UTAH DEPARTMENT OF HEALTH AND HUMAN SERVICES DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES POLICY AND PROCEDURES	
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ENTRY INTO AND MOVEMENT WITHIN THE SERVICE SYSTEM	
RATIONALE: The intent of this policy is to establish procedures for division staff to follow when a Person moves in to and within the service system. Authorizing Code: 26B-6-403 Rule: R539-1, R539-2 Forms: 818, 818B	

Original Effective:	Revision:	Next Review Due:
NA	10/26/2026	3/1/2029

I. DESCRIPTION

The purpose of this policy is to establish procedures for division staff to follow when a Person transitions into or out of waiver and non-waiver services, or moves within the service system.

II. DEFINITIONS

The following terms are defined for this policy as:

A. **Administrative team:** means the director and the assistant directors of the Division of Services for People with Disabilities.

B. **Division:** means the Division of Services for People with Disabilities as defined in Section 26B-6-401.

C. **Division of Finance and Administration (DFA):** means the division within the Department of Health and Human Services (DHHS) that partners with other divisions within DHHS to provide accountability for taxpayer dollars.

D. **Eligibility review committee (ERC):** means the committee as described in Policy 1.63 that provides an eligibility recommendation in cases where an individual does not clearly meet the state eligibility requirements for HCBS and a recommendation is needed.

E. **Federal Medical Assistance Percentage (FMAP):** means the federal share of state Medicaid expenses, used for Medicaid, CHIP, and other assistance programs. These funds are matched at a federally determined percentage of appropriated state funding.

F. **HCBS waiver or waiver:** means home and community-based services, which are long term services and supports provided to individuals in their homes or other community

settings that satisfy the requirements of 42 CFR 441.301(c)(4) (2025). The division's HCBS waivers include: Acquired Brain Injury Waiver (ABIW); Community Supports Waiver (CSW); Community Transitions Waiver (CTW); Limited Supports Waiver (LSW); and Physical Disabilities Waiver (PDW).

G. **Intermediate care facility (ICF):** means the state plan residential entitlement program for eligible Utahns with intellectual disabilities and related conditions that offers healthcare and other services in addition to room and board. It is an alternative to HCBS services for individuals who choose not to use HCBS, or who are on the division waiting list while waiting for HCBS service.

H. **Level of care:** means the frequency and intensity of supports needed as assessed by division staff using documentation from a physician, health care facility, or other service provider, in order to deliver services that meet the needs of a Person.

I. **Person:** means an eligible individual receiving a division service, or on the waiting list.

J. **Person-centered support plan (PCSP):** means the support plan developed through the person-centered planning process that complies with 42 CFR 441-301(c)(2).

K. **Request for services (RFS):** means a process integrated into USTEPS that facilitates the creation of a person-centered budget through an initial budget, and then any budget adjustments that are made by submitting the following to the RFS team for review: proposed service codes; units; rates; designated start and end dates; and evidence of need.

L. **Skilled nursing facility (SNF):** means an inpatient medical facility providing 24-hour, high-level nursing care and specialized rehabilitation services for temporary recovery or chronic condition management.

M. **Spend-down:** means a required monthly payment to the Medicaid program for a Person whose income level or assets are above the limit for financial eligibility for Medicaid, including for a waiver service. A spend-down may be paid by the Person to allow them to become eligible by "spending down" their excess income like a deductible until they reach the eligibility threshold for coverage.

N. **State funded non-waiver services (non-waiver services):** means division services paid for by Utah general fund appropriations, and does not include federal funds for HCBS waivers provided through FMAP.

O. **Support coordinator:** means an employee of the division (division support coordinator) or an individual contracted with the division who assists with:
    1. assessing the need of a Person receiving division funding;
    2. completing written documentation of support;
    3. developing a service and support plan for a Person receiving division funding;
    4. monitoring the appropriate spending of a Person's annual budget;
    5. monitoring the health and welfare of a Person; and
    6. monitoring the quality of each service used by a Person receiving division funding.

P. **Waiver Manager (WM):** means division staff responsible for the operation of a specific waiver or waivers, who may delegate certain responsibilities to a designee.

III. POLICY

A. When a Person transitions into or moves within the service system, the division shall ensure that the Person is given a choice of services and supports to meet their assessed needs.
    1. The division may assist a Person to identify providers using the Invitation to Submit Offer to Provide Services process if the Person or their guardian or family have not already decided on a provider they want to work with.

B. In cases where a Person chooses not to receive waiver services, the division shall inform the Person of the option to receive only the state funded (non-waiver) portion of their total budget.
    1. The RFS team shall review the Person's request and arrive at a consensus on a waiver-based service plan based on the Person's assessed need. The state funded portion of the Person's budget shall then be calculated using the current FMAP rate.
    2. Any requested increases shall be reviewed using the same process as described in (B)(1) and be based on documented and assessed individual needs. Additional non-waiver services shall be subject to the availability of funds.
    3. A Person may have reductions in non-waiver services or be discharged from non-waiver services completely due to budget shortfalls, reduced legislative allocations, or reevaluations of eligibility.

C. A Person may receive non-waiver services, subject to the availability of funds if the Person does not meet the financial eligibility requirements for Medicaid.

D. A Person may also receive non-waiver services, subject to the availability of funds if the Person is temporarily ineligible for Medicaid as a result of:
    1. a period of incarceration, hospitalization, or a stay in a rehabilitation facility with an expected length exceeding 90 days, with non-waiver services resuming or initiating upon the Person's release or discharge back into the community;
    2. a required spend-down that is the result of their personal income level or assets when the Person chooses not to pay the spend-down;
    3. level of care eligibility requirements for division services have been met, but the Person has been determined ineligible for Medicaid by DWS; or
    4. the Person has voluntarily chosen not to receive waiver services.

E. A Division support coordinator shall ensure the continuity of services for a Person receiving non-waiver services or for a Person who does not have an external support coordinator.

F. A division support coordinator assigned to a Person who only receives non-waiver services shall review eligibility conditions at least annually.
    1. The support coordinator shall review the Person's waiver eligibility by evaluating their circumstances and then assisting the Person with applying for Medicaid if those circumstances have changed. This review shall be documented in a USTEPS activity log note or in the PCSP.
    2. The support coordinator shall review the Person's division eligibility and level of care eligibility at least annually.
    3. If the level of care requirements for waiver services are met, but the Person is not enrolled in waiver services, the support coordinator shall record the decision as "Eligible" and note the reason why the Person is not enrolled in waiver services.

4. If the support coordinator believes that the Person no longer meets division eligibility or level of care requirements, the case shall be referred to the ERC and services shall continue to be provided pending the ERC review. Services may continue to be provided, and any changes as a result of review shall comply with Policy 1.11 "Notice of agency action and hearing rights."

G. A Person who receives non-waiver services and who experiences a change in circumstances that qualify them for waiver services may elect to transition into waiver services.

H. The division shall not require a Person to have a new psychological evaluation when transitioning from non-waiver services into waiver services if the Person has had a psychological evaluation within five years of the original level of care determination.

I. The RFS team shall establish initial base budgets as ongoing funding, with separate one-time funds permitted to support periods of stabilization as needed.

IV. PROCEDURE

A. Entry into Funded Supports

1. When a Person is selected to come off the waiting list and eligibility for division funded services has been confirmed, the division shall determine whether the Person meets the level of care criteria before enrolling the Person in the appropriate Medicaid waiver program.

2. A level of care determination may be done by:
    a) a Qualified Intellectual Disability Professional (QIDP) as defined in R432-152-3 for a Person entering the Community Supports or Community Transitions Waivers;
    b) an Acquired Brain Injury support coordinator (ABISC) for a Person entering the Acquired Brain Injury Waiver;
    c) an Administrative Case Manager for a Person entering the Physical Disabilities Waiver; or
    d) a division staff member for a Person entering the Limited Supports Waiver.

3. The QIDP shall review criteria and document a level of care determination of "eligible" or "ineligible" in USTEPS.

4. A division support coordinator shall ensure that the appropriate financial eligibility is recorded based on a Person's qualifying diagnosis using these codes:
    a) SG – Intellectual Disability or Related Condition;
    b) BG – Acquired Brain Injury;
    c) LG – Limited Supports;
    d) PG – Physical Disability; or
    e) TG – Community Transitions.

5. A division support coordinator shall schedule an initial planning meeting with a Person, and guardian where applicable, and other team members selected by the Person.

6. A division support coordinator may initiate an accelerated planning meeting for a Person who is entering services through the Emergency Services Management

Committee.

a) The division support coordinator may forgo some elements of the initial planning meeting in these emergency situations.
b) In these cases, the division support coordinator shall reconvene a more thorough planning meeting within 30 days after service entry.

7. If a Person meets the level of care necessary to qualify for waiver services, the Person shall be given a choice of receiving services through a HCBS waiver program or through an:
    a) Intermediate Care Facility (ICF) for people with intellectual disabilities or related conditions; or
    b) a Skilled Nursing Facility (SNF) for people with acquired brain injury or a physical disability.

8. A division support coordinator shall document a Person's choice on the Choice of Service System Form 818 by obtaining the Person's, or guardian's where applicable, signature and then uploading the form into UPI.

9. If a Person chooses to receive services through a waiver, a division support coordinator shall assist them in establishing Medicaid eligibility.

10. If a Person chooses to receive services through an ICF or SNF, the Person shall be given the option of remaining on the division waiting list or of being removed from the waiting list altogether and being designated as "episode closed." The Person's decision shall be documented in a USTEPS Log Note.

11. If a Person chooses to receive services through a waiver, a division support coordinator shall start the process of establishing Medicaid waiver eligibility by:
    a) completing the Waiver Referral Form 927 in USTEPS;
    b) specifying on the Form 927 the appropriate HCBS waiver for which the Person is qualified; and
    c) sending the Form 927 to the Long-Term Care Team (LTCUnit@utah.gov) at DWS.

12. After receiving Form 927 from DWS, a division support coordinator shall:
    a) review the accuracy of the effective date, client ID#, and client name;
    b) review how much the Person shall be required to spend-down, if applicable, in order to receive Medicaid waiver services;
    c) record the decision in the "Medicaid Eligibility" section of USTEPS; and
    d) if the waiver has been approved, update the financial eligibility code for the appropriate waiver.

13. A division support coordinator shall use the following financial eligibility codes:
    a) SM for the Community Supports Waiver;
    b) BM for the Acquired Brain Injury Waiver;
    c) LM for the Limited Supports Waiver
    d) PM (Legislative Appropriation) or PN (DIH Portability Funding) for the Physical Disabilities Waiver; or
    e) TM for the Community Transitions Waiver.

14. If a Person is required to spend-down any funds in order to receive waiver services, a division support coordinator shall notify the Person, or guardian where applicable, of the amount of the spend-down prior to the start of any waiver

services. The division support coordinator shall advise the Person, or guardian where applicable, that the spend-down shall be paid each month in order for the Person to receive waiver services.

15. During the initial planning process, a division support coordinator shall:
    a) review all applicable records for the Person; and
    b) conduct any new assessments necessary to determine the Person's current support needs, Utah Comprehensive Assessment of Needs and Strengths (UCANS), Employment Pathway Tool, and Person-Centered Profile.

16. After conducting all applicable and necessary assessments, a division support coordinator shall develop a proposed PCSP based on the Person's assessed needs.
    a) The proposed PCSP budget shall specify the total amount of money to be allocated. DFA staff shall calculate what portion of the total allocation shall be division funds based upon the current FMAP rate.
    b) The proposed PCSP budget shall be submitted as a Request for Services (RFS) to the Request for Services team for approval.

B. <u>Entry into funded services that are permanently state funded. Does not apply to LSW.</u>
    1. The division support coordinator shall build the individual's full budget based on assessed need and submit it to the RFS team.
    2. The RFS team shall evaluate the budget to ensure it aligns with the Person's assessed need.
    3. If the budget aligns with the Person's assessed need, the RFS team shall forward the budget to the administrative team for awareness and to the DFA Administrative Services Manager to calculate the state-funded portion using the current FMAP rate.
    4. The RFS team shall finalize the request using the calculated state-funded amount.
    5. The division support coordinator shall retain case management responsibility for as long as the individual receives state funds only.

C. <u>Entry into funded services that are temporarily state funded only (awaiting Medicaid eligibility). Does not apply to LSW.</u>
    1. The division support coordinator shall create the full budget based on assessed need and submit it to the RFS team.
    2. The RFS team shall evaluate the budget to ensure it aligns with the Person's assessed need.
    3. If the budget aligns with the Person's assessed need, the RFS team shall forward it to the administrative team to review, approve, and confirm that no temporary alternative supports or funding solutions exist.
    4. Upon approval, the RFS team shall notify the DFA accountant or senior accountant. The assigned budget manager shall track and monitor the Person's Medicaid eligibility status monthly.
    5. The division support coordinator shall monitor the case and initiate the transition to waiver funding when Medicaid is awarded.
        f) If Medicaid is denied, the division support coordinator shall assess the Person's service structure to adjust services to the state-funded allocation (e.g., transitioning from Residential Habilitation Services to Supported Living).
        g) The division support coordinator shall escalate unresolvable Medicaid

denials to the administrative team for review and final decision within 12 months of the denial, or following the resolution of all formal SSI/Medicaid appeals.

D. Moving from non-waiver services to waiver services.
   1. If a Person who receives non-waiver services has a change in circumstances that results in the Person becoming eligible for Medicaid, and the Person chooses to enroll in waiver services, a division support coordinator shall assist the Person in transitioning into waiver services.
      a) The division support coordinator shall document the Person's decision and choice of service system on the applicable Form 818, obtaining the Person's, or legal guardian's where applicable, signature and then uploading the form into UPI.
      b) The division support coordinator shall start the process of establishing Medicaid waiver eligibility by submitting a form 927 to the Department of Workforce Services.

   2. The division support coordinator shall submit a new proposed budget including waiver funds through the Request for Services Process as outlined in Division Policy and Procedure 1.49 "Request for Services" and in the Medicaid Provider Manual for Support Coordinators "Request for Services". The assigned budget specialist shall include the support coordinator external services funding into the proforma budget.

   3. Once a Person's proposed budget has been approved and the pro-forma budget has been adjusted, a division support coordinator shall:
      a) revise the Person's PCSP;
      b) add any additional services or supports the Person needs; and
      c) update the Person's PCSP budget with those additional services or units of service.

E. Moving from waiver services to non-waiver services.
   1. A Person may choose to move from waiver to non-waiver services at any time.
   2. Division staff shall follow voluntary disenrollment protocol outlined in Policy 1.30 Medicaid HCBS Disenrollment Protocol, to disenroll a Person from waiver services to non-waiver services.

F. Moving to HCBS from an institutional setting.
   1. If a Person is discharged from an institution into a home and community-based setting through CSW or CTW, the division shall code the Person as TG or SG in USTEPS once the RFS is approved and funding is added to the pro-forma budget.
   2. The division support coordinator shall submit Form 927 to DWS after the Person's discharge from the institution.
   3. Upon receipt of the processed Form 927 from DWS, the community transitions waiver manager shall update the financial eligibility record, and the division support coordinator shall update the USTEPS financial eligibility code to TM.
   4. The RFS team shall follow the RFS process to establish an initial base budget after (F)(1-3) have been completed.