'd otherwise have to pay for human help) and (2) use a discretionary amount of their budget to purchase items not otherwise listed in the budget or reserved for permissible purchases.<sup>248</sup> <sup>249</sup> Additionally, per 42 CFR 441.454, states have the option of disbursing cash prospectively to individuals, or their representatives, as applicable, self-directing their PAS.

**Section 1915(k) Community First Choice Option.** The 1915(k) Community First Choice benefit is an optional Medicaid program that allows states to provide home and community-based attendant services and supports to eligible Medicaid enrollees under their state plan.<sup>250</sup> Under 1915(k) authority, a state can request a waiver of certain income and resource requirements (Section

1902(a)(10)(C)(i)(III) of the SSA).<sup>251</sup> States must establish a Development and Implementation Council for the purpose of consulting and collaborating with the state in the development and implementation of the state's CFC benefit.<sup>252</sup> States may NOT target 1915(k) benefit. Services must be provided on a statewide basis, in a manner that provides such services and supports in the most integrated setting appropriate to the individual's needs, and without regard to the individual's age, type or nature of disability, severity of disability, or the form of home and community-based attendant services and supports that the individual requires in order to lead an independent life.<sup>253</sup> If a state chooses to provide CFC, the state must provide the following services: (a) assistance with ADLs, IADLs, and health-related tasks; (b) acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks; (c) backup systems or mechanisms to ensure continuity of services and supports; and (d) voluntary training on how to select, manage and dismiss attendants.<sup>254</sup> <sup>255</sup> Further, states have the option to provide transition costs and may not provide assistive devices/technology, medical supplies or equipment, nor home modifications.<sup>256</sup> <sup>257</sup> Under the self-directed service model, states may choose to disburse cash prospectively or issue vouchers, but neither is required.<sup>258</sup> Finally, states receive enhanced Federal match of six (6) additional percentage points for CFC services and supports.<sup>259</sup>

**Section 1115 Research and Demonstration Waivers.** The §1115 authority allows states to provide HCBS under an “experimental, pilot, or demonstration project that [is] found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program.”<sup>260</sup> The §1115 authority is very broad and enables the Secretary to waive multiple requirements under Section 1902 of the Social Security Act if such waivers promote the objectives of the Medicaid program.<sup>261</sup> Section 1115 waivers vary in size and scope and have been used to expand coverage or benefits, change policies for existing Medicaid populations (e.g., testing premiums or other eligibility requirements), modify delivery systems, restructure financing or authorize new payments (e.g., supplemental payments or incentive-based payments), as well as make other program changes.<sup>262</sup> Because §1115 authority is intended for research and demonstration purposes, states must have an approved evaluation strategy in place that is publicly available.<sup>263</sup> Additionally, states are subject to comprehensive reporting requirements, including submission of quarterly, annual, interim and final evaluation reports.<sup>264</sup> Finally, §1115 waivers are subject to shifting presidential priorities. Incoming administrations may let waivers expire, choosing not to renew certain waiver provisions if they don't align with the administration's waiver priorities or if they determine the provisions do not promote the objectives of the Medicaid program.<sup>265</sup> Additionally, outlined in waiver approval terms and conditions, CMS reserves the right to withdraw §1115 waiver or expenditure authorities at any time (including those already in operation under an active/approved waiver).<sup>266</sup>

**Section 1915(b) Waivers.** Section 1915(b) waiver authority provides states with the flexibility to modify their Medicaid delivery systems in the following four (4) ways:

- §1915(b)(1) allows states to require Medicaid enrollees to enroll in managed care
- §1915(b)(2) allows states to designate a locality to act as a “central broker” to assist Medicaid enrollees in choosing among competing health care plans

- §1915(b)(3) allows states to use cost savings made possible through the recipients' use of more cost-effective medical care to provide additional services
- §1915(b)(4) allows states to limit the enrollees' choice of providers (except in emergency situations and with respect to family planning services).<sup>267 268</sup>

Under 1915(b) authority, a state can request a waiver of freedom of choice requirements (Section 1902(a)(23) of the SSA), comparability requirements (Section 1902(a)(10)(B) of the SSA), and state-wideness requirements (Section 1902(a)(1)).<sup>269</sup> States may use 1915(b)(4) waivers to limit the number or type of providers who can furnish specific Medicaid services—for example, for disease management, employment, or case management—as long as such restrictions do not substantially impair access to services of adequate quality where medically necessary.<sup>270</sup> Section 1915(b)(4) waivers can be used in both fee-for-service as well as managed care arrangements.<sup>271</sup>

## LTSS Medicaid Program-Specific Authorities

Medicaid program-specific authorities that can be used to provide LTSS include:

***Money Follows the Person.*** The Money Follows the Person (MFP) program is a federal grant program that supports states through flexible funding in rebalancing their long-term services and supports systems from serving individuals in institutional settings to home and community-based settings.<sup>272</sup> The goals of the MFP program include:

- Prioritizing the use of HCBS over services provided in institutional settings.
- Eliminating barriers for states that would otherwise prevent or restrict the flexible use of Medicaid funds for individuals who receive long-term services and supports in their preferred setting.
- Increasing the ability of state Medicaid programs to provide HCBS to individuals who choose to transition from institutional settings to home and community-based settings.
- Ensuring quality assurance procedures are in place for individuals receiving HCBS and continuous quality improvement in such services.<sup>273</sup>

Medicaid beneficiaries are eligible to participate in the MFP program if they have resided in an institution for at least 60 days and individuals are eligible for services for a one-year period following their last day of institutionalization.<sup>274</sup> Under the MFP program states can receive an enhanced FMAP (up to 90%) for qualified HCBS and demonstration HCBS.<sup>275</sup> Additionally, states can receive 100% FMAP for Supplemental Services, Administrative Expenses, and HCBS Capacity Building.<sup>276</sup> It is important to note that the MFP program is currently funded by Congress through 2027.<sup>277</sup>

***Program of All-Inclusive Care for the Elderly.*** The Program of All-Inclusive Care for the Elderly (PACE) provides comprehensive medical and social services to older and medically fragile adults through an interdisciplinary team made up of at least 11 federally mandated provider types.<sup>278</sup> This interdisciplinary team is responsible for assessing needs, developing care plans, and delivering all services (including acute care services and when necessary, nursing facility services).<sup>279</sup> The benefit package for all PACE participants includes: Primary Care, Hospital Care, Medical Specialty Services, Prescription Drugs (including Medicare Part D drugs), Nursing Home Services, Nursing Services,



Personal Care Services, Emergency Services, Home Care, Physical Therapy, Occupational Therapy, Adult Day Health Care, Recreational Therapy, Meals, Dental Care, Nutritional Counseling, Social Services, Laboratory/X-Ray, Social Work Counseling, End of Life Care and Transportation.<sup>280</sup> Hospital, Nursing Home, Home Health, and other specialized services are generally furnished under contract.<sup>281</sup> There are no limitations or condition as to amount, duration or scope of services and there are no deductibles, copayments, coinsurance, or other cost sharing that would otherwise apply under Medicare or Medicaid.<sup>282</sup> PACE is a Medicare program and states can elect to provide PACE services to Medicaid beneficiaries as an optional benefit.<sup>283</sup> The PACE program is a managed care benefit with capped financing.<sup>284</sup> To become a PACE organization, expand a service area, or add a center, an entity must submit a complete application to CMS.<sup>285</sup> PACE organizations enter a three-way agreement with CMS and the state that describes federal requirements for PACE.<sup>286</sup> PACE organizations are required to submit data on 23 medical and non-medical utilization elements on a quarterly cadence to the Health Plan Management System, in addition to submitting Medicare encounter data to CMS.<sup>287</sup> The PACE program is relatively small because of the large start-up costs involved, physician buy in, coverage of only those who meet a nursing facility level of care and who live in PACE service areas, and very discreet targeted catchment areas.<sup>288</sup>

**Health Homes.** Health homes integrate physical and behavioral health (both mental health and substance abuse) and long-term services and supports for high-need, high-cost Medicaid populations with chronic illnesses.<sup>289</sup> The goal of the Medicaid health home state plan option is to promote access to and coordination of care.<sup>290</sup> To be eligible for health home services, an individual must be a Medicaid beneficiary diagnosed with the following according to state-defined criteria: (1) two chronic conditions; (2) one chronic condition and risk for a second; or (3) a serious mental illness. The statute creating health homes listed chronic conditions that include mental health conditions, substance use disorder, asthma, diabetes, heart disease, and overweight (body mass index over 25).<sup>291</sup> States may propose other conditions to CMS for incorporation into their health home models.<sup>292</sup> States have flexibility to define the core health home services, but they must provide all six core services.<sup>293</sup> Core health home services include: comprehensive care management, care coordination, health promotion, comprehensive transitional care/follow-up, patient & family support, and referral to community & social support services.<sup>294</sup> States receive enhanced federal funding (90 percent federal match) for health home services for the first eight fiscal quarters from the effective SPA date, and, after that, states receive their usual match rate.<sup>295</sup> The [Health Home Information Resource Center](#) (HHIRC) located on Medicaid.gov provides useful information to States considering the health home Medicaid State Plan option.

**In Lieu of Services Under Managed Care Programs.** States and managed care plans have the ability to cover services or settings that are substitutes for services or settings covered under the state plan as “in lieu of services and settings” (also known as ILOSs) in accordance with 42 CFR §§ 438.3(e)(2) and 438.16.<sup>296</sup> ILOS is an innovative option states may consider employing in Medicaid managed care programs to reduce health disparities and address unmet health-related social needs such as housing instability and nutrition insecurity, through the use of a service or setting that is provided to an enrollee in lieu of a service or setting (ILOS) covered under the state plan.<sup>297</sup> ILOSs must advance the objectives of the Medicaid program, be cost effective, be medically appropriate,

preserve individuals' rights and protections, and are subject to monitoring, oversight and evaluation.<sup>298</sup> States will also be required to submit at least three distinct annual ILOS reports: (1) projected ILOS capitation as a percentage of total capitation (for the coming year); (2) a final report on actual ILOS capitation paid as a percentage of total capitation paid; and (3) a summary report of actual ILOS spending based on claims and encounter data from managed care plans.<sup>299</sup>

# Appendix F: Comparative Analysis of Utah’s Existing 1915(c) HCBS Waiver Programs

In each section, table “A” summarizes and compares DSPD waivers, and table “B” summarizes and compares DIH and DAAS waivers.

## Basics of the Waivers

Appendix F – Table 1-A: Basics of the Waivers (DSPD)

Waiver Section	Community Supports Waiver	Community Transitions Waiver	Limited Supports Waiver	Physical Disabilities Waiver	Acquired Brain Injury
<b>Purpose (Main 2)</b>	To provide support services for people to live as independently and productively as possible while living in a community setting of their choice.	To provide support services for individuals who are moving out of intermediate care facilities for individuals with intellectual disabilities (ICF/ID).	To provide support services for individuals who live in their own home. Waiver services are intended to assist participants to live as independently and productively as possible while living in their community.	To provide support services for people with significant physical disabilities who live in the community. Limited to individuals who self-direct their services.	To provide support services statewide to meet the needs of individuals with acquired brain injuries to live as independently as possible while residing in the community-based setting of their choice.
<b>Level(s) of Care (Main 1-F)</b>	ICF/IID	ICF/IID	NF and ICF/IID	NF	NF
<b>Concurrent Operation with Other Authorities (Main 1-G)</b>	None	None	None	None	None

<b>Waivers Requested (Main 4)</b>	Comparability and Income and Resources for the Medically Needy	Comparability and Income and Resources for the Medically Needy	Comparability and Income and Resources for the Medically Needy	Comparability and Income and Resources for the Medically Needy	Comparability and Income and Resources for the Medically Needy
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Appendix F – Table 1-B: Basics of the Waivers (DIH and DAAS)

Waiver Section	New Choices Waiver	Medically Complex Children	Tech Dependent Med Fragile Individuals	Individuals Age 65 or Older
<b>Purpose (Main 2)</b>	To provide support services for individuals who are moving out of for individuals residing in medical institutions (non-IMD), nursing facilities, small health care facilities, and licensed assisted living facilities.	To provide support services for the parents and caretakers of medically complex children thereby assisting enrollees to live as independently and productively as possible within their communities.	To provide support services for technology dependent, medically fragile individuals with complex medical conditions who would otherwise require placement in a Medicaid nursing facility.	To provide support services for individuals age 65 or older to remain in a home and community-based setting of their choice rather than a facility.
<b>Level(s) of Care (Main 1-F)</b>	NF	NF	NF	NF
<b>Concurrent Operation with Other Authorities (Main 1-G)</b>	None	None	None	None
<b>Waivers Requested (Main 4)</b>	Comparability and Income and Resources for the Medically Needy	Comparability and Income and Resources for the Medically Needy	Comparability and Income and Resources for the Medically Needy	Comparability and Income and Resources for the Medically Needy



## Waiver Administration and Operation (Appendix A)

Appendix F – Table 2-A: Waiver Administration and Operation (DSPD)

Waiver Section	Community Supports Waiver	Community Transitions Waiver	Limited Supports Waiver	Physical Disabilities Waiver	Acquired Brain Injury
<b>Authority for Waiver Operation (App A-1)</b>	DSPD	DSPD	DSPD	DSPD	DSPD
<b>Use of Contracted Entities (App A-3)</b>	No	No	No	No	No
<b>Use of Local Entities (App A-4)</b>	No	No	No	No	No

Appendix F – Table 2-B: Waiver Administration and Operation (DIH and DAAS)

Waiver Section	New Choices Waiver	Medically Complex Children	Tech Dependent Med Fragile Individuals	Individuals Age 65 or Older
<b>Authority for Waiver Operation (App A-1)</b>	DIH	DIH	DIH	DAAS
<b>Use of Contracted Entities (App A-3)</b>	No	No	No	No
<b>Use of Local Entities (App A-4)</b>	No	No	No	Ten Area Agencies on Aging (AAA)

## Targeting Criteria (Appendix B)

Appendix F – Table 3-A: Targeting Criteria (DSPD)

Waiver Section	Community Supports Waiver	Community Transitions Waiver	Limited Supports Waiver	Physical Disabilities Waiver	Acquired Brain Injury
<b>Target Group(s) (App B-1-a)</b>	ID/DD/Both	ID/DD/Both	ID/DD/Both Aged/ Disabled/ Both (Specific)	Aged/ Disabled/ Both (General)	Aged/ Disabled/ Both (Specific)
<b>Target Sub-Group(s) and Ages (App B-1-a)</b>	Autism, DD, ID: All Ages	Autism, DD, ID: All Ages	Autism, DD, ID: All Ages Brain Injury: 18+	Aged: 65+ Physical Disability: 18-64	Brain Injury: 18+
<b>Additional Targeting Criteria (App B-1-b)</b>	<ul style="list-style-type: none"> <li>- ID or related condition</li> <li>- Substantial functional limitations in three or more areas of major life activity</li> </ul>	<ul style="list-style-type: none"> <li>- ID or related condition</li> <li>- Substantial functional limitations in three or more areas of major life activity</li> <li>- Limited to individuals with at least 12-month stay in ICF and currently receiving ICF benefits</li> <li>- Others when in need of Professional Nursing Services</li> </ul>	<ul style="list-style-type: none"> <li>- ID or related condition</li> <li>- Substantial functional limitations in three or more areas of major life activity</li> <li>- Acquired Brain Injury (not congenital induced by birth trauma)</li> <li>- Qualifying International Classification of Diseases code diagnosis</li> <li>- Comprehensive Brain Injury Assessment (CBIA) Score 36 and 136</li> </ul>	<ul style="list-style-type: none"> <li>- Disability resulting in functional loss of two or more limbs and expected to last longer than 12 months</li> </ul>	<ul style="list-style-type: none"> <li>- Acquired Brain Injury (not congenital induced by birth trauma)</li> <li>- Qualifying International Classification of Diseases code diagnosis</li> <li>- Comprehensive Brain Injury Assessment (CBIA) Score 36 and 136</li> </ul>

Appendix F – Table 3-B: Targeting Criteria (DIH and DAAS)

Waiver Section	New Choices Waiver	Medically Complex Children	Tech Dependent Med Fragile Individuals	Individuals Age 65 or Older
<b>Target Group(s) (App B-1-a)</b>	Aged/ Disabled/ Both (General)	Aged/ Disabled/ Both (Specific)	Aged/ Disabled/ Both (Specific)	Aged/ Disabled/ Both (General)
<b>Target Sub-Group(s) and Ages (App B-1-a)</b>	Aged: 65+ Physical Disability: 18-64 Other Disability: 18-64	Medically Fragile: 0-19	Medically Fragile: 0-20 Tech Dependent: 0-20	Aged: 65+
<b>Additional Targeting Criteria (App B-1-b)</b>	<ul style="list-style-type: none"> <li>- Receiving NF for 90d</li> <li>- Receiving SHCF 365d</li> <li>- Receiving AL for 365d</li> <li>- Receiving medical institution for 3d and discharge to NF for 60d</li> <li>- Receiving other 1915(c) waiver services in need of NF</li> <li>- No Psychiatric</li> <li>- No Intensive skilled LOC</li> <li>- No ICF/IID LOC</li> </ul>	<p>Child must have had within the last 24 months (or since the birth if less than 24 months):</p> <ul style="list-style-type: none"> <li>- 3 or more organ systems affected; AND</li> <li>- 3 or more specialty clinicians involved; AND</li> <li>- Prolonged dependence (&gt; 3 months) on medical devices or treatments intended to support adequate organ function.</li> </ul>	<ul style="list-style-type: none"> <li>- Requires services so inherently complex that they can only be safely and effectively performed by, or under the direction of a skilled nursing professional.</li> <li>- Must be dependent on one or more of the listed technologies</li> </ul>	None

## Individual Cost Limit (Appendix B)

Appendix F – Table 4-A: Individual Cost Limit (DSPD)

Waiver Section	Community Supports Waiver	Community Transitions Waiver	Limited Supports Waiver	Physical Disabilities Waiver	Acquired Brain Injury
<b>Individual Cost Limit (App B-2)</b>	None	None	- Lower Than Institutional Costs - \$19,605.00 (WY1) adjusted annually - Additional \$10,000 for emergencies	None	None

Appendix F – Table 4-B: Individual Cost Limit (DIH and DAAS)

Waiver Section	New Choices Waiver	Medically Complex Children	Tech Dependent Med Fragile Individuals	Individuals Age 65 or Older
<b>Individual Cost Limit (App B-2)</b>	None	None	None	None

## Eligibility and Entrance (Appendix B)

Appendix F – Table 5-A: Eligibility and Entrance (DSPD)

Waiver Section	Community Supports Waiver	Community Transitions Waiver	Limited Supports Waiver	Physical Disabilities Waiver	Acquired Brain Injury
<b>Number of Participants (WY5) (App B-3-a)</b>	6,575 with max 6,400 served at any point	580	120	105 with max 90 served at any point	164 with max 157 served at any point
<b>Reserved Capacity (App B-3-c)</b>	None	Requiring Professional Nursing Services (20 slots)	None	None	None
<b>Selection of Entrants (Waiting List) (App B-3-f)</b>	Entrance based on priority of need NAQ Assessment	Entrance based on time spent waiting	Entrance based on priority of need NAQ Assessment	Entrance based on priority of need NAQ Assessment	Entrance based on priority of need NAQ Assessment
<b>Eligibility Groups (App B-4)</b>	SSI recipients Optional state supplement Optional categorically needy 100% FPL BBA working disabled group Medically needy  1902(a)(10)(A)(i)(IV) 42 CFR 435.135 1634(c)/1634(d)  1902(a)(10)(A)(i)(II)  Optional 217 HCBS Group 300% FBR	SSI recipients Optional state supplement Optional categorically needy 100% FPL BBA working disabled group Medically needy  42 CFR 435.135 1634(c)/1634(d) 1619(b)  Optional 217 HCBS Group 300% FBR	SSI recipients Optional state supplement Optional categorically needy 100% FPL BBA working disabled group Medically needy  42 CFR 435.135 1634(c)/1634(d) 1619(b)  Optional 217 HCBS Group 300% FBR	SSI recipients Optional state supplement Optional categorically needy 100% FPL BBA working disabled group Medically needy  Optional 217 HCBS Group 300% FBR	SSI recipients Optional state supplement Optional categorically needy 100% FPL BBA working disabled group Medically needy  42 CFR 435.135 1634(c)/1634(d)  1902(a)(10)(A)(i)(II)  Optional 217 HCBS Group 300% FBR

Appendix F – Table 5-B: Eligibility and Entrance (DIH and DAAS)

Waiver Section	New Choices Waiver	Medically Complex Children	Tech Dependent Med Fragile Individuals	Individuals Age 65 or Older
<b>Number of Participants (WY5) (App B-3-a)</b>	2,500 with max 1,925 served at any point	930 with max 900 served at any point	150 with max 139 served at any point	550 with max 500 served at any point
<b>Reserved Capacity (App B-3-c)</b>	Residing in NF or other med institution (Not AL)  (540 slots)	None	Children with Spinal Muscular Atrophy Type I  (5 slots)	None
<b>Selection of Entrants (Waiting List) (App B-3-f)</b>	Entrance based on time spent waiting	Entrance based on priority of need  Weighted Factors	Entrance based on priority of need  Weighted Factors	Entrance based on priority of need  Demographic Intake and Screening (DIS) form
<b>Eligibility Groups (App B-4)</b>	SSI recipients Optional state supplement Optional categorically needy 100% FPL BBA working disabled group Medically needy  42 CFR 435.135 1634(c)/1634(d) 1619(b)  Optional 217 HCBS Group 300% FBR	SSI recipients Optional state supplement Optional categorically needy 100% FPL  Medically needy  Optional 217 HCBS Group 300% FBR	SSI recipients  Optional categorically needy 100% FPL BBA working disabled group Medically needy  42 CFR 435.117 42 CFR 435.118 42 CFR 435.301 42 CFR 435.308  Optional 217 HCBS Group 300% FBR	SSI recipients Optional state supplement Optional categorically needy 100% FPL  Medically needy  Optional 217 HCBS Group 300% FBR

## Level of Care (Appendix B)

Appendix F – Table 6-A: Level of Care (DSPD)

Waiver Section	Community Supports Waiver	Community Transitions Waiver	Limited Supports Waiver	Physical Disabilities Waiver	Acquired Brain Injury
<b>LOC Criteria (App B-6-d)</b>	<p>ICF/IID LOC:                      - Diagnosis ID or closely related condition                      - 7+ years – Substantial Functional Limitation in at least 3 areas of major life activity                      - Under 7 years substantial functional limitations assumed based on diagnosis</p>	<p>ICF/IID LOC:                      - Diagnosis ID or closely related condition                      - 7+ years – Substantial Functional Limitation in at least 3 areas of major life activity                      - Under 7 years substantial functional limitations assumed based on diagnosis</p>	<p>ICF/IID LOC:                      - Diagnosis ID or closely related condition                      - 7+ years – Substantial Functional Limitation in at least 3 areas of major life activity                      - Under 7 years substantial functional limitations assumed based on diagnosis</p> <p>NF LOC (2 of 3)                      - Due to med conditions, requires substantial physical assistance with daily living activities                      - Physician has determined person requires nursing facility care                      - Support needs cannot be safely met in a less structured setting, or without HCBS</p>	<p>NF LOC (2 of 3)                      - Due to med conditions, requires substantial physical assistance with daily living activities                      - Physician has determined person requires nursing facility care                      - Support needs cannot be safely met in a less structured setting, or without HCBS</p>	<p>NF LOC (2 of 3)                      - Due to med conditions, requires substantial physical assistance with daily living activities                      - Physician has determined person requires nursing facility care                      - Support needs cannot be safely met in a less structured setting, or without HCBS</p>

<b>Assessment Tool (App B-6-d)</b>	<p>Level of care determination screen in the Utah Systems for Tracking Eligibility, Planning, and Services (USTEPS).</p> <p>Utah Comprehensive Assessment of Needs and Strengths (UCANS)</p>	<p>Level of care determination screen in the Utah Systems for Tracking Eligibility, Planning, and Services (USTEPS).</p> <p>Utah Comprehensive Assessment of Needs and Strengths (UCANS)</p>	<p>Level of care determination screen in the Utah Systems for Tracking Eligibility, Planning, and Services (USTEPS).</p> <p>Utah Comprehensive Assessment of Needs and Strengths (UCANS)</p> <p>Comprehensive Brain Injury Assessment (CBIA). The applicant must score between 36 - 136</p>	<p>Level of care determination screen in the Utah Systems for Tracking Eligibility, Planning, and Services (USTEPS).</p> <p>InterRAI Minimum Data Set – Home Care (MDS-HC)</p>	<p>Level of care determination screen in the Utah Systems for Tracking Eligibility, Planning, and Services (USTEPS).</p> <p>Comprehensive Brain Injury Assessment (CBIA). The applicant must score between 36 - 136</p>
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Appendix F – Table 6-B: Level of Care (DIH and DAAS)

Waiver Section	New Choices Waiver	Medically Complex Children	Tech Dependent Med Fragile Individuals	Individuals Age 65 or Older
<b>LOC Criteria (App B-6-d)</b>	NF LOC (2 of 3) - Due to med conditions, requires substantial physical assistance with daily living activities - Physician has determined person requires nursing facility care - Support needs cannot be safely met in a less structured setting, or without HCBS	NF LOC (2 of 3) - Due to med conditions, requires substantial physical assistance with daily living activities - Physician has determined person requires nursing facility care - Support needs cannot be safely met in a less structured setting, or without HCBS	NF LOC (2 of 3) - Due to med conditions, requires substantial physical assistance with daily living activities - Physician has determined person requires nursing facility care - Support needs cannot be safely met in a less structured setting, or without HCBS	NF LOC (2 of 3) - Due to med conditions, requires substantial physical assistance with daily living activities - Physician has determined person requires nursing facility care - Support needs cannot be safely met in a less structured setting, or without HCBS
<b>Assessment Tool (App B-6-d)</b>	InterRAI Minimum Data Set – Home Care (MDS-HC)	Medical Acuity and Critical Needs Grid	Technology Dependent Waiver Comprehensive Assessment	InterRAI Minimum Data Set – Home Care (MDS-HC)

## Participant Services (Appendix C)

Appendix F – Table 7-A: Participant Services (DSPD)

Waiver Section	Community Supports Waiver	Community Transitions Waiver	Limited Supports Waiver	Physical Disabilities Waiver	Acquired Brain Injury
<b>Summary of Services (App C-1)</b>	Residential Hab Supported Living Extended Living Personal Assist Homemaker	Residential Hab Supported Living Extended Living Personal Assist Homemaker	Attendant Care	Personal Attend	Residential Hab Supported Living Extended Living  Homemaker





	Relatives/LGs may be paid for providing: - Personal Assistance - Respite - Homemaker - Chore - Companion - Fm/Ind Train - Supp Living - Transportation	Relatives/LGs may be paid for providing: - Personal Assistance - Respite - Homemaker - Chore - Companion - Fm/Ind Train - Supp Living - Transportation	Relatives/LGs may be paid for providing: - Attendant Care - Respite - Behavioral Services - Transportation	Relatives/LGs may be paid for providing: - Personal Attendant Services - Transportation	Relatives/LGs may be paid for providing: - Respite - Homemaker - Chore - Companion - Supp Living - Transportation
<b>Additional Limits on Amount of Waiver Services (App C-4)</b>	Not Applicable	Not Applicable	Not Applicable	Using Personal Assistance Critical Needs Assessment and the needs identified in the InterRAI MDS-HC, the case manager estimates the participant's prospective budget amount.	Not Applicable

Appendix F – Table 7-B: Participant Services (DIH and DAAS)

Waiver Section	New Choices Waiver	Medically Complex Children	Tech Dependent Med Fragile Individuals	Individuals Age 65 or Older
<b>Summary of Services (App C-1)</b>	Adult Residential Attendant Care Homemaker Chore Services Respite  Adult Day Care Habilitation Cmmtly Transition	Personal Attend  Respite (Multi)	Personal Attend  Respite (Multi)	Personal Attend Homemaker Chore Services Respite (Multi)  Adult Day Health Companion Cmmtly Transition



	<p>Budget Assist Transportation Caregiver Train</p> <p>Supportive Maint</p> <p>Med Admin Assist Home Meals Home Adapt</p> <p>PERS SMES Asst Tech Device</p> <p>Financial Mgmt Consumer Prep</p> <p>Case Mgmt</p>			<p>Budget Assist Transportation</p> <p>Supportive Maint Ext Home Health Ext Home Health Med Remind Home Meals Adapt Home Massage Tx PERS SMES</p> <p>Financial Mgmt</p> <p>Case Mgmt</p>
<b>Case Management (App C-1-b)</b>	Waiver Service	Admin Activity	Admin Activity	Waiver Service
<b>Policies for Payment to LRIs, Relatives and Legal Guardians (App C-2- d and C-2-e)</b>	<p>LRI may be paid for up to 40 hours per week of Attendant Care Services</p> <p>Relatives/LGs may be paid for providing:</p> <ul style="list-style-type: none"> <li>- Attendant Care</li> <li>- Respite</li> <li>- Homemaker</li> <li>- Chore</li> </ul>	<p>LRI may be paid for up to 13 hours per week of Personal Attendant Services</p> <p>Relatives/LGs may be paid for providing:</p> <ul style="list-style-type: none"> <li>- Personal Attendant</li> <li>- Respite</li> </ul>	<p>LRI may be paid for up to 13 hours per week of Personal Attendant Services</p> <p>Relatives/LGs may be paid for providing:</p> <ul style="list-style-type: none"> <li>- Personal Attendant</li> <li>- Respite</li> <li>- PD Nursing</li> <li>- In-Home Feeding</li> </ul>	<p>LRI may be paid for up to 40 hours per week of Personal Attendant Services</p> <p>Relatives/LGs may be paid for providing:</p> <ul style="list-style-type: none"> <li>- Personal Attendant Services</li> </ul>
<b>Additional Limits on Amount of Waiver Services (App C-4)</b>	Not Applicable	Not Applicable	Not Applicable	Not Applicable



## Participant-Centered Planning and Service Delivery (Appendix D)

Appendix F – Table 8-A: Participant-Centered Planning and Service Delivery (DSPD)

Waiver Section	Community Supports Waiver	Community Transitions Waiver	Limited Supports Waiver	Physical Disabilities Waiver	Acquired Brain Injury
<b>Plan Development Assessment Tool (App D-1-d)</b>	Utah Comprehensive Assessment of Needs and Strengths (UCANS)	Utah Comprehensive Assessment of Needs and Strengths (UCANS)	Utah Comprehensive Assessment of Needs and Strengths (UCANS)  Comprehensive Brain Injury Assessment (CBIA)	InterRAI Minimum Data Set- Home Care (MDS-HC)	Comprehensive Brain Injury Assessment (CBIA)

Appendix F – Table 8-B: Participant-Centered Planning and Service Delivery (DIH and DAAS)

Waiver Section	New Choices Waiver	Medically Complex Children	Tech Dependent Med Fragile Individuals	Individuals Age 65 or Older
<b>Plan Development Assessment Tool (App D-1-d)</b>	InterRAI Minimum Data Set- Home Care (MDS-HC)	Silent	Silent	InterRAI Minimum Data Set- Home Care (MDS-HC)

## Participant Direction of Services (Appendix E)

Appendix F – Table 9-A: Participant Direction of Services (DSPD)

Waiver Section	Community Supports Waiver	Community Transitions Waiver	Limited Supports Waiver	Physical Disabilities Waiver	Acquired Brain Injury
<b>Estimated # SAS (WY5) (App E-1-n)</b>	2,300 (out of 6,400)	10 (out of 580)	30 (out of 120)	105 (out of 90)	20 (out of 157)
<b>Self-Administered Services (App E-1-g)</b>	Supported Living Personal Assist Homemaker Chore Services Respite (Multi) Fam/Ind Training Transportation	Supported Living Personal Assist Homemaker Chore Services Respite (Multi) Fam/Ind Training Transportation	Attendant Care Respite Supported Emp Peer Supp SAS Transportation	Personal Attend Transportation	Supported Living Homemaker Chore Services Respite (Multi) Companion Transportation

Appendix F – Table 9-B: Participant Direction of Services (DIH and DAAS)

Waiver Section	New Choices Waiver	Medically Complex Children	Tech Dependent Med Fragile Individuals	Individuals Age 65 or Older
<b>Estimated # SAS (WY5)(App E-1-n)</b>	55 (out of 1,925)	300 (out of 900)	15 (out of 150)	55 (out of 500)
<b>Self-Administered Services (App E-1-g)</b>	Attendant Care Homemaker Respite	Personal Attend Respite (Multi)	Personal Attend Respite (Multi) In-Home Feeding	Personal Attend

## Participant Safeguards (Appendix G)

Appendix F – Table 10-A: Participant Safeguards (DSPD)

Waiver Section	Community Supports Waiver	Community Transitions Waiver	Limited Supports Waiver	Physical Disabilities Waiver	Acquired Brain Injury
<b>Restraints Permitted? (App G)</b>	Yes	Yes	Yes	No	Yes
<b>Restrictive Interventions Permitted? (App G)</b>	Yes	Yes	Yes	No	Yes
<b>Seclusion Permitted? (App G)</b>	Yes	Yes	Yes	No	Yes

Appendix F – Table 10-B: Participant Safeguards (DIH and DAAS)

Waiver Section	New Choices Waiver	Medically Complex Children	Tech Dependent Med Fragile Individuals	Individuals Age 65 or Older
<b>Restraints Permitted? (App G)</b>	No	No	No	No
<b>Restrictive Interventions Permitted? (App G)</b>	No	No	No	No
<b>Seclusion Permitted? (App G)</b>	No	No	No	No

## Financial Accountability (Appendix I)

Appendix F – Table 11-A: Financial Accountability (DSPD)

Waiver Section	Community Supports Waiver	Community Transitions Waiver	Limited Supports Waiver	Physical Disabilities Waiver	Acquired Brain Injury
<b>Copayments (App I-7-a)</b>	No	No	No	No	No
<b>Other Cost Sharing (App I-7-b)</b>	No	No	No	No	No

Appendix F – Table 11-B: Financial Accountability (DIH and DAAS)

Waiver Section	New Choices Waiver	Medically Complex Children	Tech Dependent Med Fragile Individuals	Individuals Age 65 or Older
<b>Copayments (App I-7-a)</b>	No	No	No	No
<b>Other Cost Sharing (App I-7-b)</b>	No	No	No	No

# IT Systems

Appendix F – Table 12: IT Systems by Divisio

Waiver Section	Division of Services for People with Disabilities	Division of Integrated Healthcare	Division of Aging and Adult Services
<b>Application / Eligibility Systems</b>	Utah Systems for Tracking Eligibility, Planning, and Services (USTEPS).	Provider Reimbursement Information System for Medicaid (PRISM) Pega Platform	Provider Reimbursement Information System for Medicaid (PRISM) Pega Platform
<b>Case Management / Planning Systems</b>	USTEPS	Provider Reimbursement Information System for Medicaid (PRISM) Pega Platform	Provider Reimbursement Information System for Medicaid (PRISM) Pega Platform
<b>Provider Enrollment Systems</b>	Provider Reimbursement Information System for Medicaid (PRISM) Provider Portal	Provider Reimbursement Information System for Medicaid (PRISM) Provider Portal	Provider Reimbursement Information System for Medicaid (PRISM) Provider Portal
<b>Incident Reporting and Management Systems</b>	USTEPS Provider Interface (UPI)	Provider Reimbursement Information System for Medicaid (PRISM) Pega Platform	Provider Reimbursement Information System for Medicaid (PRISM) Pega Platform
<b>Service Authorization and Provider Claims System</b>	<ul style="list-style-type: none"> <li>- Plans of care including specifications of amount, frequency and duration of prescribed services are documented in USTEPS by case managers and result in payment authorizations in CAPS.</li> <li>- Providers request payment through the DHSS Contract, Approval and Provider System (CAPS)</li> <li>- DSPD requests reimbursement from DIH through Provider Reimbursement Information System for Medicaid (PRISM)</li> </ul>	Provider Reimbursement Information System for Medicaid (PRISM)	Provider Reimbursement Information System for Medicaid (PRISM)

# Appendix G: Waiver Restructuring Details

Appendix G – Table 1: DSPD Waiver Restructuring Details

	New DSPD Supports Waiver	New DSPD Comprehensive Waiver
<b>Purpose (Main 2)</b>	The purpose of the supports waiver would be to provide services to individuals who live with family members or in their own home and have less intensive needs than people on the comprehensive waiver.	The purpose of the comprehensive waiver would be to provide services to individuals who: <ul style="list-style-type: none"> <li>• require out-of-home residential support and supervision, or</li> <li>• require intensive levels of in-home services, or</li> <li>• have resided in an ICF/IID and desire to transition to the community.</li> </ul>
<b>Level(s) of Care (Main 1-F)</b>	Nursing Facility (NF), or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)	Nursing Facility (NF), or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
<b>Target Group(s) (App B-1-a)</b>	ID/DD/Both Aged/Disabled/Both (General) Aged/Disabled/Both (Specific)	ID/DD/Both Aged/Disabled/Both (General) Aged/Disabled/Both (Specific)
<b>Sub-Group(s) &amp; Ages (App B-1-a)</b>	Autism, DD, ID      All Ages Physical Disability      18+ Brain Injury      18+	Autism, DD, ID      All Ages Physical Disability      18+ Brain Injury      18+
<b>Additional Targeting Criteria (App B-1-b)</b>	<p>Individuals must be able to have their needs safely met within the specified cost limit</p> <p>AND must meet the following additional criteria for their respective target group:</p> <p>Additional Criteria for ID/DD/Both</p> <ul style="list-style-type: none"> <li>• ID or related condition</li> <li>• Substantial functional limitations in three or more areas of major life activity</li> </ul> <p>Additional Criteria for Aged/Disabled/Both (General)</p> <ul style="list-style-type: none"> <li>• Disability resulting in functional loss of two or more limbs and expected to last longer than 12 months</li> </ul>	<p>Individuals must either:</p> <ol style="list-style-type: none"> <li>(1) Require out-of-home residential support and supervision, or</li> <li>(2) Require intensive levels of in-home services, or</li> <li>(3) Have resided in an ICF/IID for at least 60 days, and desire to transition to the community.</li> </ol> <p>AND must meet the following additional criteria for their respective target group:</p> <p>Additional Criteria for ID/DD/Both</p> <ul style="list-style-type: none"> <li>• ID or related condition</li> <li>• Substantial functional limitations in three or more areas of major life activity</li> </ul> <p>Additional Criteria for Aged/Disabled/Both (General)</p>

	<p>Additional Criteria for Aged/ Disabled/Both (Specific)</p> <ul style="list-style-type: none"> <li>• Acquired Brain Injury (not congenital induced by birth trauma)</li> <li>• Qualifying International Classification of Diseases code diagnosis</li> <li>• Comprehensive Brain Injury Assessment (CBIA) Score 36 and 136</li> </ul>	<ul style="list-style-type: none"> <li>• Disability resulting in functional loss of two or more limbs and expected to last longer than 12 months</li> </ul> <p>Additional Criteria for Aged/ Disabled/Both (Specific)</p> <ul style="list-style-type: none"> <li>• Acquired Brain Injury (not congenital induced by birth trauma)</li> <li>• Qualifying International Classification of Diseases code diagnosis</li> <li>• Comprehensive Brain Injury Assessment (CBIA) Score 36 and 136</li> </ul>
<p><b>Individual Cost Limits (App B-2)</b></p>	<p>Yes. Cost Limit Less than Institutional Costs.</p> <p>Prior to entrance into the waiver a complete assessment of an individual’s needs is performed. The assessment is done in cooperation with the individual and any family and authorized representatives. If the individual’s needs cannot be assured within the cost limit, they are denied entrance to the DSPD Supports Waiver and referred for triage to the Comprehensive Waiver. No individual is authorized for DSPD Supports Waiver enrollment where their health and safety cannot be assured.</p> <p>If the individual experiences a change in condition or circumstances after being admitted to the DSPD Supports Waiver, additional services not to exceed 10% of the specified cost limit may be authorized to address their time-limited needs. Additionally, the individual may be referred to the Comprehensive Waiver through its reserved waiver capacity.</p>	<p>No Cost Limit.</p>
<p><b>Reserved Waiver Capacity (App B-3-c)</b></p>	<p>Reserved Capacity should be retained for:</p> <p>(1) Emergency Placements</p>	<p>Reserved Capacity should be retained for:</p> <p>(1) Transition from Limited Waiver due to increased need</p> <p>(2) Transition from ICF/IID after at least a 60-day stay. (with sufficient # to cover CTW participants)</p> <p>(3) Emergency Placements</p>



<b>Selection of Entrants to Waiver (Waiting list) (App B-3-f)</b>	<p>Yes. Prioritized entrance to the waiver from waiting list.</p> <p>Each applicant is evaluated for level of need using standardized methodology and screening tool. Three key areas are reviewed: 1) severity of need, 2) the applicant’s caregiver and support system, 3) time spent on the waiting list.</p> <p>Time Spent on Waiting List should be weighted most heavily.</p>	<p>Yes. Prioritized entrance to the waiver from waiting list.</p> <p>Each applicant is evaluated for level of need using standardized methodology and screening tool. Three key areas are reviewed: 1) severity of need, 2) the applicant’s caregiver and support system, 3) time spent on the waiting list.</p> <p>Severity of Need should be weighted most heavily.</p>
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Appendix G – Table 2: DIH Waiver Restructuring Details

	<b>New DIH Consolidated Complex Needs Waiver</b>	<b>Amended New Choices Waiver</b>												
<b>Purpose (Main 2)</b>	<p>The purpose of the new DIH consolidated complex needs waiver is to provide services to individuals who:</p> <ul style="list-style-type: none"> <li>• are medically fragile, or</li> <li>• have medically complex needs that must be supported by a nursing professional, or</li> <li>• are technology dependent.</li> </ul>	<p>The purpose of this New Choices waiver is to provide services to individuals who:</p> <p>(1) Reside in a qualified setting and desire to transition to the community, or</p> <p>(2) Receiving services through Utah’s DIH Consolidated Complex Needs waiver and have been identified in need of immediate (or near immediate) nursing facility admission absent enrollment into this waiver program</p>												
<b>Level(s) of Care (Main 1-F)</b>	<p>Nursing Facility (NF)</p>	<p>Nursing Facility (NF)</p>												
<b>Target Group(s) (App B-1-a)</b>	<p>Aged/Disabled/Both (Specific)</p>	<p>Aged/Disabled/Both (General) Aged/Disabled/Both (Specific)</p>												
<b>Sub-Group(s) &amp; Ages (App B-1-a)</b>	<table border="0"> <tr> <td>Medically Fragile</td> <td>Ages 0 - 20</td> </tr> <tr> <td>Tech Dependent</td> <td>Ages 0 - 20</td> </tr> </table>	Medically Fragile	Ages 0 - 20	Tech Dependent	Ages 0 - 20	<table border="0"> <tr> <td>Physical Disability</td> <td>18+</td> </tr> <tr> <td>Other Disability</td> <td>18+</td> </tr> <tr> <td>Medically Fragile</td> <td>21+</td> </tr> <tr> <td>Tech Dependent</td> <td>21+</td> </tr> </table>	Physical Disability	18+	Other Disability	18+	Medically Fragile	21+	Tech Dependent	21+
Medically Fragile	Ages 0 - 20													
Tech Dependent	Ages 0 - 20													
Physical Disability	18+													
Other Disability	18+													
Medically Fragile	21+													
Tech Dependent	21+													



<p><b>Additional Targeting Criteria (App B-1-b)</b></p>	<p>Individuals must also meet one of the following three sets of criteria:</p> <p>(1) <u>Medically Fragile Criteria:</u> Child must have had within the last 24 months (or since the birth if less than 24 months):</p> <ul style="list-style-type: none"> <li>• 3 or more organ systems affected; AND</li> <li>• 3 or more specialty clinicians involved in the child’s care or treatment in a comprehensive clinic with different specialty clinicians; AND</li> <li>• Prolonged dependence (&gt; 3 months) on medical devices or treatments intended to support adequate organ function.</li> </ul> <p>(2) <u>Medically Complex Criteria:</u> Requires services so inherently complex that they can only be safely and effectively performed by, or under the direction of a skilled nursing professional.</p> <p>(3) <u>Technology Dependent Criteria:</u> Must be dependent on one or more of the following technologies:</p> <ul style="list-style-type: none"> <li>• daily dependence on mechanical vent; OR</li> <li>• daily dependence on Bi-level Positive Airway Pressure (Bi-PAP) for 18 hours or more a day; OR</li> <li>• daily dependence on tracheostomy-based respiratory support; OR</li> <li>• daily dependence on Continuous Positive Airway Pressure (C-PAP) or Bi-level Positive Airway Pressure (Bi-PAP) or High Flow Nasal Cannula (HFNC) for less than 18 hours per day; OR</li> <li>• dependence on intravenous administration of nutritional substances or medications through a central line, which the physician anticipates will be necessary for a period of at least six months</li> </ul>	<p>Individuals must also meet one of the following criteria:</p> <ul style="list-style-type: none"> <li>• Receiving nursing facility care for 60 days</li> <li>• Receiving small health care facility (Type N) care for 365 days</li> <li>• Receiving Assisted Living care for 365 days</li> <li>• Receiving licensed medical institution care for 3 days and discharge to NF care for 60 days</li> <li>• Receiving other 1915(c) waiver services in need of nursing facility care</li> <li>• Previously disenrolled from New Choices and no interruption to NF care, or</li> <li>• Receiving services through Utah’s DIH Consolidated Complex Needs waiver and have been identified in need of immediate (or near immediate) nursing facility admission absent enrollment into this waiver program</li> </ul> <p>Individuals will not be eligible for this waiver if transferring from hospital or NF where receiving psychiatric LOC, receiving intensive skilled LOC, or receiving ICF/IID LOC.</p>
<p><b>Individual Cost Limits (App B-2)</b></p>	<p>No Cost Limit.</p>	<p>No Cost Limit.</p>



<b>Reserved Waiver Capacity (App B-3-c)</b>	Reserved Capacity should be retained for: (1) Transition from Nursing Facility (NF), Small health care facility (SHCF), or other licensed medical institutions (not AL) (2) Emergency Placements	Reserved Capacity should be retained for: (1) Transition from Utah’s DIH Consolidated Complex Needs waiver (2) Transition from Nursing Facility (NF), Small health care facility (SHCF), or other licensed medical institutions (not AL) (3) Emergency Placements
<b>Selection of Entrants to Waiver (Waiting List) (App B-3-f)</b>	Entrance to the waiver prioritized based on highest need.  Each applicant is evaluated for level of need using standardized methodology and screening tool. Three key areas are reviewed: 1) severity of need, 2) the applicant’s caregiver and support system, 3) time spent on the waiting list.  Severity of Need should be weighted most heavily.	Entrance to the waiver prioritized based on highest need.  Each applicant is evaluated for level of need using standardized methodology and screening tool. Three key areas are reviewed: 1) severity of need, 2) the applicant’s caregiver and support system, 3) time spent on the waiting list.  Severity of Need should be weighted most heavily.

Appendix G – Table 3: DAAS Waiver Restructuring Details

	<b>Amended DAAS Supports Waiver</b>	<b>New DAAS Comprehensive Waiver</b>
<b>Purpose (Main 2)</b>	The purpose of this supports waiver is to provide services to individuals who live with family members or in their own home and have less intensive needs than people on the comprehensive waiver.	The purpose of this comprehensive waiver is to provide services to individuals who: (1) require out-of-home residential support and supervision (2) require intensive levels of in-home services, or (3) reside in a Nursing Facility (NF) and desire to transition to the community.
<b>Level(s) of Care (Main 1-F)</b>	Nursing Facility (NF)	Nursing Facility (NF)
<b>Target Group(s) (App B-1-a)</b>	Aged/Disabled/Both (General)	Aged/Disabled/Both (General)
<b>Sub-Group(s) &amp; Ages (App B-1-a)</b>	Aged 65+	Aged 65+
<b>Additional Targeting</b>	None	None



<b>Criteria (App B-1-b)</b>		
<b>Individual Cost Limits (App B-2)</b>	<p>Yes. Cost Limit Less than Institutional Costs.</p> <p>Prior to entrance into the waiver a complete assessment of an individual’s needs is performed. The assessment is done in cooperation with the individual and any family and authorized representatives. If the individual’s needs cannot be assured within the cost limit, they are denied entrance to the DAAS Supports Waiver and referred for triage to the Comprehensive Waiver. No individual is authorized for DAAS Supports Waiver enrollment where their health and safety cannot be assured.</p> <p>If the individual experiences a change in condition or circumstances after being admitted to the DAAS Supports Waiver, additional services not to exceed 10% of the specified cost limit may be authorized to address their time-limited needs. Additionally, the individual may be referred to the Comprehensive Waiver through its reserved waiver capacity.</p>	No Cost Limit.
<b>Reserved Waiver Capacity (App B-3-c)</b>	<p>Reserved Capacity should be retained for:</p> <p>(1) Emergency Placements</p>	<p>Yes. Reserved Capacity should be retained for:</p> <p>(1) Transition from Limited Waiver due to increased need</p> <p>(2) Emergency Placements</p>
<b>Selection of Entrants to Waiver (Waiting List) (App B-3-f)</b>	<p>Entrance to the waiver prioritized based on highest need.</p> <p>Each applicant is evaluated for level of need using standardized methodology and screening tool. Three key areas are reviewed: 1) severity of need, 2) the applicant’s caregiver and support system, 3) time spent on the waiting list.</p> <p>Time Spent on Waiting List should be weighted most heavily.</p>	<p>Entrance to the waiver prioritized based on highest need.</p> <p>Each applicant is evaluated for level of need using standardized methodology and screening tool. Three key areas are reviewed: 1) severity of need, 2) the applicant’s caregiver and support system, 3) time spent on the waiting list.</p> <p>Severity of Need should be weighted most heavily.</p>



# Appendix H: Potential Waiver Service Offerings for Reconfigured Waivers

Appendix H – Table 1: DSPD Potential Waiver Service Offerings for Reconfigured Waivers

New DSPD Supports Waiver	New DSPD Comprehensive Waiver
Residential Supports Remote Residential Supports Supported Living Personal Care Services Homemaker Chore Services Companion Services Respite	Residential Supports Residential Habilitation - Group Homes - Certified Private Residences - Prof Parent Homes - Host Homes - DCFS/JJS Settings Supported Living Personal Care Services Homemaker Chore Services Companion Services Respite
Community Supports Day Supports Community Transition Services - Maximum \$2,000 Caregiver Training Personal Budget Assistance Ind/Family Peer Support Non-Medical Transportation	Community Supports Day Supports Community Transition Services - Maximum \$2,000 Caregiver Training Personal Budget Assistance Ind/Family Peer Support Non-Medical Transportation
Employment Supports Prevocational Services - (Time Limited) Career Exploration and Planning - (Time/Activity Limited) Supported Employment Services Workplace Assistance Services	Employment Supports Prevocational Services - (Time Limited) Career Exploration and Planning - (Time/Activity Limited) Supported Employment Services Workplace Assistance Services
Health and Safety Supports Behavior Supports PD Nursing Services	Health and Safety Supports Behavior Supports PD Nursing Services



- (Extended SP) Home Health Services - (Extended SP) Nursing Oversight Services Medication Monitoring Massage Therapy PERS Environ Adapt - Home Environ Adapt – Vehicle Specialized Med Equip & Supp	- (Extended SP) Home Health Services - (Extended SP) Nursing Oversight Services Medication Monitoring Massage Therapy PERS Environ Adapt - Home Environ Adapt – Vehicle Specialized Med Equip & Supp
SD Information & Supports Financial Management Services Consumer Preparation Services Individual Goods & Services - Maximum \$2,000	SD Information & Supports Financial Management Services Consumer Preparation Services Individual Goods & Services - Maximum \$2,000

*Appendix H – Table 2: DIH Potential Waiver Service Offerings for Reconfigured Waivers*

<b>New DIH Complex Needs Waiver</b>	<b>Amended DIH New Choices Waiver</b>
Residential Supports Personal Care Services Skilled Nursing Respite Routine Respite	Residential Supports Adult Residential Services Personal Care Services Homemaker Chore Services Companion Services Respite
Community Supports Family Support Services Ind/Family Peer Support Non-Medical Transportation	Community Supports Day Supports Community Transition Services - Maximum \$2,000 Caregiver Training Personal Budget Assistance Ind/Family Peer Support Non-Medical Transportation
Employment Supports Prevocational Services - (Time Limited) Career Exploration and Planning	Employment Supports Prevocational Services - (Time Limited) Career Exploration and Planning

- (Time/Activity Limited) Supported Employment Services Workplace Assistance Services	- (Time/Activity Limited) Supported Employment Services Workplace Assistance Services
Health and Safety Supports Behavior Supports PD Nursing Services - (Extended SP) Home Health Services - (Extended SP) In-Home Feeding Therapy Nursing Oversight Services Environ Adapt - Home Environ Adapt – Vehicle Specialized Med Equip & Supp Assistive Technology Devices - Maximum \$2,000 / device	Health and Safety Supports Behavior Supports PD Nursing Services - (Extended SP) Home Health Services - (Extended SP) Nursing Oversight Services Home Delivered Meals Medication Admin Assistance Medication Monitoring PERS Environ Adapt - Home Environ Adapt – Vehicle Specialized Med Equip & Supp Assistive Technology Devices - Maximum \$2,000 / device
SD Information & Supports Financial Management Services Consumer Preparation Services	SD Information & Supports Financial Management Services Consumer Preparation Services

*Appendix H – Table 3: DAAS Potential Waiver Service Offerings for Reconfigured Waivers*

<b>Amended DAAS Supports Waiver</b>	<b>New DAAS Comprehensive Waiver</b>
Residential Supports Personal Care Services Homemaker Chore Services Companion Services Respite	Residential Supports Out-of-Home Residential Supports (Assisted Living) Personal Care Services Homemaker Chore Services Companion Services Respite
Community Supports Adult Day Health Community Transition Services - Maximum \$2,000 Ind/Family Peer Support	Community Supports Adult Day Health Community Transition Services - Maximum \$2,000 Ind/Family Peer Support



Personal Budget Assistance Non-Medical Transportation	Personal Budget Assistance Non-Medical Transportation
Employment Supports Prevocational Services - (Time Limited) Career Exploration and Planning - (Time/Activity Limited) Supported Employment Services Workplace Assistance Services	Employment Supports Prevocational Services - (Time Limited) Career Exploration and Planning - (Time/Activity Limited) Supported Employment Services Workplace Assistance Services
Health and Safety Supports Behavior Supports Skilled Nursing Services - (Extended SP) Home Health Services - (Extended SP) Nursing Oversight Services Home Delivered Meals Medication Monitoring PERS Environ Adapt - Home Environ Adapt – Vehicle Specialized Med Equip & Supp	Health and Safety Supports Behavior Supports Skilled Nursing Services - (Extended SP) Home Health Services - (Extended SP) Nursing Oversight Services Home Delivered Meals Medication Monitoring PERS Environ Adapt - Home Environ Adapt – Vehicle Specialized Med Equip & Supp
SD Information & Supports Financial Management Services Consumer Preparation Services	SD Information & Supports Financial Management Services Consumer Preparation Services



# Endnotes

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