SECTION 2

HOME AND COMMUNITY BASED SERVICES WAIVER For INDIVIDUALS WITH AN ACQUIRED BRAIN INJURY

Table of Contents

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 (HCBS) provided to eligible recipients as an alternative to institutional care. The State of Utah has provided Medicaid-reimbursed home and community-based waiver services to individuals with an acquired brain injury since October 1, 1995. The Division of Medicaid and Health Financing (DMHF) received approval from CMS through a waiver renewal process to continue operating the Home and Community Based Services Waiver for Individuals with an Acquired Brain Injury (ABI Waiver) through June 30, 2019. The approval includes:

1. The 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 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 institutional NF 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 NF services.

2. The 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 ABI Waiver program. The day to day operations have been delegated to the Department of Human Services (DHS), Division of Services for People with Disabilities (DSPD), through an interagency agreement with the SMA. This agreement and the State Implementation Plan (SIP) describe the responsibilities that have been delegated to DSPD as the Operating Agency (OA) for the Waiver program.

1 - 1 Acronyms and Definitions

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

ABI Acquired Brain Injury

CBIA Comprehensive Brain Injury Assessment

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
HCBS	Home and Community-Based Services
MAR	Maximum Allowable Rate
NF	Nursing Facility
NOA	Notice of Action
OA	Operating Agency
PCSP	Person Centered Support Plan
PHI	Personal and Protected Health Information
PII	Personal Identifiable Information
RAS	Request for Additional Services
RFP	Request for Proposal
SIP	State Implementation Plan
SMA	State Medicaid Agency

1 - 2 CMS Approved State Implementation Plan

A. The CMS approved SIP for the ABI Waiver serves as the State's authority to provide HCBS 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 ABI Waiver, providers should refer to the SIP. In the event provisions of this manual are found to be in conflict with the SIP, the SIP will take precedent.

2 SERVICE AVAILABILITY

Home and community-based waiver services are covered benefits only when provided to an individual:

A. With an acquired brain injury who has established eligibility for state matching funds through DHS in accordance with UCA 62A-5;

B. Who has been determined to meet the eligibility criteria defined in the current CMS approved ABI Waiver SIP pursuant to a written Person Centered Support Plan (PCSP); and

C. Pursuant to a written Person Centered Support Plan (PCSP).

2 - 1 Eligibility for ABI Waiver Services

A. Home and community-based waiver services are covered benefits only for a limited number of eligible Medicaid recipients who require the level of care provided in a NF, or the equivalent care provided through the ABI Waiver. In determining whether the applicant has mental or physical conditions that meet this level of care requirement, the individual responsible for assessing level of care shall document that the applicant meets the criteria as established in Utah Administrative Rule 414-502-3.

B. The individual responsible for the assessment will also document that the applicant meets the following additional targeting criteria:

1. 18 years of age or older;

2. Diagnosed with an ABI defined as being injury related and neurological in nature which may include cerebral vascular accident and brain injuries that have occurred after birth;

3. As a result of the ABI, received a qualifying International Classification of Diseases code diagnosis from the most recent revision of the classification, clinical modification, as outlined in Division Directive 1.40 - Qualifying Acquired Brain Injury Diagnoses; and

4. Obtained an eligible score on the Comprehensive Brain Injury Assessment (CBIA) as outlined in Utah Administrative Rule 539-1-8(1)(c).

C. The ABI Waiver cannot serve individuals:

1. Whose functional limitations are due solely to mental illness, substance abuse, personality disorder, hearing impairment, visual impairment, learning disabilities, behavior disorders, aging process, or individuals with deteriorating diseases such as multiple sclerosis, muscular dystrophy, Huntington's chorea, ataxia, or cancer;

2. Who have suffered congenital brain injury or brain injuries induced by birth trauma; and/or

3. Who have been diagnosed with an intellectual disability.

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 ABI Waiver.

F. Inpatients of hospitals, NFs, or Intermediate Care Facilities for people with Intellectual Disabilities 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 ABI Waiver). The term Intermediate Care Facilities for people with Intellectual Disabilities, which is used in this document, is equivalent to intermediate care facilities for persons with mental retardation (ICFs/MR) under Federal law.

2 - 2 Applicant Freedom of Choice of NF or Waiver

A. When an individual is determined eligible for ABI Waiver services, the individual and the individual's legal representative if applicable will be offered the choice of NF or home and community-based care.

B. A copy of the DSPD publication *AN INTRODUCTORY GUIDE—Division of Services for People with Disabilities* (Guide), which describes the array of services and supports available in Utah through both NFs and the Home and Community Based Services (HCBS) waiver programs, is given to each individual applying for waiver services.

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 PCSP has been agreed to by all parties; and

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

C. Once the individual has received a copy of the Guide, chosen home and community based waiver services and the choice has been documented by the support coordinator in USTEPS, 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 PCSP. It is, however, the individual's option to choose NF care at any time during the period they are enrolled in a waiver program.

2 - 3 Waiver Participant Freedom of Choice

A. Upon enrollment in the ABI Waiver, the ABI Waiver enrollee, and the individual's legal guardian if applicable, will be given the opportunity to choose the providers of ABI 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 individual's PCSP.

B. The ABI Waiver support coordination agency will review the contents of the written PCSP with the participant prior to implementation. If the participant is not given the choice of HCBS as an alternative to NF care, is denied the ABI Waiver service(s) of their choice, or is denied the waiver provider(s) of their choice, the agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, Subpart E.

C. 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 B above.

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

A. When the need arises, participants are separated from the HCBS 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;

   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 and should include a written statement signed by the participant or their legal representative when applicable detailing their intent to disenroll from the ABI Waiver program as well as discharge planning activities completed by the Support Coordinator 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 is determined ineligible for Medicaid services by the Department of Workforce Services as a result of no longer meeting the financial requirements for Medicaid eligibility; or

   iii. Participant enters a skilled nursing facility for a stay of more than 90 days.

   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:

   i. Participant no longer meets the institutional NF level of care requirements for the Waiver;

   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;

   v. Participant, or their legal representative when applicable, requests a transfer of the participant from the ABI Waiver directly to another waiver program when a stay at a nursing facility has not been involved; and/or

   vi. Participant's whereabouts are unknown for more than 30 days and participant has not yet been determined ineligible for Medicaid services by the Department of Workforce Services.

   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. Support Coordinator 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

A. An individual and the individual's legal representative will receive a written NOA form 522, and 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 DHS or an administrative hearing process at the Department of Health (DOH), 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/DHS in accordance with UCA 62A-5 will be addressed through the DHS hearing process. Decisions made through DHS may be appealed to DOH strictly for procedural review. Appealed decisions demonstrating that DHS followed the fair hearing process will be upheld by the DOH 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. DSPD 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 an NOA. 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

A. Home and community based waiver services for participants with an ABI are covered benefits only when delivered by qualified providers that are enrolled with the SMA to provide the services as part of the ABI Waiver. In addition to this Medicaid provider agreement, all providers of ABI Waiver services must also have a current contract with DHS/DSPD.

B. The SMA 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 as defined in the ABI Waiver SIP.

C. DHS in conjunction with the Bureau of Contract Management will issue solicitations to possible providers of waiver services through a request for proposal (RFP). All solicitations for each RFP are posted through the BidSync.com website. To submit an RFP, a provider must register with BidSync.com and can do so free of charge. RFPs always remain open, allowing for continuous recruitment. A review committee evaluates the proposals against the criteria contained in the RFP 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 have the option to allow DHS/DSPD to bill Medicaid on its behalf for covered Medicaid services, or providers have the option to 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

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 ABI Waiver SIP and the terms and conditions contained in the DSPD contract.

3 – 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 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 - 5 Breach Reporting/Data Loss

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.

3 - 6 Provider Rights to a Fair Hearing

A. The DOH offers hearing rights to providers who have experienced any adverse action taken by DOH/DMHF, or by the OA. Providers must submit a written request for a hearing to DOH in order to access the hearing process. Please refer to the DOH/DMHF 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 an ABI Waiver provider,

2. Contract reimbursement rates,

3. Sanctions or other adverse actions related to provider performance, or

4. Improper conduct by DSPD in performing delegated ABI Waiver responsibilities.

3- 7 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

4 SUPPORT COORDINATION

4 - 1 Support Coordinator Qualifications

Qualified support coordinators shall possess at least a Bachelors degree in nursing, behavioral science or a human services related field such as social work, sociology, special education, rehabilitation counseling, or psychology and demonstrate competency relating to the planning and delivery of health services to the ABI population through a successful completion of a training program approved by the SMA.

4 - 2 Support Coordination and the PCSP

A. The PCSP is the mechanism through which all necessary ABI Waiver services (as determined during the initial and ongoing comprehensive needs assessment process) are detailed in terms of the amount, frequency, and duration of the intervention to be provided to meet identified objectives.

B. The amount, frequency and duration of each service listed within the PCSP is intended to provide a budget estimate of the services required to meet the assessed needs of each participant over the course of a plan year. Utah Medicaid recognizes that a participant's needs may change periodically due to temporary or permanent conditions which may require changes to the annual PCSP budget.

C. The support coordinator is responsible to monitor service utilization for each participant under their care. When the support coordinator determines that a participant may require an increase in services, a request for additional services (RAS) must be submitted to DSPD for approval.

D. The annual PCSP budget is the sum of all approved services within the PCSP including additional services authorized through an approved RAS that are added to the PSCP over the entire plan year. In this way, Utah Medicaid applies an annualized aggregate to the PCSP budget.

E. Services may not exceed the amount allotted through the annual PCSP budget. Billing in excess of the annual PCSP budget will be subject to a recovery of funds.

4 – 3 Support Coordination Encounters

While quarterly face to face visits is the standard, the support coordinator has the discretion to conduct face to face visits with the client more frequently than quarterly. In all cases, frequency will be dependent on the assessed needs of the client and will not exceed 90 days without a face to face visit.

A. Support Coordinators will visit individuals receiving residential supports no less than once every 30 days or at a rate directed by the DSPD program manager. Such visits shall occur in the person's place of residence at least once every 60 days. However, no more than two of these visits during each plan year may occur at other naturally-occurring settings within the participant's community provided that the support being offered to the participant during those visits shall be rendered by staff of the residential care provider.

This approach promotes Support Coordinators having specific information about their expected roles and responsibilities on an individualized waiver participant basis. Program performance reviews assess the accuracy and effectiveness of the link between the determination of need, the PCSP, the implementation of support coordination services and the ongoing evaluation of progress toward the stated objectives.

4 - 4 Assessment Instrument

The CBIA serves as the standard comprehensive assessment instrument for the ABI Waiver.

5 SELF-DIRECTED EMPLOYEE MODEL

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 ABI 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 employee(s). Individuals and/or their chosen representatives may avail themselves of the assistance offered them within the Consumer Preparation Service should they request and/or be assessed as requiring additional support and assistance in carrying out these responsibilities.

B. Financial management services are offered in support of the SAS option. A financial management services provider (Fiscal Agent) facilitates the employment of individuals by the ABI Waiver participant 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 ABI Waiver participant 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 bill to DHS/DSPD on Form 520. DHS/DSPD pays the Fiscal Agent then submits the billing claim(s) to DOH for reimbursement. All payments are made through the Fiscal Agent under contract with DSPD. Payments are not issued to the waiver participant, but to and in the name of the employee hired by the person or their representative.

6 WAIVER COVERED SERVICES RATE SETTING METHODOLOGY

A. DHS has entered into an administrative agreement with DOH/DMHF to set 1915c HCBS waiver rates for waiver covered services. The DHS rate-setting process is designed to comply with requirements under the 1915c HCBS ABI Waiver program and other applicable Medicaid rules. There are four principal methods used in setting the DHS Maximum Allowable Rate (MAR) level. 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

B. The Support Coordination covered waiver service provider rate is calculated using the cost survey of current providers' 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.

C. Annual MAR schedules may be held constant or modified with a cost of living adjustment 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.

D. The SMA 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.

7 SERVICE PROCEDURE CODES

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

WAIVER SERVICE	CODE	UNIT OF SERVICE
Behavioral consultation service I	H0004	15 minute
Behavioral consultation service II	H0023	15 minute
Behavioral consultation service III	H2019	15 minute
Chore services	S5120	15 minute
Companion services	S5135	15 minute
Companion services - daily	S5136	Per day
Consumer Preparation Services	T1027	15 minute
Day supports (site/non-site)	T2021	15 minute
Day supports (site/non-site) - daily	T2020	Per day
Environmental Adaptations (home)	S5165	Per episode
Environmental Adaptations (vehicle)	T2039	Per episode
Extended living supports	H2021	15 minute
Financial management services	T2040	Per month
Homemaker services	S5130	15 minute
Living start-up costs	T2038	Per episode
Personal assistance	S5125	15 minute
Personal assistance - daily	S5126	Daily
Personal budget assistance	H0038	15 minute
Personal budget assistance - daily	H2014	Per day
Personal emergency response systems (install)	S5160	Per episode
Personal emergency response systems (monthly)/Medication dispenser	S5161	Per month
Personal emergency response systems (purchase)	S5162	Per episode
Professional medication monitoring I (LPN)	H0034	Per episode
Professional medication monitoring II (RN)	H2010	Per episode

Residential habilitation - facility based	T2031	Per day
Residential habilitation - facility based - DCFS	T2016	Per day
Residential habilitation - host home	S5140	Per day
Respite care, unskilled (routine and intensive)	S5150	15 minute
Respite care (routine, intensive, group) - daily	S5151	Per day
Respite care, out of home (intensive/group-R&B included)	H0045	Per day
Respite care, weekly	T2036	Per week
Specialized medical equipment, monthly fee	T2028	Per month
Specialized medical equipment, purchase	T2029	Each
Supported employment	T2018	Per day
Supported employment - daily	T2019	15 minute
Supported living	T2017	15 minute
Transportation, non-medical, per mile	S0215	Per mile
Transportation, non-medical, per day	T2002	Per day
Transportation, non-medical, UTA	T2003	Per one way trip
Transportation, non-medical, multi-pass	T2004	Per month
Waiver support coordination	T2022	Per month

8 INCIDENT REPORTING PROTOCOL

Purpose:

The State Medicaid Agency has the administrative authority over all 1915(c) Medicaid 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 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 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 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.

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 participant's **admission to a hospital.**

2. Attempted Suicides
Suicide attempts that resulted in the participant'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 participant. (Infringement of personal privacy rights is defined as an unwanted restriction imposed upon the participant.) 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 participant's medication that resulted in the participant's **admission to a hospital**.

6. 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.

7. 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.

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 participant 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 SMA:

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

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. 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 participant's funds.

2. Attempted Suicides
Suicide attempts that **did not** result in the participant being admitted to a hospital.

3. 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.

4. Law Enforcement Involvement
Activities perpetrated by the participant 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 participant's medication which result in the participant experiencing adverse side effects requiring medical treatment at a medical clinic or emergency room.

6. Unexpected Hospitalization
Injuries, aspiration or choking experienced by participants 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 participant that resulted in **admission to a hospital for medical treatment** .which is reportable to the SMA).*

Procedure for Reporting to the OA

- 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.

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
- 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