Section 2

Home and Community-Based Services Waiver for Individuals with Physical Disabilities

Table of Contents

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*).

1-1 General Policy

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. Since June 1, 1998 the State of Utah has provided Medicaid reimbursed home and community based waiver services to individuals with Physical Disabilities. 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 Physical Disabilities (PD Waiver) through June 30, 2016. The approval includes:

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 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 "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.

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.

The State Medicaid Agency (SMA) has ultimate administrative oversight and responsibility for the PD 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 delegate to DSPD as the Operating Agency (OA) for the Waiver program.

1-2 Acronyms and Definitions

For purposes of the PD waiver, the following acronyms and definitions apply:

CMS

Centers for Medicare and Medicaid Services

DHS
Department of Human Services

DMHF
Division of Medicaid and Health Financing

DOH
Department of Health

DSPD
Division of Services for People with Disabilities

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

RFS
Request for Services

PD
Physical Disabilities

SIP
State Implementation Plan

SMA
State Medicaid Agency

1-3 CMS Approved State Implementation Plan

The CMS approved SIP for the PD 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.

This manual does not contain the full scope of the SIP. To understand the full scope and requirements of the PD 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 Provider Participation

Refer to provider manual, *Section I: General Information* for provider enrollment information.

2-1 Provider Enrollment

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

Any willing provider that meets the qualifications defined in the PD Waiver SIP may enroll at any time to provide a PD Waiver service by contracting DSPD. DSPD will facilitate completion and submission of the required Medicaid provider application and completion of the required local contract. The provider is only authorized to provide the waiver services specified in Attachment A of the Medicaid provider agreement submitted by the provider.

2-2 Provider Reimbursement

Providers will be reimbursed according to the specified reimbursement rate (s) contained in the negotiated contract with DSPD.

Providers may only claim Medicaid reimbursement for services that are authorized by the administrative case manager on the approved PCSP. Claims must be consistent with the amount, frequency and duration authorized by and documented on the PCSP.

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, the terms and conditions of the PD Waiver SIP and the terms and conditions contained in the DSPD contract.

2-4 Data Security & 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.

2-5 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.

2-6 Provider Rights to a Fair Hearing

The DOH affords 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 I, Chapter 6-15, Administrative Review/Fair Hearing.*

Adverse actions that providers may appeal include:

- Actions relating to enrollment as a PD Waiver provider,
- Contract reimbursement rates,
- Sanctions or other adverse actions related to provider performance, or
- Improper conduct by DSPD in performing delegated PD Waiver responsibilities.

2-7 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

3 Service Availability

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

- With physical disabilities who has established eligibility for state matching funds through DHS in accordance with UCA 62A-5;
- Who has been determined to meet the eligibility criteria defined in the current CMS approved PD Waiver SIP;
- Pursuant to a written Person Centered Support Plan (PCSP).

3-1 Eligibility for PD Waiver Services

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 NF, or the equivalent care provided through the PD 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 Code, Title R414-502-3, Utah Medicaid Program.

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

- 18 years of age or older;

- Has at least one personal attendant trained (or willing to be trained) and available to provide the authorized waiver services in a residence that is safe and can accommodate the personnel and equipment (if any) needed to adequately and safely care for the individual;
- Is medically stable, has a physical disability and requires, in accordance with a physician's written documentation, at least 14 hours per week of personal assistance services (as described in Appendix B of the PD Waiver SIP) in order to remain in the community and prevent unwanted institutionalization. For purposes of the PD Waiver, the applicant's qualifying disability and need for personal assistance services are attested to by a medically determinable physical impairment which the physician expects will last of a continuous period of not less than 12 months and which has resulted in the applicant's functional loss of two or more limbs. The physical impairment must also be to such an extent that the assistance of another trained person(s) is required in order to accomplish activities of daily living and instrumental activities of daily living.
- Has decision making capability, as certified by a physician, of selecting, training, and supervising their own attendant(s) (Individuals possessing decision making capability, but having communication deficits or limited English proficiency may select a representative to communicate decisions on the individual's behalf).
- Has the capacity to manage their own financial and legal matters.

If a person is eligible for more than one of the waivers operated by the Division of Services for People with Disabilities (DSPD), DSPD will educate the individual about their choices and will advise the individual about which of the waivers will likely best meet their needs.

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 PD Waiver.

Inpatients of hospitals, nursing facilities, or Intermediate Care Facilities for people with Intellectual Disabilities are not eligible to receive waiver services (except as specifically permitted for discharge planning in the 90-day period prior to their discharge to the PD 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.

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

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

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

If available capacity exists in the PD Waiver, a pre-enrollment screen of health, welfare, and safety needs will be completed by a PD Waiver representative. The applicant will be advised of the preliminary needs identified and given the opportunity to choose to receive services to meet the identified needs through a NF or the PD Waiver. The applicant's choice will be documented in writing, signed by the applicant, and maintained as part of the individual record.

Once the individual has chosen to enroll in the PD Waiver and the choice has been documented, subsequent review of choice of program will only be required at the time a substantial change in the participant's condition results in a change in the written PCSP. It is, however, a PD Waiver participant's option to choose institutional NF care at any time and voluntarily disenroll from the PD Waiver.

3-3 PD Waiver Participant Freedom of Choice

Upon completion of the comprehensive assessment instrument, the participant in participation with the administrative case manager will participate in the development of the PCSP to address the participant's identified needs.

The waiver participant, and their legal representative if applicable, will be given the opportunity to choose the providers of waiver services identified on the PCSP if more than one qualified provider is available to render the services. The participant's choice of providers will be documented in the PCSP.

The administrative case manager 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 PD Waiver services(s) of their choice or is denied the waiver provider(s) of their choice, the administrative case manager will provide an opportunity for a fair hearing, under 42 CFR Part 431, Subpart E.

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 above.

3-4 Termination of Home and Community-Based Waiver Services

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 DSPD that is expected to facilitate the following:

- Appropriate disenrollment and movement among waiver programs when applicable;
- Effective utilization of waiver program potential;
- Effective discharge and transition planning;
- Provision of information, affording participants the opportunity to exercise all applicable waiver rights; and
- Program quality assurance/quality improvement measures.

All of the various circumstances for which it is permissible for DSPD to disenroll a participant from the waiver program can be grouped into three distinct disenrollment categories.

A. 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 form the skilled nursing facility.

Voluntary disenrollments require administrative case managers to notify the DSPD PD Waiver program manager. DSPD, either through the program manager or other authorized designee, will in turn send written notification to the 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 PD Waiver program as well as discharge planning activities completed by the administrative case manager with the waiver participant as part of the disenrollment process.

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

- Death of the Participant;
- 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
- Participant enters a skilled nursing facility for a stay of more than 90 days.

Pre-Approved involuntary disenrollments require administrative case managers to notify the DSPD PD Waiver 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.

C. 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:

- Participant no longer meets the institutional NF 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 PCSP and/or is unwilling to negotiate a PCSP that meets minimal safety standards;
- Participant has demonstrated non-compliance with a signed participant agreement with DSPD; and/or
- Participant, or their legal representative when applicable, requests a transfer of the participant from the PD Waiver directly to another waiver program when a stay at a nursing facility has not been involved; and/or
- 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:

- The administrative case manager shall compile information to articulate the disenrollment rationale.
- The administrative case manager will then submit disenrollment rationale information to their DSPD PD Waiver program manager for review of the documentation of administrative case management activities and of the disenrollment recommendation.
- If DSPD management staff concurs with the recommendation, a request for disenrollment approval will be forwarded to DMHF for a final decision.
- 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.
- 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.
- A DMHF final disenrollment decision will be communicated in writing to both the administrative case manager and the state-level program management staff.

If the special circumstance disenrollment request is approved by DMHF, the administrative case manager will provide the participant, or their legal representative when applicable, with the required written notice of action (NOA).

The administrative case manager 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 Hearings

A participant and their legal representative, if applicable, will receive a written NOA form 522 and hearing request form 490S, from the administrative case manager if the participant is:

- Denied a choice of institutional NF or waiver program,
- Found ineligible for the waiver program,
- Denied access to the provider of choice for a covered waiver service, or
- Experiences a denial, reduction, suspension, or termination in waiver services in accordance with R539-2-5.

The NOA delineates the participant'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.

An aggrieved individual may request a formal hearing within 30 calendar days form 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.

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 DOH as the final decision.

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.

Informal Dispute Resolution

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 not limited to: concerns with a provider of waiver services, concerns with the amount, frequency, or duration of services being delivered, concerns with provider personnel, etc.

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

4 Administrative Case Management

4-1 Administrative Case Manager Qualifications

Case management in the PD Waiver is an administrative function rather than a covered PD Waiver service and is performed by employees of DSPD. Qualified administrative case managers shall be licensed in the State of Utah as a Registered Nurse in accordance with Title 58, Occupational and Professional Licensing, Utah Code Annotated, 1953 as amended, and have at least one year of paid experience working with individuals with severe physical disabilities at the time of hire.

4-2 Administrative Case Management and the PCSP

The PCSP is the mechanism through which all necessary PD 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.

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.

The administrative case manager is responsible to monitor service utilization for each participant under their care. When the administrative case manager determines that a participant may require an increase in services, a request for services (RFS) must be submitted to the PD Waiver program manager for approval.

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

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

4-3 Assessment Instrument

The Minimum Data Set – Home Care serves as the standard comprehensive instrument.

5 Self-Directed Employee Model

The self-directed employee model requires the PD Waiver participant to use a financial management services provider (Fiscal Agent) as an integral component of the PD Waiver services to assist with managing the employer-related financial responsibilities associated with the self-directed employee model. The Fiscal Agent is an agency based provider that assists the PD Waiver participant and his or her representatives, when appropriate, in performing a number of employer-related tasks without being considered the common law employer of the service providers. Tasks performed by the Fiscal Agent include documenting service workers' qualifications, collecting service worker time records, preparing payroll for participants' service workers, and withholding, filing, and depositing federal, state, and local employment taxes.

Participant employed service workers complete a time sheet for work performed. The participant confirms the accuracy of the time sheet, signs it, and forwards it to the Fiscal Agent for processing. The Fiscal Agent files a claim for reimbursement to the Medicaid MMIS system, through the DHS CAPS system, completes the employer-related responsibilities, deducts the established administrative fee, and forwards payment directly to the service worker for the services documented on the time sheet.

6 Waiver Covered Services Rate Setting Methodology

DHS has entered into an administrative agreement with DOH/DMHF to set 1915(c) HCBS waiver rates for waiver covered services. The DHS rate-setting process is designed to comply with requirements under the 1915(c) HCBS PD Waiver program and other applicable Medicaid rules. There are four principle 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 include:

- existing market survey or cost survey of current providers
- component cost analysis
- comparative analysis
- community price survey

Annual MAR schedules may be held constant or modified with a cost of living adjustment for any or all of the PD 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.

The State Medicaid Agency will maintain records of changes to the MAR authorized for each PD 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 Waiver for Individuals with Physical Disabilities.

Waiver Service	Code	Unit of Service
Financial management services	T2040	Per month
Medication Dispenser	T2029	Per episode
Medication Dispenser (monthly fee)	T2028	Per month
Personal attendant services	S5125	15 minute
Personal emergency response systems (install)	S5160	Per episode
Personal emergency response systems (monthly fee)	S5161	Per month
Personal emergency response systems (purchase)	S5162	Per episode

8 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 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.

- **Abuse/Neglect (Either Alleged of Substantiated)**
  Incidents of abuse or neglect, that resulted in the participant's **admission to a hospital**.

- **Attempted Suicides**
  Suicide attempts that resulted in the participant's **admission to a hospital**.

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

- **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).

- **Medication Errors**
  Errors relating to a participant's medication that resulted in the participant's **admission to a hospital**.

- **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.

- **Unexpected Deaths**
  All deaths are considered unexpected with the exception of:
  a. Participants receiving hospice care; and/orb. Deaths due to natural causes, general system failure or terminal/chronic health conditions.

- **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.**

- **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 participant 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. 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, death and investigations that conclude with disenrollment.

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.

- **Abuse/Neglect/Exploitation (Either Alleged or Substantiated)**
  Incidents of abuse or neglect, that resulted in medical treatment at a medical clinic or emergency room, or exploitation of participant's funds.

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

- **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 requires evacuation.

- **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.

- **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.

- **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 Quality Assurance Team:

- On the first business day after a critical incident has occurred, the administrative case manager will notify both the PD Waiver program manager and OA Quality Assurance Team via email, telephone or in person.

- Within ten business days after notification, the administrative case manager will submit a completed *Critical Incident Investigation* form to the OA Quality Assurance Team.

- Within five business days after receiving the *Critical Incident Investigation* form, the OA Quality Assurance Team will review the investigation form submitted by the administrative case manager and will contact the administrative case manager if additional information or action is required.

- When the OA Quality Assurance Team determines the investigation is complete, the OA Quality Assurance Team will document any findings or corrective action requirements on the OA Quality Assurance Team portion of the investigation form. The OA Quality Assurance Team will send the administrative case manager a copy of the finalized document, closing the case. In some cases, the OA Quality Assurance Team and/or PD Waiver program manager may continue to monitor findings or corrective actions.

- Within two weeks after closing the case, the administrative case manager will notify the participant or the participant's representative (in person, by phone or in writing) of the investigation results and document notification in the participant's record. The following types of incidents are excluded from the notification letter requirement: suicide, death and investigations that conclude with disenrollment.

Required Reports

<u>OA Quarterly Report</u>

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

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 fourteen 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)

SMA Annual Report

The SMA will submit an annual report of all reportable incidents to the SMA, 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 for all waivers:

- Number of incidents
- Number of incidents by category: incidents such as abuse/neglect/exploitation, law enforcement involvement, medication errors and unexpected hospitalizations 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 noticed 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