Section 2

Utah Home and Community Based Services Waiver for Individuals Age 65 or Older

Provider Manual

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1 General Information

This manual is designed to be used in conjunction with the *Utah Medicaid Provider Manual, Section I: General Information (Section I: General Information)*. This can be found on the Utah Medicaid website, https://medicaid.utah.gov/utah-medicaid-official-publications.

1-1 General Policy

Under section 1915(c) of the Social Security Act (SSA), 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 medical and non-medical assistance services provided to eligible recipients as an alternative to institutional care. The State of Utah has offered the Medicaid reimbursed Home and Community-Based Services (HCBS) Waiver for Individuals Age 65 or Older since July 1, 1992. On July 1, 2015, the Division of Medicaid and Health Financing (DMHF) received approval from CMS to continue operating the HCBS Waiver for Individuals Age 65 or Older (Aging Waiver) through June 30, 2025. The approval includes waivers of:

- The "comparability" requirements in subsection 1902(a)(10)(B) of the Social Security Act; and
- The institutional deeming requirements in subsection 1902(a)(10)(C)(i)(III) of the Social Security Act.

A. Waiver of Comparability

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 State's criteria for Medicaid reimbursement in a nursing facility (NF). "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 facility-based services. This means that, in the aggregate, the total annual Medicaid expenditures for waiver participants, including their State Plan services, cannot exceed the estimated Medicaid expenditures had those same participants received Medicaid-funded NF services.

B. Waiver of Institutional Deeming Requirements

Under the waiver of institutional deeming requirements, the State uses more liberal eligibility income and resource calculations when determining recipients' Medicaid eligibility.

1-2 Definitions and Acronyms

For purposes of the Aging Waiver, the following definitions and acronyms apply:

AAA
Area Agency on Aging

Aging Waiver
Home and Community- Based Services Waiver for Individuals Age 65 or Older

BLTSS
Bureau of Long Term Services and Supports

CMA
Case Management Agency

CMS
Centers for Medicare and Medicaid Services

DAAS
Division of Aging and Adult Services

DAAS Designee
Authorized representative to act for the Division of Aging and Adult Services (Currently this refers specifically to Area Agencies on Aging (AAAs) although DAAS may designate a different organization if any AAA chooses not to be a designee)

DHS
Department of Human Services

DMHF
Division of Medicaid and Health Financing

FMS
Financial Management Services

HCBS
Home and Community Based Services

HCPCS Codes
Healthcare Common Procedure Coding System Codes

ICF/ID
Intermediate Care Facility for individuals with Intellectual Disabilities.

LOC
Level of Care

MAR
Maximum Allowable Rate
MDS-HC

Minimum Data Set for Home Care; the Aging Waiver assessment instrument used to determine level of care (LOC)

NF
Nursing Facility

NOD
Notice of Decision

PAS
Personal Attendant Service

PCCP
Person-Centered Care Plan

SAS Model
Self-Administered Services Model; a method of providing services in which the participant administers their own care, acting as the direct employer

SIP
State Implementation Plan

SMA
State Medicaid Agency

SSA
Social Security Act

TE Modifier
Modifier code used when billing claims to specify the service was provided by a Licensed Practical Nurse

TN Modifier
Modifier code used when billing claims to specify a rural rate enhancement

UDOH
Utah Department of Health

1-3 CMS Approved State Implementation Plan

The State Implementation Plan (SIP) for the Aging Waiver approved by CMS serves as the State's authority to provide home and community-based services to the target group under its Medicaid plan. That document and all attachments constitute the terms and conditions of the program.

This manual does not contain the full scope of the Aging Waiver SIP. To understand the full scope and requirements of the Aging Waiver program, the SIP should be referenced. In the event provisions of this manual are found to be in conflict with the SIP, the SIP will take precedent.

2 Provider Participation

Aging Waiver services are covered benefits only when delivered by a provider enrolled with the State Medicaid Agency (SMA) and with the DAAS designee to provide the services as part of the waiver.

2-1 Provider Enrollment

Any willing provider that meets the qualifications defined in the Aging Waiver SIP may enroll at any time to provide an Aging Waiver service by enrolling through the Utah Medicaid PRISM Provider Portal. Providers may enroll by submitting a provider enrollment application through the PRISM Provider Portal. The PRISM Provider Portal link is located on the Utah Medicaid website at: http://medicaid.utah.gov. Refer to provider manual, *Section I: General Information* for detailed provider enrollment information. Any setting in which services were not being provided under an approved state plan, waiver or demonstration as of March 1, 2014, must be in compliance with regulations for the HCBS Settings Rule by the effective date of the program (the time the state submits a claim for Federal HCBS reimbursement).

2-2 Provider Reimbursement

Providers must bill with the appropriate NPI or Medicaid provider number associated with the waiver and area.

Providers will be reimbursed according to the specified reimbursement rate(s) contained in the Provider Fee Schedule.

Providers may only claim Medicaid reimbursement for services that are ordered by DAAS or their designee. Claims must be consistent with the amount, frequency and duration ordered by DAAS or their designee. Personal Attendant Services (PAS) participant-employed providers may only be reimbursed for their services out of state or out of country for up to two weeks when the participant and PAS provider travel together. Only two visits per year are allowed. Additional visits need to be approved by the Division of Aging and Adult Services (DAAS).

AAA's may be held financially responsible for issuing a care plan or service authorization form to a provider that does not match the services, start and end date, correct service name as defined in the SIP and unit of service as defined in the current codes and rates sheet, number of units, frequency of service, HCPCS code and/or provider name listed on an individual's approved care plan.

2-3 Standards of Service

Providers must adhere to service standards and limitations described in this manual, the terms and conditions of the Medicaid provider agreement and the terms and conditions of the Aging Waiver SIP. In addition, providers participating in the Aging Waiver must adhere to the following requirement covering interactions with DAAS or their designee responsible for the day to day administration of the program:

- Submit to each applicable DAAS designee a monthly written summary report of claims submitted for Medicaid reimbursement. The summary report shall be submitted within 10 calendar days after the end of each month, and shall detail for each waiver participant the specific Waiver services provided, the units of service billed for each service, the dates of service and the reimbursement amount billed.

2-4 Data Security and Privacy

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 participant 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.

2-5 Breach Reporting/Data Loss

Providers must report to DAAS 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 DAAS within 5 business days of the breach. The provider will also cooperate with any investigation of the breach or data loss.

2-6 Provider Rights to a Fair Hearing

The Department provides hearing rights to providers who have had any adverse action taken by the Utah Department of Health, DMHF, DAAS, or their designee, and who submit a written request for a hearing to the agency. This includes actions of a DAAS designee relating to enrollment of waiver providers, free choice of available providers by waiver participants, reimbursement rates, sanctions, or other adverse actions related to provider performance or improper conduct of the agency in performing delegated waiver responsibilities.

A *Request for Hearing/Agency Action form (Hearing Request)* is available on the Utah Medicaid website at: https://medicaid.utah.gov/utah-medicaid-forms. This form may also be requested from the Office of Administrative Hearings by calling (801) 538-6576. Hearing requests must be filed with the Office of Administrative Hearings within 30 calendar days from the date of the adverse action.

3 Participant Eligibility and Service Availability

Aging Waiver services are covered benefits only when provided to an individual determined to meet the eligibility criteria defined in the CMS approved Aging Waiver SIP and only pursuant to a written Comprehensive Care Plan.

3-1 Eligibility for Aging Waiver Services

Aging Waiver services are covered benefits for a limited number of Medicaid eligible participants for whom there is a reasonable indication that they might need the services provided in a Medicaid-certified NF in the near future unless they receive home and community-based services. The cost of which would be reimbursed under the Medicaid State Plan.

A. Eligibility Activities

DAAS or their designee is responsible at a minimum, for conducting the following activities:

Aging Waiver Application Activities (performed at the time a Demographic Intake and Screening is conducted with the participant):

- Respond to inquiries by an interested participant regarding the waiver program.
- Determine whether the waiver has available capacity within the limit delineated in Appendix B-3 (Table b-3-a) of the SIP.
- Provide education related to the services covered by the waiver.
- Conduct an initial assessment if available capacity exists to determine if the participant meets LOC requirements, has an imminent need for the services provided in a NF, and meets all other program eligibility requirements described in Items 2 through 6 of the Aging Waiver SIP.
- Assist the participant to complete the Medicaid financial eligibility determination process.
- Assist the participant to request a fair hearing if an adverse agency action is taken in relation to the waiver application.

Freedom of Choice Activities (performed at the time a participant is determined to be eligible for the Aging Waiver):

- Identify the general service needs of the participant.
- Inform the participant of the services the waiver program can provide and the services a Medicaid NF can provide to meet the identified general needs.
- Offer the participant choice of the waiver program or the Medicaid NF program and document the choice selected.
- Assist the participant to request a fair hearing if choice of the waiver program is denied.

Enrollment Activities (performed at the time it is determined sufficient Aging Waiver capacity is available to permit an individual to be enrolled into the Waiver):

- Conduct a comprehensive assessment (MDS-HC) to determine if the participant meets LOC requirements.
- Develop an initial Comprehensive Care Plan based on the needs identified by the comprehensive assessment.
- Assist the participant in selecting a waiver case management agency (CMA).
- At the intervals specified in the Aging Waiver SIP, conduct ongoing comprehensive assessments to determine if the participant continues to meet LOC requirements, has an imminent need for the services that would be provided in a NF, meets all other program eligibility requirements in the Aging Waiver SIP, and develop updated Comprehensive Care Plans annually or based on need.
- Assist the individual to request a fair hearing if choice of the waiver CMA is denied.

B. Mental or Physical Condition Determination

In determining whether the applicant has mental or physical conditions that can only be cared for in a NF, or the equivalent care provided through the Aging Waiver, the licensed professional responsible for assessing LOC shall document that the applicant meets the criteria as established in Utah Administrative Code, Title R414-502-3, Utah Medicaid Program.

C. Eligibility Restrictions

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 met through the Aging Waiver program.

Inpatients of hospitals, NFs, or Intermediate Care Facilities for People with Intellectual Disabilities (ICFs/ID) are not eligible to receive waiver services (except as specifically permitted for case management discharge planning in the 90-day period before their discharge to the Aging Waiver).

3-2 Applicant Freedom of Choice of NF or Aging Waiver

Medicaid recipients who meet the eligibility requirements of the Aging Waiver may choose to receive services in a NF or the Aging Waiver if available capacity exists to address health, welfare, and safety needs.

If no available capacity exists in the Aging Waiver, the applicant will be advised in writing that he or she may access services through a NF or may wait for open capacity in the Aging Waiver.

If available capacity exists in the Aging Waiver, a comprehensive assessment will be completed by DAAS or their designee. The applicant will be advised of the needs identified and given the opportunity to choose to receive services to meet the identified needs through a NF or the Aging Waiver. The applicant's choice will be documented in writing, signed by the applicant, and maintained as part of the applicant's record.

Once the applicant has chosen to enroll and become a participant in the Aging Waiver and the choice has been documented, subsequent review of choice of program will only be required at the time of a substantial change in the participant's condition resulting in a change in the Comprehensive Care Plan. It is, however, an Aging Waiver participant's option to choose facility-based care at any time and voluntarily disenroll from the Aging Waiver.

3-3 Aging Waiver Participant Freedom of Choice

Upon enrollment in the Aging Waiver, the individual now becomes a participant on the waiver. The participant will be given choice among available waiver case management agencies (CMAs). The participant's choice will be documented in the case record.

Upon completion of a comprehensive needs assessment by DAAS or their designee, the participant will be active in the development of the Comprehensive Care Plan and the Person-Centered Care Plan (PCCP) to address the participant's identified needs.

The participant will be given a choice of services to meet an identified need if more than one cost-effective option exists.

The participant will be given a choice of available qualified providers of Aging Waiver services identified in the Comprehensive Care Plan.

DAAS or their designee will review the contents of the written Comprehensive Care Plan with the participant prior to implementation. The written Comprehensive Care Plan is signed by the participant and constitutes a formal notice of the agency's decision regarding authorized services to be provided to the participant.

Subsequent revisions to the participant's Comprehensive Care Plan may occur as a result of the annual re-assessment, or a result of a significant change in the participant's health, welfare, or safety and as otherwise warranted.

A significant change is defined as a major change in the participant's status that:

- is not self-limiting;
- impacts more than one area of the participant's health and safety status; and
- inter-disciplinary review is required and/or revision of the Comprehensive Care Plan.

Note: A condition is defined as self-limiting when the condition will normally resolve itself without intervention by Aging Waiver services. Generally, if the condition has not resolved within approximately two weeks, a comprehensive reassessment should begin.

A reassessment is required if significant change is consistently noted in two or more areas of decline, or two or more areas of improvement.

A LOC screening will also be conducted at the conclusion of an inpatient stay in a medical facility.

During the review of the written care plan, the participant will be informed in writing of any decision to deny, suspend, reduce, or terminate a waiver service listed in the service plan and will be informed of the right to a fair hearing.

3-4 Termination of Aging Waiver Service

When the need arises, participants are separated from the Home and Community Based waiver program through a disenrollment process.

The disenrollment process is a coordinated effort between DMHF and DAAS that is expected to facilitate the following:

- Verification that the disenrollment is appropriate for the waiver participant;
- Movement among waiver programs (when applicable);
- Ensuring effective utilization of waiver program services;
- Effective discharge and transition planning;
- Distribution of information to participants describing all applicable waiver rights; and
- Program quality assurance.

All of the various circumstances for which it is permissible for participants to be disenrolled from the waiver program can be grouped into three distinct disenrollment categories.

A. Voluntary disenrollments are cases in which the participants, or their legal representative (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 that case managers notify DAAS within 10 days from the date of the disenrollment. No DMHF prior review or approval of the decision to disenroll is required.

Additional documentation will be maintained by the case management agency that includes a written statement signed by the participant, or their legal representative (when applicable) describing their intent to disenroll from the waiver program. This documentation should also outline discharge planning activities completed by the case manager with the waiver participant as part of the disenrollment process.

B. Pre-Approved involuntary disenrollments are cases in which the participants are involuntarily disenrolled from the waiver for any of the following reasons including:

- Death of the participant;
- Participant has been determined to no longer meet the financial requirements for the Medicaid program eligibility by the Department of Workforce Services;
- Participant enters a skilled nursing facility, and the expected length of stay will exceed 90 days or longer (as verified by a physician) If the participant exceeds the 90 day stay, it needs DAAS approval;
- Participant has moved out of state;
- Participant's whereabouts are unknown for 30 days or more and all avenues to locate the participant have been exhausted; or
- Participant has been incarcerated.

Pre-Approved involuntary disenrollments require that case managers notify the DAAS program manager 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. Documentation will be maintained by the case management agency, detailing the discharge planning activities completed with the waiver participant as part of the disenrollment process when appropriate.

C. Special circumstance disenrollments are cases in which participants are involuntarily disenrolled for reasons that are non-routine in nature and involve circumstances that are specific to the participant. These cases require prior review by DAAS and a second level approval by the Bureau of Long Term Services and Supports (BLTSS) Quality Assurance Unit. Examples of this type of disenrollment include:

- Participant no longer meets the level of care requirements for the waiver;
- Participant's health and safety needs cannot be met by the waiver program's services and supports;
- Participant has demonstrated non-compliance with the agreed upon care plan and is unwilling to negotiate a plan of care that meets minimal safety standards;
- Participant has demonstrated non-compliance with a signed health and safety agreement with DAAS or their designee; or
- Participant poses imminent danger to themselves or others.

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

- The AAA shall compile information to articulate the disenrollment rationale;
- This information will then be submitted to DAAS for review of the case management activities, as well as the disenrollment recommendation;

- If DAAS staff concurs with the recommendation, a request for disenrollment approval will be forwarded to the BLTSS Quality Assurance Unit for a final decision;
- The BLTSS Quality Assurance Unit will review and assure that all State Plan, waiver, non-waiver and other available services/resources have been fully utilized to meet the participant's needs;
- DAAS and/or the BLTSS Quality Assurance Unit may facilitate meetings with appropriate parties, as needed, to complete the review and make an appropriate final decision on the proposed disenrollment; and
- The BLTSS Quality Assurance Unit will communicate a final disenrollment decision to DAAS.

If the special circumstance disenrollment request is approved, DAAS or their designee will provide the participant, or their legal representative (when applicable), with the required written Notice of Decision (NOD) and right to fair hearing information.

The case management agency 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 participant's case record.

3-5 Fair Hearing

DMHF provides a participant, applying for or receiving Aging Waiver services, an opportunity for a hearing upon written request, if the participant is:

- Not given the choice between facility-based (NF) care and Aging Waiver services.
- Denied the waiver provider(s) of choice if more than one provider is available to render the service(s).
- Denied, reduced, suspended, or terminated access to waiver services.
- Experiences a reduction, suspension or termination of waiver services identified as necessary to prevent facility placement.

An applicant, participant, or their legal representative when applicable, will receive a written NOD from DAAS or their designee if the participant is denied a choice between facility-based (NF) care and Aging Waiver services, found ineligible for the waiver program or denied access to the provider of choice for a covered waiver service. The NOD delineates the participant's right to appeal the decision.

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

The participant is encouraged to utilize an informal dispute resolution process to expedite equitable solutions but may forgo or interrupt the available informal resolution process at any time by completing a request for hearing and directing the request to the Department of Health, DMHF, for a formal hearing and determination. An informal dispute resolution process does not alter the requirements of the formal fair hearings process. The participant must still file a request for hearing and a request for continuation of services within the mandatory time frames established by the DMHF. An informal dispute resolution must occur prior to the deadline for filing the request for continuation of service and/or the request for formal hearing or be conducted concurrent with the formal hearing process.

A *Request for Hearing/Agency Action form (Hearing Request)* is available on the Utah Medicaid website at: https://medicaid.utah.gov/utah-medicaid-forms. This form may also be requested from the Office of Administrative Hearings by calling (801) 538-6576.

4 Case Management

Case management serves the purpose of maintaining the individual in the Home and Community- Based Services Waiver in accordance with the program requirements and the participant's assessed service needs, and coordinating the delivery of quality waiver services.

4-1 Case Management Encounters

To better focus primary attention on providing the specific level of case management intervention needed on an individualized basis, as determined during the initial and ongoing comprehensive needs assessment process, the individual Comprehensive Care Plan will be the vehicle through which the level of assessed need for case management will be detailed in terms of the amount, duration, and frequency of intervention to be provided. This approach will also promote case managers having specific information about their expected roles and responsibilities to an individualized waiver participant. Program performance reviews will assess the accuracy and effectiveness of the link between the determination of need, the Comprehensive Care Plan and the implementation of case management services.

4-2 Plan of Care Unit Calculation

The comprehensive care plan is intended to be an estimate of the service units required to meet the assessed needs of each participant over the course of the plan of care year. DMHF recognizes that a participant's needs may change periodically due to temporary or permanent conditions which may require amendments to the participant's care plan.

DAAS is responsible to monitor service utilization for each recipient for whom DAAS or their designee created a comprehensive care plan. When DAAS or their designee determines that the assessed service needs of a participant exceed the amount that has been approved on that participant's existing plan of care, DAAS or their designee should submit an amendment/change to increase the number of units to meet the need. Amendments/changes must be made prior to the expiration of the plan of care.

The plan of care year is the sum of all approved units including amendments/changes over the entire year. In this way, Utah Medicaid applies an annualized aggregate of all plan of care units.

Providers may not exceed the units authorized on the approved care plan. Billing in excess of the approved number of units will be subject to recovery of funds by Utah Medicaid.

4-3 MDS-HC Assessment Instrument

The InterRAI Minimum Data Set – Home Care (MDS-HC) serves as the standard comprehensive assessment instrument used in the Aging Waiver. This instrument determines the needs of the participant. Registered Nurses use this instrument when creating the comprehensive care plan.

4-4 Conflict Free Case Management

Case management services are expected to be provided without conflict of interest. Provider entities having the capacity to perform case management functions and other waiver or non-waiver services must assure that the functions of the entity are clearly separated and their respective responsibilities well defined and must abide by the conflict free case management guidelines.

1. If the AAA is enrolled to provide other waiver services in addition to case management services or if they are an enrolled Medicare or Medicaid provider for other non-waiver services, they must pay careful attention to conflict of interest rules during the care plan development process. AAA's are not permitted to be listed on a participant's care plan as a paid provider of any other waiver or non-waiver service except in the following circumstances:

A. Previous to February 1, 2019, if a participant was assessed to need goods and/or services through any of the following AW services the AAA may purchase the goods and/or service(s) from a non-Medicaid retailer or other entity and then receive direct Medicaid reimbursement through the usual and customary claims reimbursement process to pay the non-Medicaid retailer or other entity. For the following instances, it is permitted for the AAA to be listed on the care plan as a pass-through payment entity in order to ensure access to care:
    i. Chore Services
    ii. Community Living Services
    iii. Environmental Accessibility Adaptations
    iv. Specialized Medical Equipment/Supplies/Assistive Technology
    v. Supplemental Meals

B. Effective February 1, 2019, the State Medicaid Agency implemented the use of a financial transaction services contractor to pay for goods and services purchased from retail stores, general contractors or other entities not directly enrolled as Medicaid providers. Beginning February 1, 2019, AAA's will not be permitted to act as a pass-through payment agent for the above listed services.

5 Participant-Directed Employer Authority

The participant-directed employee authority (SAS model) requires the waiver participant to use a waiver Financial Management Services (FMS) provider as an integral component of the waiver service to assist with managing the employer-related financial responsibilities associated with the employer-employee relationship. The waiver FMS is a person or organization that assists waiver participants and their representatives, when applicable, in performing a number of employer-related tasks. The tasks performed by the waiver FMS include

documenting service provider's qualifications, collecting service provider time records, preparing payroll for participant's service providers and withholding, filing and depositing federal, state and local employment taxes. PAS employees complete time sheets for work performed. The participant, or their legal representative when applicable, confirms the accuracy of the time sheet, signs it and forwards it to the waiver FMS for processing. The waiver FMS files a claim for reimbursement through the Medicaid MMIS system, until superseded by the Provider Reimbursement and Information System for Medicaid (PRISM), and upon receipt of payment, forwards payment directly to the service provider for the services rendered.

6 Waiver Covered Services Rate Setting Methodology

The Department of Human Services (DHS) has entered into an administrative agreement with the Department of Health, DMHF, to set 1915(c) HCBS Waiver rates for waiver covered services. The DHS rate-setting process is designed to comply with the requirements under the 1915(c) HCBS Waiver program and other applicable Medicaid rules. There are four principle methods used in setting the DHS Maximum Allowable Rate (MAR). Each method is designed to determine a fair market rate. The four principle methods are:

- Existing market survey or cost survey of current providers
- Component cost analysis
- Comparative analysis
- Community price survey

The Case Management covered waiver service provider rate is calculated using the cost survey of current provider's methodology in general but includes an added procedure in which each fiscal year the SMA establishes specific cost center parameters to be used in calculating the annual MAR.

Annual MAR schedules may be held constant or modified with a Cost of Living Adjustment (COLA) for any or the entire 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.

7 Prior Authorization of Waiver Services

No prior authorization of waiver covered services by the SMA is required. Provider participation and service delivery will be governed by waiver quality management systems for assuring proper development and implementation of plans of care, assuring waiver services are provided by qualified providers and assuring financial accountability for funds paid to providers for the waiver program.

8 Billing

Refer to the provider manual, *Section I: General Information*, for detailed billing instructions.

8-1 Time Limit to Submit Claims

Providers are requested to submit claims within 90 days of the delivery of services; however, Medicaid allows for a 12-month claim submission and correction period. All claims and adjustments for services must be received by Medicaid within twelve months from the date of the service. New claims received past the one year filing deadline will be denied. Any corrections to a claim must also be received and/or adjusted within the same

twelve month timeframe. If a correction is received after the deadline, no additional funds will be reimbursed. The one year timely filing period is determined from the date of service or "from" date on the claim.

8-2 Financial Management Services Reimbursement

Reimbursement for PAS includes reimbursement for all mandatory employer payroll taxes, and workman's compensation insurance premiums. These costs should be paid in addition to the self-administered service rate established between the waiver participant and the employee. For example, if a waiver participant negotiates an hourly wage of $10 per hour with their self-administered services employee, mandatory employer burden costs (e.g. Social Security and Medicare taxes, Federal Unemployment taxes, and Worker's Compensation Insurance premiums) are paid in addition to the $10 per hour wage. The employee's income tax withholding should be deducted from the negotiated wage.

8-3 Use of the U3 Modifier

All claims billed to the Medicaid program for Aging Waiver services will need to be billed with the U3 modifier. Claims billed without the U3 modifier will result in a denied claim, and no reimbursement will be received for the service(s).

8-4 Use of the TE Modifier

The TE modifier is used when respite care services are provided by a LPN for an Aging Waiver participant.

8-5 Use of the TN Modifier

The use of the TN rural enhancement modifier is authorized in the Aging Waiver for the purpose of assuring access to waiver covered services in rural areas of the State where waiver service providers are required to travel extended distances to deliver services. The rate enhancement adjusts the per unit of reimbursement to account for the additional travel-related expenses not included in the normal rate setting process. For purposes of the rural enhancement rate, rural counties are all counties in Utah with the exception of Weber, Davis, Salt Lake, and Utah Counties.

The following limitations are imposed on the use of the rural enhancement:

- DAAS or their designee must authorize use of the rural enhancement rate at the time the services are ordered.
- The location assigned as the provider's normal base of operation must be in a county designated as rural;
- The location from which the service provider begins the specific trip must be in a county designated as rural;
- The location where the service is provided to the Waiver participant must be in a county designed as rural;
- The direct distance traveled by the provider from the starting location of the trip to the waiver participant must be a minimum of 25 miles with no intervening stops to provide waiver or State plan services to other Medicaid participants. When a single trip involves service encounters for purposes of

qualifying for the rural enhancement (i.e. each leg must involve a direct travel distance of 25 miles or more); and

- When a single participant encounter involves multiple services, one line item (service) for a participant encounter will qualify for the use of the TN rural enhancement modifier. (For example, if the provider visits a waiver participant and provides two hours of homemaker services, thirty minutes of budget assistance, and one hour of companion services, the provider may apply the TN modifier to the line of two hours of homemaker services, both hours will receive the additional reimbursement. If the provider chooses to apply the TN Modifier to one hour of companion services, they will receive the additional reimbursement for only one hour). Claims submissions utilizing the TN modifier for multiple services for a single participant encounter will be subject to recoupment.

8-6 Calculating Claims Using the TN Modifier

When using the TN rural enhancement modifier for a claim, providers should bill the total amount to be reimbursed (base amount with a 1.75 increase). The Medicaid MMIS system computes the Maximum Allowable Base Rate in the MMIS system reference file multiplied by 1.75 and compares that number to the actual billed amount. The MMIS system, until superseded by the Provider Reimbursement and Information System for Medicaid (PRISM), then pays the actual billed amount up to the MAR X 1.75.

8-7 Uniform Authorization of the Rural Enhancement Rate

It is the responsibility of DAAS or their designee to authorize any provider to bill for services using the rural enhancement code modifier. The use of the rural enhancement rate should be applied uniformly across the State according to the following guidelines:

- If the initial authorization was verbal, DAAS or their designee will follow up with a written service authorization for rural enhanced reimbursement and will provide a copy of the written authorization to the person responsible for monitoring Aging Waiver billings.

- DAAS or their designee is responsible to monitor the Medicaid billing statements to assure providers are appropriately using the rural enhancement rate. In the event of inappropriate use of the rural enhancement rate, the DAAS designee will notify DAAS.

- When possible, providers must coordinate service delivery to minimize the use of the TN modifier by combining multiple service encounters in a single trip.

8-8 Electronic Visit Verification

Electronic visit verification (EVV) requirements, defined in section 12006 of the 21st Century Cures Act, are effective for Utah Medicaid beginning July 1, 2019. EVV requirements apply to all personal care services and home health care services provided under a 1915 (c) Home and Community Based Waiver. Choice of reporting systems for EVV are by provider preference, but must meet all federal requirements, including the standards set in the Health Insurance Portability Accountability Act. The State will not implement a mandatory model for use. All provider choice EVV systems must be compliant with requirements of the Cures Act including:

1) type of service performed;

2) individual receiving the service;

3) date of the service;

4) location of service delivery;

5) individual providing the service;

6) time the service begins and ends; and

7) the date of creation of the electronic record.

Additional information including technical specifications for file creation/submission and EVV resources can be found at https://medicaid.utah.gov/evv

9 Service Procedure Codes

The HCPCS codes listed below are covered by Medicaid under the Aging Waiver.

Waiver Service	HCPCS Code	Unit of Service
Adult day health, licensed	S5102	per day
Case management, base	T1016	15 minutes
Case management, rural enhancement	T1016 TN	15 minutes
Chore services, base	S5120	each
Chore services, rural enhancement	S5120 TN	each
Adult companion services	S5135	15 minutes
Adult companion services, rural enhancement	S5135 TN	15 minutes
Environmental accessibility adaptions	S5165	per service
Supplemental meals, base	S5170	per meal
Supplemental meals, rural enhancement	S5170 TN	per meal
Homemaker services	S5130	15 minutes
Homemaker services, rural enhancement	S5130 TN	15 minutes
Personal attendant service, agency, base	T1019	15 minutes

Personal attendant service, agency, rural enhancement	T1019 TN	15 minutes
Personal attendant service, participant employed	S5125	15 minutes
Personal budget assistance	H0038	15 minutes
Personal budget assistance, rural enhancement	H0038 TN	15 minutes
Personal emergency response system – purchase, rental, repair	S5162	each
Personal emergency response system – response center service	S5161	per month
Personal emergency response – installation, testing, removal	S5160	each
Personal emergency response – installation, testing, removal, rural enhancement	S5162 TN	each
Medication reminder system	S5185	per month
Respite care, unskilled, base	S5150	15 minutes
Respite care, unskilled, rural enhancement	S5150 TN	15 minutes
Respite care, home health aide, base	T1005 TE	per hour
Respite care, home health aide, rural enhancement	T1005 TE, TN	per hour
Respite care, nursing facility	H0045	per day
Specialized medical equipment/supplies/assistive technology	T2029	each
Enhanced state plan supportive maintenance home health aide services, base	T1021	per hour
Enhanced state plan supportive maintenance home health aide services, rural enhancement	T1021 TN	per hour
Transportation services (non-medical), base	T2003	one way trip
Transportation services (non-medical), base, rural enhancement	T2003 TN	one way trip
Transportation services (non-medical), van, base	T2005	one way trip
Transportation services (non-medical), van rural enhancement	T2005 TN	one way trip
Community living services	T2038	per service
Financial management services	T2040	per month

10 Mandatory Adult Protective Services Reporting Requirements

All suspected incidents of abuse, neglect or exploitation must be reported in accordance with Utah State Law 76-5-111, Utah Code annotated 62-A-3-305 and State Rule R510-302.

Any person who has reason to believe that any vulnerable adult has been the subject of abuse, neglect, or exploitation shall immediately notify Adult Protective Services intake or the nearest law enforcement agency. When the initial report is made to law enforcement, law enforcement shall immediately notify Adult Protective Services intake. Adult Protective Services and law enforcement shall coordinate, as appropriate, their efforts to provide protection to the vulnerable adult.

When the initial report or subsequent investigation by Adult Protective Services indicates that a criminal offense may have occurred against a vulnerable adult, it shall notify the nearest local law enforcement agency. The law enforcement agency shall initiate an investigation in cooperation with Adult Protective Services.

Anyone who in good faith makes a report or otherwise notifies a law enforcement agency, the division, or Adult Protective Services of suspected abuse, neglect, or exploitation is immune from civil and criminal liability in connection with the report or other notification.

Any person who willfully fails to report suspected abuse, neglect, or exploitation of a vulnerable adult is guilty of a class B misdemeanor.

Under circumstances not amounting to a violation of Section 76-8-508, a person who threatens, or attempts to intimidate a vulnerable adult who is subject of a report, a witness, the person who made the report, or any other person cooperating with an investigation conducted pursuant to this chapter is guilty of a class B misdemeanor.

The physician-patient privilege does not constitute grounds for excluding evidence regarding a vulnerable adult's injuries, or the cause of those injuries, in any judicial or administrative proceeding resulting from a report made in good faith pursuant to this part.

An adult is not considered abused, neglected, or a vulnerable adult for the reason that the adult has chosen to rely solely upon religious, non-medical forms of healing in lieu of medical care.

11 Incident Reporting Protocol

The State Medicaid Agency (SMA) has the administrative authority over all 1915(c) Medicaid Home and Community Based Services (HCBS) Waivers. Waiver programs must provide adequate and appropriate services that safeguard the health and welfare of all enrolled participants. Waiver programs must also assure financial accountability for funds expended for HCBS services. While these responsibilities are delegated to the Operating Agencies (OA), the SMA retains final authority and has the final responsibility to assure that appropriate actions have taken place when a critical incident or event occurs, and in cases when appropriate safeguards were not in place, that an analysis is conducted and appropriate strategies have been implemented to safeguard participants.

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 that are 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.

A. Level One Incidents and Events – Reportable to the SMA

The following list of the incidents/events 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. Unexpected Hospitalization

Admission to the hospital for medical treatment related to one or more of the following reasons:

a. Injuries that result in the loss of physical or mental function.

(*i.e.; loss of limb, paralysis, brain injury or memory loss*);

b. Alleged/substantiated abuse or neglect;
c. Attempted suicide;
d. Medication errors;
e. Self-Injurious behavior; and/or
f. Serious burns
g. Substance Abuse

2. Exploitation (Either Alleged or Substantiated)

Unfairly taking advantage of a participant due to his/her age, health, and/or disability.

a. Serious and/or patterned/repeated event(s)- involving a single participant,
b. Involving multiple participants.

3. Human Rights Violations

a. Serious infringements of participant human rights (jeopardizing the health and safety of the participant);
b. *Exceptions*;
    i. Restrictive/intrusive intervention(s) must be clearly defined in individualized Behavior Support Plans and/or Care Plan/Person Centered Support Plans pursuant to 42 CFR §441.301(c)(4)(5).
    ii. Emergency Behavioral Interventions as defined by Utah Administrative Code, Title R539-4-6 are not considered a Human Rights Violation.

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. Missing Persons

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

a. Participants who have been missing for at least twenty-four hours; or
b. Regardless of the number of hours missing – any participant 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 participant in peril.

6. Unexpected Deaths

All deaths are considered unexpected *with the exception of:*

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

A death related to an adverse event that occurs while the participant is receiving treatment in an in-patient facility, which is regulated by Health Facilities Licensing and Certification, should be reported as an unexpected death, the QA/SMA team may opt not to require an investigation. ***(Reportable to Health Facilities Licensing)***

7. Waste, Fraud or Abuse of Medicaid Funds

Alleged or confirmed waste, fraud or abuse of Medicaid funds

a. Perpetrated by the provider, or
b. Perpetrated by the participant.

8. Law Enforcement Involvement

Charges filed against the participant for activities resulting in the:

a. Hospitalization of another (i.e. aggravated assault),
b. Death of another; and/or
c. Abuse and or exploitation of a vulnerable person, due to age, health, and/or disability.

9. Private Health Information (PHI)/Personal Identifiable Information (PII) Security Breach

Any activity that could potentially put sensitive information at risk of unauthorized use, access, disclosure, or modification.

<u>Procedure for Reporting to the State Medicaid Agency:</u>

- On the first business day after a critical incident has occurred[1], 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.

[1] In some cases it will not be possible to report the incident by the next business day after 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.

- 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 participant or the participant'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 attempt, missing person, death and investigations that conclude with dis-enrollment and/or are not concluded within six months of the original incident date.

B. Level Two Incidents and Events – Reportable to the OA

The following incidents must be reported by providers, participants 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. Unexpected Medical Treatment (requiring immediate medical treatment at an emergency room)

Medical treatment related to one or more of the following reasons:

a. Abuse/Neglect/Exploitation (Either Alleged or Substantiated);
b. Medication Errors and/or;
c. Substance Abuse.

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

a. Exploitation of a participant's funds or property;
b. Theft and/or diverting of a participant's medication(s); and/or
c. Sexual assault/abuse/exploitation (regardless of medical treatment).

3. Human Rights Violations

Such as:

a. Unauthorized use of restrictive interventions- including but not limited to restraints (physical, mechanical or chemical) ;
b. Misapplied restrictive interventions, (included in the BSP);
c. Unauthorized use of seclusion; and/or
d. Unwelcome infringement of personal privacy rights;
e. Violations of individual rights to dignity and respect.
f. *Exceptions*;
    i. Restrictive/intrusive intervention(s) must be clearly defined in individualized Behavior Support Plans and/or Care Plan/Person Centered Support Plans pursuant to 42 CFR §441.301(c)(4)(5).
    ii. Emergency Behavioral Interventions as defined by Utah Administrative Code, Title R539-4-6 are not considered a Human Rights Violation.

Operating Agencies are responsible to ensure providers are compliant with 42 CFR §441.301(c)(4)(5)

4. Attempted Suicides

An attempted suicide which **did not** result in the participant being admitted to a hospital. (Suicide attempts do not include suicidal thoughts or threats without actions)

5. Compromised Working or Living Environment

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

6. Law Enforcement Involvement

a. Participant(s)
   i. Criminal charges filed (Not including those reportable to the SMA)
b. Staff
   i. Criminal charges filed (*Make report to APS/CPS* (when necessary).
   ii. When staff is issued a moving violation while transporting participant(s).

For this category, the date of the incident will be recorded as the date on which the filing of charges occurred.

7. Unexpected Hospitalization

Admission to the hospital for medical treatment related to one or more of the following reasons:

a. Injuries
b. Aspiration
c. Choking

These do not include medical diagnoses that pose an expected risk for aspiration or choking. Also excluded from this category are 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 participant 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[2], 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 participant or the participant's representative (in person, phone or in writing) of the investigation results and document notification in the

[2] In some cases it will not be possible to report the incident by the next business day after occurrence. In those cases, the incident must be reported the first business day after discovery. The OA 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.

participant's record. The following types of incidents are excluded from the notification requirement: suicide attempt, death, and investigations that conclude with dis-enrollment and/or are not concluded within six months of the original incident date.

Required Reports

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

B. 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 participant/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

C. State Medicaid Agency Annual Report

- 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