

Utah Medicaid Provider Manual	Home and Community Based Services Medicaid Autism Waiver
Division of Medicaid and Health Financing	Updated January 2015

SECTION 2

MEDICAID AUTISM WAIVER

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1 GENERAL POLICY

A. Under Section 1915(c) of the Social Security Act, a State may request approval through the federal Centers for Medicare and Medicaid Services (CMS) to “waive” certain statutory requirements in order to use Medicaid funds for an array of home and community-based services provided to eligible recipients as an alternative to institutional care. The State of Utah has provided Medicaid-reimbursed home and community-based waiver services for individuals with intellectual disabilities and other related conditions since July 1, 1987. On September 25, 2012 the Division of Medicaid and Health Financing received approval from CMS to begin operating the Medicaid Autism Waiver (the Waiver). The approval includes:

1. Waiver of comparability requirements in subsection 1902(a)(10)(B) of the Social Security Act. In contrast to Medicaid State Plan service requirements, under a waiver of comparability, the State is permitted to provide covered waiver services to *a limited number* of eligible individuals who meet the level of care criteria for Medicaid reimbursement in an intermediate care facility for persons with intellectual disabilities (ICF/ID). The term ICF/ID, which is used in this document, is equivalent to intermediate care facility for persons with mental retardation (ICF/MR) under Federal law.

Waiver services need not be comparable in amount, duration or scope to services covered under the State Plan. However, each year the State must demonstrate that the waiver is a cost-effective or a “cost-neutral” alternative to institutional (ICF/ID) services. This means that, in the aggregate, the total annual Medicaid expenditures for waiver recipients, including their State Plan services, cannot exceed the estimated Medicaid expenditures had those same recipients received Medicaid-funded ICF/ID services.

2. Waiver of institutional deeming requirements in section 1902(a)(10)(C)(I)(III) of the Social Security Act. Under the waiver of institutional deeming requirements, the State uses more liberal eligibility income and resource calculations when determining recipients’ Medicaid eligibility.

B. The State Medicaid Agency (SMA) has ultimate administrative oversight and responsibility for the Waiver program. The day to day operations have been delegated to the Department of Human Services, Division of Services for People with Disabilities (DSPD), through an interagency agreement with the SMA. This agreement and the State Implementation Plan describe the responsibilities that have been delegated to DSPD as the Operating Agency for the Waiver program.

1 - 1 Acronyms and Definitions

For purposes of the Medicaid Autism Waiver (the Waiver), the following acronyms and definitions apply:

CMS	Centers for Medicare and Medicaid Services
DHS	Department of Human Services
DMHF	Division of Medicaid and Health Financing
DOH	Department of Health
DSPD	Division of Services for People with Disabilities

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HCBS Home and Community-Based Services

ICF/ID Intermediate Care Facility for Persons with Intellectual Disabilities

*This is equivalent to intermediate care facility for persons with mental retardation (ICF/MR) under Federal law.

MAW Medicaid Autism Waiver

NOA Notice of Action

OA Operating Agency

PCSP Participant Centered Support Plan

SIP State Implementation Plan

SMA State Medicaid Agency

1 - 2 CMS Approved State Implementation Plan

- A. The CMS approved State Implementation Plan (SIP) for the Medicaid Autism Waiver (MAW or the Waiver) serves as the State’s authority to provide home and community-based services to the target group under its Medicaid plan. The SIP and all attachments constitute the terms and conditions of the program.
- B. This manual does not contain the full scope of the SIP. To understand the full scope and requirements of the Waiver, providers should refer to the SIP.

2 SERVICE AVAILABILITY

- A. Waiver services are covered benefits only when provided to an individual determined to meet the eligibility criteria defined in the current Medicaid Autism Waiver SIP and only pursuant to a written Participant Centered Support Plan (PCSP) that has been approved by the Division of Services for People with Disabilities (DSPD).

2 - 1 Eligibility for Medicaid Autism Waiver Services

- A. Waiver services are limited to individuals with the following condition(s):
 - 1. Must have a diagnosis of an intellectual disability as per 42CFR483.102(b)(3) or a condition closely related to an intellectual disability as per 42CFR435.1010.
 - 2. Conditions closely related to an intellectual disability do not include individuals whose functional limitations are due solely to mental illness, substance abuse, personality disorder, hearing impairment, visual impairment, learning disabilities, behavior disorders, physical problems, borderline intellectual functioning, aging process, terminal illnesses, or developmental disabilities that do not result in an intellectual impairment.
- B. In addition, individuals served in this waiver program must also demonstrate substantial functional

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limitations in three or more areas of major life activity and meet the ICF/ID level of care criteria as described in R414-502-7.

- C. This waiver is limited to persons with disabilities who have established eligibility for State matching funds through the Utah Department of Human Services (DHS) in accordance with UCA 62A-5. If the waiver applicant is determined to be ineligible for state matching funds through DSPD/DHS, the participant will be given an opportunity to appeal the decision through the DHS hearing process as described in Section 2-5 of this provider manual. Decisions made through the DHS hearing process on the question of DSPD eligibility will be the final decision.
- D. If a person is eligible for more than one of the waivers operated by DSPD, the division will educate the individual about their choices and will advise the individual about which of the waivers will likely best meet their needs.
- E. An individual will not be enrolled if it is determined during the eligibility assessment process that the health, welfare, and safety of the individual cannot be maintained through the Waiver.
- F. Inpatients of hospitals, nursing facilities, or ICFs/ID are not eligible to receive waiver services (except as specifically permitted for support coordination discharge planning in the 90-day period prior to their discharge to the Waiver).

2 - 2 Applicant Freedom of Choice of ICF/ID or Waiver

- A. When an individual is determined eligible for waiver services, the individual and the individual's legal representative if applicable, will be informed of the alternatives available under the waiver and offered the choice of institutional care (ICF/ID) or home and community-based care.
- B. A copy of the DSPD publication *AN INTRODUCTORY GUIDE—Division of Services for People with Disabilities* (hereafter referred to as the Guide), which describes the array of services and supports available in Utah including intermediate care facilities for persons with intellectual disabilities and the HCBS Waiver program, is given to each individual applying for waiver services. In addition, individuals will be given a 2-sided *Informational Fact Sheet* (Form IFS-10) which describes the eligibility criteria and services available through both the waiver program and through ICFs/ID.
- C. If no available capacity exists in the Waiver, the applicant will be advised that he or she may access services through an ICF/ID or may re-apply when new applications are being accepted.
- D. If available capacity exists in the Waiver, a pre-enrollment screening of health, welfare, and safety needs will be completed by a Waiver representative. The applicant will be advised of the preliminary needs identified and given the opportunity to choose to receive services to meet the identified needs through an ICF/ID or the Waiver. The applicant's choice will be documented in writing, signed by the applicant, and maintained as part of the individual record.
 - 1. Choice of waiver services will only be offered if:
 - i. The individual's needs assessment indicates the services the individual requires, including waiver services, are available in the community;
 - ii. The individual support plan has been agreed to by all parties; and

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iii. The health and safety of the individual can be adequately protected in relation to the delivery of waiver services and supports.

- E. Once the individual has chosen home and community-based waiver services, the choice has been documented on Form 818 by the Support Coordinator and the individual has received a copy of the Guide and the Informational Fact Sheet, subsequent review of choice of program will only be required at the time a substantial change in the enrollee's condition results in a change in the individual support plan. It is, however, the individual's option to choose institutional (ICF/ID) care at any time during the period they are in the waiver.
- F. If the participant is not given the choice of home and community-based services as an alternative to institutional care, the participant will be given an opportunity for a fair hearing as described in Section 2-5 of this provider manual.

2 - 3 Waiver Participant Freedom of Choice

- A. The individual and the individual's legal representatives if applicable, in conjunction with the support coordinator and any others that the individual wishes to invite, will participate in the development of the Participant Centered Support Plan (PCSP) to address the individual's identified needs.
- B. The waiver participant, and the individual's legal representative if applicable, will be given the opportunity to choose the providers of waiver services identified on the PCSP if more than one qualified provider is available to render the services. The individual's choice of providers will be documented in the PCSP. The individual may also choose to change providers at any time.
- C. The waiver support coordinator will review the contents of the written PCSP with the participant prior to implementation. If the participant is denied the waiver service(s) or their choice or the waiver provider(s) of their choice, they will be given an opportunity in writing for a fair hearing as described in Section 2-5 of this provider manual.
- D. Subsequent revision of the participant's PCSP as a result of annual re-assessment or significant change in the participant's health, welfare, or safety requires proper notice to the participant as described in item D above, plus notice that the participant has the right to select to receive services in a Medicaid ICF/ID in lieu of continued participation in the waiver.

2 - 4 Termination of Home and Community-Based Waiver Services

- A. When the need arises, participants are separated from the Home and Community Based waiver program through a disenrollment process.
 - 1. The disenrollment process is a coordinated effort between DMHF and DSPD that is expected to facilitate the following:
 - i. Appropriate disenrollment and movement among waiver programs when applicable;
 - ii. Effective utilization of waiver program potential;
 - iii. Effective discharge and transition planning;

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- iv. Provision of information, affording participants the opportunity to exercise all applicable waiver rights; and
 - v. Program quality assurance/quality improvement measures.
- B. All of the various circumstances for which it is permissible for DSPD to disenroll an individual from the waiver program can be grouped into three distinct disenrollment categories.

1. Voluntary disenrollments are cases in which participants, or their legal representatives when applicable, choose to initiate disenrollment from the waiver. Disenrollments are also considered voluntary when the waiver participant enters a skilled nursing facility for a stay of less than 90 days and chooses not to transition back to the original waiver program. This includes cases in which the participant transitions to another waiver program from the skilled nursing facility.

Voluntary disenrollments require Support Coordinators to notify their DSPD program manager. DSPD, either through the program manager or other authorized designee, will in turn send written notification to DMHF within 10 days from the date of disenrollment. No DMHF prior review or approval of the decision to disenroll is required. Documentation will be maintained by DSPD, detailing the discharge planning activities completed with the waiver participant as part of the disenrollment process.

2. Pre-Approved involuntary disenrollments are cases in which participants are involuntarily disenrolled from the waiver for any of the following reasons including:
 - i. Death of the Participant;
 - ii. Participant no longer meets the financial requirements for Medicaid program eligibility, including instances in which the participant is no longer a resident of the state of Utah and/or the participant is incarcerated for more than 30 consecutive days;
 - iii. Participant enters a skilled nursing facility for a stay of more than 90 days; or
 - iv. Participant no longer meets the age requirement for the Waiver.

Pre-Approved involuntary disenrollments require Support Coordinators to notify their DSPD program manager. DSPD, either through the program manager or other authorized designee, will in turn send written notification to DMHF within 10 days from the date of disenrollment. No DMHF prior review or approval of the decision to disenroll is required as the reasons for pre-approved involuntary disenrollment have already been approved by the SMA. Documentation will be maintained by DSPD, detailing the discharge planning activities completed with the waiver participant as part of the disenrollment process when appropriate.

3. Special circumstance disenrollments are cases in which participants are disenrolled from the waiver for reasons that are non-routine in nature. These cases require prior review and approval by DMHF and involve circumstances that are specific to the participant involved. Examples of this type of disenrollment include:

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- i. Participant no longer meets the institutional level of care requirements for the Waiver: Intermediate Care Facility for Persons with Intellectual Disability (ICF/ID);
- ii. Participant's health and safety needs cannot be met by the Waiver program's services and supports;
- iii. Participant has demonstrated non-compliance with the agreed upon care plan and is unwilling to negotiate a PCSP that meets minimal safety standards;
- iv. Participant has demonstrated non-compliance with a signed participant agreement with DSPD; and/or
- v. Participant, or their legal representative when applicable, requests a transfer of the participant from the MAW directly to another waiver program when a stay at a nursing facility has not been involved.
- vi. Participant's whereabouts are unknown for more than 30 days.

The special circumstance disenrollment review process will consist of the following activities:

- a. The Support Coordinator shall compile information to articulate the disenrollment rationale.
- b. Supports Coordinators will then submit disenrollment rationale information to their DSPD program manager for a review of the documentation of support coordination activities and of the disenrollment recommendation.
- c. If DSPD management staff concurs with the recommendation, a request for disenrollment approval will be forwarded to DMHF for a final decision.
- d. DMHF will review and assure the available array of Medicaid waiver and non-waiver services, and other available resources, have been fully utilized to meet the participant's health and safety needs.
- e. DMHF may facilitate case staffing meetings with appropriate parties, as needed, to complete the review and make an appropriate final decision on the proposed disenrollment.
- f. A DMHF final disenrollment decision will be communicated in writing to both the Support Coordinator and the state-level program management staff.

If the special circumstance disenrollment request is approved by DMHF, the Support Coordinator will provide the participant, or their legal representative when applicable, with the required written notice of action (NOA) and right to fair hearing information.

The Support Coordinator will initiate discharge planning activities sufficient to assure a smooth transition to an alternate Medicaid program and/or to other services. Discharge planning activities shall be documented in the individual's case record.

2 - 5 Fair Hearings

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- A. An individual and the individual’s legal representative will receive a written Notice of Action (NOA), Form 522 and a Hearing Request Form 490S, from the waiver support coordinator if the individual is:
 - 1. Denied a choice of institutional or waiver program,
 - 2. Found ineligible for the waiver program,
 - 3. Denied access to the provider of choice for a covered waiver service, or
 - 4. Experiences a denial, reduction, suspension, or termination in waiver services in accordance with R539-2-5.

- B. The NOA delineates the individual’s right to appeal the decision through an informal hearing process at the Department of Human Services or an administrative hearing process at the Department of Health, or both. The individual is encouraged to utilize an informal dispute resolution process to expedite equitable solutions.

- C. An aggrieved individual may request a formal hearing within 30 calendar days from the date written notice is issued or mailed, whichever is later. DMHF may reinstate services for participants or suspend any adverse action for providers if the aggrieved person requests a formal hearing not more than ten (10) calendar days after the date of action.

- D. Appeals related to establishing eligibility for state matching funds through DSPD/Utah Department of Human Services in accordance with UCA 62A-5 will be addressed through the Department of Human Services hearing process. Decisions made through the Department of Human Services may be appealed to the Department of Health strictly for procedural review. Appealed decisions demonstrating that the Department of Human Services followed the fair hearing process will be upheld by the Department of Health as the final decision.

- E. Documentation of notices and the opportunity to request a fair hearing is kept in the individual’s case record/file and at DSPD – State Office.

- F. Informal Dispute Resolution
 - 1. The Division of People with Disabilities has an informal dispute resolution process. This process is designed to respond to a participant’s concerns without unnecessary formality. The dispute resolution process is not intended to limit a participant’s access to formal hearing procedures; the participant may file a Request for Hearing any time in the first 30 days after receiving Notice of Action. Examples of the types of disputes include but are not limited to: concerns with a provider of waiver services, concerns with provider personnel, etc.

 - 2. Attempts to resolve disputes are completed as expeditiously as possible. No specific timelines have been identified as some issues may be resolved very rapidly while other more complex issues may take a greater period of time to resolve.

3 PROVIDER PARTICIPATION

3 - 1 Provider Enrollment

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- A. Waiver services are covered benefits only when delivered by qualified providers that are enrolled with the State Medicaid Agency to provide the services as part of the Waiver. In addition to this Medicaid provider agreement, all providers of Waiver services must also have a current contract with the Department of Human Services, Division of Services for People with Disabilities (DHS/DSPD).
- B. The State Medicaid Agency will enter into a provider agreement with all willing providers who are selected by participants and meet licensure, certification, competency requirements and all other provider qualifications.
- C. The Utah Department of Human Services in conjunction with the Bureau of Contract Management will issue a Statement of Interest and Qualifications (SOIQ) for the purpose of entering into a contract with willing and qualified individuals and public or private organizations. The SOIQ is distributed to all qualified providers and remains open, allowing for continuous recruitment. A review committee evaluates the proposals against the criteria contained in the SOIQ and selects those who meet the qualifications.

3 - 2 Provider Reimbursement

- A. Providers will be reimbursed according to the specified reimbursement rate(s) contained in the negotiated contract with DSPD.
- B. Providers will bill Medicaid directly through the Utah MMIS system. Providers may only claim Medicaid reimbursement for services that are authorized on the approved PCSP. Claims must be consistent with the amount, frequency and duration authorized by and documented on the PCSP.

3 - 3 Standards of Service

- A. Providers must adhere to service standards and limitations described in this manual, the terms and conditions of the Medicaid provider agreement, the terms and conditions of the Waiver SIP and the terms and conditions contained in the DSPD contract.

3 - 4 Provider Rights to a Fair Hearing

- A. The Department of Health offers hearing rights to providers who have experienced any adverse action taken by the Utah Department of Health, Division of Medicaid and Health Financing, or by the operating agency, Department of Human Services, Division of Services for People with Disabilities. Providers must submit a written request for a hearing to the Utah Department of Health in order to access the hearing process. Please refer to the Utah Department of Health, Division of Medicaid and Health Financing Provider Manual, General Information, Section 1, Chapter 6-15, Administrative Review/Fair Hearing.
- B. Adverse actions that providers may appeal include:
 - 1. Actions relating to enrollment as a Waiver provider,
 - 2. Sanctions or other adverse actions related to provider performance, or
 - 3. Improper conduct by DSPD in performing delegated Waiver responsibilities.

3 – 5 Data Security & Privacy

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Providers are expected to take steps to ensure that all personal information related to the individual being served is protected. This includes both Personal Health Information (PHI) as well as Personally Identifiable Information (PII). Providers should use appropriate administrative, technical and physical safeguards to preserve the integrity, confidentiality, and availability of PHI/PII that they create, receive, maintain or transmit. This includes using encrypted/secure email, fax, or other HIPAA compliant methods to transmit documents containing information about the individual being served. Providers shall ensure there is limited and controlled access to PHI/PII. In the performance of its services and operations, the provider shall make efforts to use, disclose and request only the minimum amount of PHI/PII considered reasonably necessary. The provider shall also identify and protect against reasonably anticipated threats to the security or integrity of the information, protect against reasonably anticipated, impermissible uses or disclosures; and ensure compliance by their workforce.

3 – 6 Data Breach

Providers must report to DSPD and DMHF, either by email or telephone, any breach or loss of PHI/PII. This report should be completed not more than 24 hours after the provider knows, or should have reasonably known about the breach. The provider must also submit a report in writing/by email to DSPD within 5 business days of the breach. The provider will also cooperate with any investigation of the breach or data loss.

4 SCOPE OF SERVICES & SERVICE PLANNING

4 - 1 Service Planning: Comprehensive Care Plan Unit Calculation

The comprehensive care plan is intended to be an estimate of the service units required to meet the assessed needs of each client over the course of the care plan year. Utah Medicaid recognizes that a client's needs may change periodically due to temporary or permanent conditions which may require amendments to the client's care plan. Each client on the Autism Waiver will have an annual budget that should be maintained. The client's BCBA is responsible for determining the correct utilization of ISC/ISD hours for the client. The BCBA should create a treatment plan of ISC/ISD units that best fits the client's needs, so long as it stays within the client's annual budget. The BCBA can adjust both ISC and ISD hours to best fit the client's needs while maintaining the client's annual budget.

The BCBA should notify the client's Support Coordinator of the units to be used each month and the Support Coordinator should amend the PCSP to increase the number of units to meet the need. The care plan year is the sum of all approved units including amendments over the entire year. In this way, Utah Medicaid applies an annualized aggregate of all care plan units. Providers may not exceed the annualized aggregate of all approved care plan units. Billing in excess of the approved number of units will be subject to recovery of funds by Medicaid.

4 – 2 Supervision by a Board Certified Behavior Analyst

Supervision by the Board Certified Behavior Analyst should consist of both in-person visits, as well as reviews of progress notes and work completed. The BCBA is required to supervise for 1 hour out of every 10 hours that is provided by the direct services provider. That supervision should not only take the form of administrative supervision, but also consist of in-person visits and observation of the child's treatment to ensure that the care plan and treatment plan are appropriate for the child. In-person supervision by the BCBA should account for approximately 50% of all supervision. For those clients living outside of the Wasatch Front (Davis, Salt Lake,

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Utah, and Weber Counties), the BCBA may use tele-health for the supervision time. In-person visits should be used for those clients living inside the Wasatch Front.

4 - 3 Banking Of Hours

Intensive Individual Supports (IIS) are meant to be provided on a regular and ongoing basis. Banking of hours to be used at a later time is prohibited. As the treating professional, the Board Certified Behavior Analyst (BCBA), in consultation with the family, is responsible to seek authorization to provide the amount of weekly IIS services that will meet the typical, ongoing need of the child over a year period. Through the conscientious efforts of those involved in service planning, the service plan must reflect realistic utilization. It is permissible to designate two time periods within the service plan, such as utilization during the school year and utilization during the summer months. Because of the chronic nature of the services provided, in any given week, and due to a variety of unforeseen circumstances, it is understood that a child may receive slightly more or slightly less services than the typical utilization pattern listed on the service plan. These minor fluctuations in service utilization do not require further authorization from the operating agency, as long as the ratio of IIS- consultant service to IIS-direct service units is not changed, and the provider does not exceed annual budget amounts.

It is permissible to make up the treatment time a child has missed due to illness or other temporary events, however, the missed session would need to be completed as soon as is possible. During the year, if the BCBA identifies that the child’s utilization needs have changed and the change is likely to be ongoing, the BCBA must submit the anticipated change to the operating agency for approval.

4 - 4 Respite

Respite hours are meant to be a regular and ongoing service. Respite hours are to be used for an average of 3 hours per week. The family will have approximately 13 hours each month (156 during the course of a year) to be used at a maximum of 13 hours per month. Should a family need to use additional respite hours above the 13 monthly hours, the family should contact their Support Coordinator for authorization to use up to 26 hours per month. If approved, and more than 13 hours were used, the family would need to reduce the hours used in the following month.

Example: If a family needs to use 26 hours in a month, they would need to plan in advance and not use any respite hours in the month prior.

Second Example: Should a family use 16 hours in month one, they would only have 10 hours to use in month two.

If there is a specific one-time need from a family for a larger amount of respite, they should contact their support coordinator to request those hours be added to the child’s care plan. This will help to ensure that respite hours are continuing throughout the year as an ongoing service.

4 – 5 In-Home Treatment

The Medicaid Autism Waiver is designed to be a program that provides in-home ABA therapy for children with Autism. Treatment outside of the home should be occasional and should be written into the client’s care plan. Occasional treatment outside of the home should take place in a community-based setting, with the intention of integrating the client into a community-based setting. Any provider who would like to provide more than the

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occasional treatment out of home must submit to the operating agency an In-Home Treatment Exception Request Form. After submission the agency, with the State Medicaid Agency, will either approve or deny the request for outside treatment. Any treatment provided outside of the home without an approved In-Home Treatment Exception Request Form will be subject for recoupment.

4 – 6 School-Based Services

The Medicaid Autism Waiver (MAW) was developed as an in-home treatment program. We recognize the occasional need for consultant level staff to attend IEP meetings or observe a child's behavior during school time for the purpose of treatment planning. However, direct service staff should not be present in the school setting.

4 – 7 Transition Protocol

Providers should follow DSPD's transition protocol when an individual is moving from one contracted ABA provider to another. The DSPD contract outlines the requirements when an individual is leaving services. In addition to those requirements, providers are expected to be honest with families, exhibit professional respect, and may be requested to participate in a transition phone call with the receiving company.

5 SELF-ADMINISTERED SERVICES

- A. Self-Administered Services (SAS) are made available to all waiver enrollees who elect to participate in this method. Under SAS, individuals and/or their chosen representatives hire individual employees to perform a waiver service/s. The individual and/or their chosen representative are then responsible to perform the functions of supervising, hiring, assuring that employee qualifications are met, scheduling, assuring accuracy of time sheets, etc., of the individual's employees.
- B. Financial Management Services are offered in support of the self-administered option. Financial Management Services, (commonly known as a "Fiscal Agent") facilitate the employment of individuals by the waiver recipient or designated representative including: (a) provider qualification verification, (b) employer-related activities including federal, state, and local tax withholding/payments, fiscal accounting and expenditure reports and (c) Medicaid claims processing and reimbursement distribution.
- C. The waiver participant or representative remains the employer of record, retaining control over the hiring, training, management and supervision of employees who provide direct care services.
- D. Under the SAS method, the waiver participant submits their staff time sheet(s) to the Fiscal Agent. The Fiscal Agent pays the claim(s) and submits a claim to DOH for reimbursement. All payments are made through the Fiscal Agent under contract with the Division of Services for People with Disabilities. Payments are not issued to the waiver recipient, but to and in the name of the employee hired by the person or their representative.

6 INCIDENT REPORTING PROTOCOLS

I. Purpose:

The State Medicaid Agency (SMA) has the administrative authority over all 1915(c) Medicaid Home and Community Based Services (HCBS) Waivers (Waivers). Waiver programs must provide adequate and appropriate services that safeguard the health and welfare of all enrolled recipients. Waiver programs must also assure financial accountability for funds expended for HCBS services. While these responsibilities are delegated to the

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Operating Agencies (OA), the SMA retains final authority and has the final responsibility to: 1) assure that appropriate actions have taken place when a critical incident or event occurs; and 2) in cases where appropriate safeguards were not in place, that an analysis is conducted and appropriate strategies have been implemented to safeguard recipients. The Critical Incidents and Events Program is a collaborative effort between the OAs for each of the 1915(c) Waivers and the SMA. The program has two levels. Level one describes the critical incidents/events that are required to be reported by the OA to the SMA for investigation, resolution and closure. Level two describes the critical incidents/events that are required to be reported to the OA for investigation, resolution and closure.

This Standard Operating Procedure stipulates:

- Level One incidents and events required to be reported to the SMA;
- Level Two incidents and events that are required to be reported to the OA;
- The agency responsible for completing the review; and
- Associated reporting requirements.

II. Reportable Critical Incidents/Events

Level One Incidents and Events – Reportable to the SMA

The following list of the incidents/events (incidents) must be reported by the OA to the SMA. This is not an all-inclusive list. Other incidents that rise to a comparable level must be reported to the SMA.

1. Abuse/Neglect (Either Alleged or Substantiated)

Incidents of abuse or neglect, that resulted in the recipient’s admission to a hospital.

2. Attempted Suicides

Suicide attempts that resulted in the recipient’s admission to a hospital.

3. Human Rights Violations

Human rights violations such as the unauthorized use of restraints (physical, mechanical or chemical), seclusion rooms or infringement of personal privacy rights experienced by the recipient. (Infringement of personal privacy rights is defined as an unwanted restriction imposed upon the recipient.) Reporting is not required for Emergency Behavioral Interventions as defined in R539-4-6.

4. Incidents Involving the Media or Referred by Elected Officials

Incidents that have or are anticipated to receive public attention (i.e. events covered in the media or referred by the Governor, legislators or other elected officials).

5. Medication Errors

Errors relating to a recipient’s medication that resulted in the recipient’s admission to a hospital.

6. Missing Persons

For reporting purposes, the following recipients are considered to be missing:

- a. Recipients who have been missing for at least twenty-four hours; or
- b. Regardless of the number of hours missing – any recipient who is missing under unexplained, involuntary or suspicious circumstances and is believed to be in danger because of age, health, mental or physical disability, environment or weather or who could be in the company of a potentially dangerous person or some other factor that places the recipient in peril.

7. Unexpected Deaths

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All deaths are considered unexpected with the exception of:

- a. Recipients receiving hospice care; and/or
- b. Deaths due to natural causes, general system failure or terminal/chronic health conditions.

8. Unexpected Hospitalization

Serious burns, self-injurious behavior or injuries resulting in loss of physical or mental function such as a loss of limb, paralysis, brain injury or memory loss experienced by a recipient that resulted in admission to a hospital for medical treatment.

9. Waste, Fraud or Abuse of Medicaid Funds

Incidents that involve alleged or confirmed waste, fraud or abuse of Medicaid funds by either a provider or a recipient of Medicaid services.

Procedure for Reporting to the State Medicaid Agency:

- On the first business day after a critical incident has occurred¹, a representative from the OA will notify a member of the SMA Quality Assurance Team via email, telephone or in person. If the OA has any question about whether a case meets the criteria for reporting to the SMA, the OA will contact the SMA for technical assistance.
- Within ten business days after notification, the OA will submit a completed Critical Incident Investigation form to the SMA.
- Within five business days after receiving the Critical Incident Investigation form the SMA will review the investigation form submitted by the OA and will contact the OA if additional information or action is required.
- When the SMA determines the investigation is complete, the SMA will document any findings or corrective action requirements on the SMA portion of the investigation form. The SMA will send the OA a copy of the finalized document, closing the case. In some cases, the SMA may continue to monitor findings or corrective actions.
- Within two weeks after closing the case, the SMA will notify the client or the client's representative of the investigation results. A copy of the notification letter will be provided to the OA. The following types of incidents are excluded from the notification letter requirement: suicide, death and investigations that conclude with dis-enrollment.

III. Level Two Incidents and Events - Reportable to the OA

The following incidents must be reported by providers, recipients and/or their representatives to the OA, but are not required to be reported to the SMA. This is not an all-inclusive list. Other incidents that rise to a comparable level must be reported to the OA.

1. Abuse/Neglect/Exploitation (Either Alleged or Substantiated)

- a. Incidents of abuse or neglect, that resulted in medical treatment at a medical clinic or emergency room.
- b. Exploitation of recipient's funds.

2. Attempted Suicides

Suicide attempts that did not result in the recipient being admitted to a hospital.

¹ In some cases it will not be possible to report the incident by the next business day after the occurrence. In those cases, the incident must be reported the first business day after discovery. The SMA will review cases that are reported after discovery to evaluate whether the case should have been reported after occurrence, and if so, where the breakdown in reporting occurred.

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3. Compromised Working or Living Environment

An event in which the recipient's working or living environment (e.g. roof collapse, fire, etc.) is compromised and the recipient(s) require(s) evacuation.

4. Law Enforcement Involvement

Activities perpetrated by the recipient resulting in charges filed by law enforcement. For this category, the date of the incident will be recorded as the date on which the filing of charges occurred.

5. Medication Errors

Errors relating to a recipient's medication which result in the recipient experiencing adverse side effects requiring medical treatment at a medical clinic or emergency room.

6. Unexpected Hospitalization

Injuries, aspiration or choking experienced by recipients that resulted in **admission to a hospital**. (These do not include serious burns, self-injurious behavior or injuries resulting in loss of physical or mental function such as a loss of limb, paralysis, brain injury or memory loss experienced by a recipient that resulted in **admission to a hospital for medical treatment** which is reportable to the SMA).

Procedure for Reporting to the Operating Agency

- On the first business day after a critical incident has occurred, a representative from the case management or support coordination agency (case manager) will notify the OA via email, telephone or in person.
- Within ten business days after notification, the case manager will submit a completed Critical Incident Investigation form to the OA.
- Within five business days after receiving the Critical Incident Investigation form the OA will review the investigation form submitted by the case manager and will contact the case manager if additional information or action is required.
- When the OA determines the investigation is complete, the OA will document any findings or corrective action requirements on the OA portion of the investigation form. The OA will send the case manager a copy of the finalized document, closing the case. In some cases, the OA may continue to monitor findings or corrective actions.
- Within two weeks after closing the case, the case manager will notify the client or the client's representative (in person, phone or in writing) of the investigation results and document notification in the client's record. The following types of incidents are excluded from the notification requirement: suicide, death and investigations that conclude with dis-enrollment.

IV. Required Reports

OA Quarterly Report

The OA will submit a Waiver specific quarterly report to the SMA, no later than one month after the end of the quarter (October 31, January 31, April 30, July 31) that includes:

- name of the client
- date of the incident
- date the incident was reported to the OA
- category of the incident: incidents such as abuse/neglect/exploitation, law enforcement involvement, medication
- errors and unexpected hospitalization should be further categorized by type
- brief summary of the incident and its resolution
- date the case was closed

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- brief description of any corrective action required of the case manager or other provider

OA Annual Report

The OA will submit a Waiver specific annual report to the SMA, no later than two months after the end of the fiscal year (August 31) that includes:

- total number of incidents
- number of incidents by category: incidents such as abuse/neglect/exploitation, law enforcement involvement,
- medication errors and unexpected hospitalization should be further categorized by type
- number of incidents that resulted in corrective action by the case manager or other provider
- number of corrective actions that were implemented
- number of incidents where the client/representative was informed of the investigation results, and the number of
- incidents where the contact was made within 14 days of the investigation closure
- summary analysis of whether any systemic trends were noted that may require additional intervention or process
- improvement steps
 - If trends were noted, the report will include a description of the process improvement steps that will be implemented

State Medicaid Agency Annual Report

For incidents that are reportable to the SMA, the SMA will submit an annual report to the State Medicaid Director and OA Division Directors that includes:

- For each Waiver:
 - number of incidents
 - number of incidents by category: incidents such as abuse/neglect/exploitation, law enforcement involvement, medication errors and unexpected hospitalization should be further categorized by type
 - number of incidents that resulted in corrective action by the OA, case manager or other provider
 - number of corrective actions that were implemented
- Summary of all Waivers:
 - number of incidents
 - number of incidents by category: incidents such as abuse/neglect/exploitation, law enforcement involvement, medication errors and unexpected hospitalization should be further categorized by type
 - number of incidents that resulted in corrective action by the case manager or other provider
 - number of corrective actions that were implemented
 - summary analysis of whether any systemic trends were noted that may require additional intervention or process improvement steps
 - If trends were noted, the report will include a description of the process improvement steps that will be implemented.

7 WAIVER COVERED SERVICES RATE SETTING METHODOLOGY

- A. The rate-setting process is designed to comply with requirements under the 1915c HCBS Waiver program and other applicable Medicaid rules. There are four principal methods used in setting the Maximum Allowable Rate (MAR) level. Each method is designed to determine a fair market rate. The four

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principle methods are:

- existing market survey or cost survey of current providers
 - component cost analysis
 - comparative analysis
 - community price survey
- B. Annual MAR schedules may be held constant or modified with a Cost of Living Adjustment (COLA) for any or all of the Waiver covered services in lieu of completing one of the four principle methods depending on the budget allocation approved by the Utah State Legislature for the applicable fiscal year.
- C. The State Medicaid Agency will maintain records of changes to the MAR authorized for each Waiver covered service to document the rate setting methodology used to establish the MAR.

8 SERVICE PROCEDURE CODES

The procedure codes listed below are covered by Medicaid under the Medicaid Autism Waiver.

WAIVER SERVICE	CODE	UNIT OF SERVICE
Intensive Individual Support – Consultation Services	T1023	15 Minute
Intensive Individual Support – Direct Services	T2013	15 Minute
Financial Management Services	T2040	Per Month
Respite Care	S5150	15 Minute