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| Utah Medicaid Provider Manual | Home and Community Based Waiver Services |
| | New Choices Waiver |
| Division of Medicaid and Health Financing | Updated July 2015 |

**UTAH HOME AND COMMUNITY BASED WAIVER SERVICES
NEW CHOICES WAIVER
PROVIDER MANUAL**

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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 medical assistance services provided to eligible recipients as an alternative to institutional care. The State of Utah has requested Medicaid reimbursed home and community-based waiver services for individuals who are currently residing long term in nursing facilities, assisted living facilities, small health care (Type N) facilities or other licensed Utah medical institutions, except for institutions for mental disease (IMD) and wish to receive supportive services in a home or community-based setting, and who but for the provision of such services, would require nursing facility placement. On April 1, 2007, the Division of Medicaid and Health Financing received approval from CMS to begin operating the New Choices Waiver. 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 section 1902(a)(10)(C)(i)(III) of the Social Security Act

Waiver of Comparability

In contrast to Medicaid State Plan services requirements, under a waiver of comparability, the State is permitted to provide covered waiver services to eligible individuals who meet the State’s criteria for Medicaid reimbursement in a nursing facility (NF), and “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-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

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

1-1 Acronyms and Definitions

For purposes of the New Choices Waiver the following acronyms and definitions apply:

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| BACBS | Bureau of Authorization and Community Based Services |
| CMS | Centers for Medicare and Medicaid Services |
| DMHF | Division of Medicaid and Health Financing |
| HCBS | Home and Community Based Services |

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IMD Institution for Mental Disease

Licensed Utah

Medical Institution Any licensed Utah medical institution (non IMD) other than a nursing facility, assisted living facility or small health care (Type N) facility, e.g., hospital, hospice facility, etc.

LOC Level of Care

NCW New Choices Waiver -- the Medicaid 1915(c) HCBS Waiver Program

MDS-HC Minimum Data Set for Home Care is the standard comprehensive assessment instrument used in the New Choices Waiver to determine if an individual meets nursing facility level of care criteria and to assess the needs of each individual.

NF Nursing Facility

SAS Self-Administered Services is a service delivery method in which the participant and/or their chosen designee hires individual employees to deliver a waiver service rather than choosing to receive that service through the traditional agency-based service delivery method. New Choices Waiver offers 4 service types through the SAS model. (See the Self-administered Services section for more information.)

SFY State Fiscal Year (July 1 – June 30)

SIP State Implementation Plan. This is the formal way to refer to the CMS approved waiver application.

SMA State Medicaid Agency

Target Group The group of people whom the waiver is designed to serve. This waiver serves long term residents of nursing facilities, assisted living facilities, small health care facilities (Type N) or other licensed Utah medical institutions (non-IMD) who wish to receive services in a home or community –based setting.

1-2 CMS Approved Waiver State Implementation Plan

1. The State Implementation Plan (SIP) for the New Choices Waiver, approved by CMS, gives the State the authority to provide home and community services to the target group under its Medicaid plan. That document and all attachments constitute the terms and conditions of the program.

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2. This manual does not contain the full scope of the Waiver State Implementation Plan. To understand the full scope and requirements of the New Choices Waiver program, refer to the Waiver State Implementation Plan.
3. If anything written in this manual is found to be in conflict with the State Implementation Plan, the State Implementation Plan will take precedence.

2 SERVICE AVAILABILITY

1. Home and community-based waiver services are covered benefits only when provided:
 - A. to an individual who meets the eligibility criteria defined in the CMS approved Waiver State Implementation Plan;
 - B. pursuant to a written and approved comprehensive care plan.

2-1 Eligibility for Waiver Program

1. Home and community-based New Choices Waiver services are covered benefits only for Utah Medicaid recipients who meet nursing facility level of care criteria as defined in R414-502, and who:
 - A. are 18 years of age or older at the time of application;
 - B. one of the following six (6) scenarios describes their current situation:
 - i. Are receiving nursing facility care and have been continuously receiving nursing facility care for a minimum of 90 days prior to admission; or
 - ii. Are receiving care in a small health care facility (Type N) and have been continuously receiving Type N facility care for a minimum of 365 days prior to application; or
 - iii. Are receiving licensed assisted living facility care and have been continuously receiving assisted living facility care for a minimum or 365 days prior to application; or
 - iv. Are receiving Medicare or Medicaid reimbursed care in another type of licensed Utah medical institution that is not an institution for mental disease (IMD) on an extended stay of at least 30 days, and will discharge to a Medicaid reimbursed nursing facility for an extended stay of at least 60 days absent enrollment into the waiver program; or
 - v. Are receiving Medicaid reimbursed services through another of Utah's 1915(c) HCBS waivers and have been identified in need of immediate (or near immediate) nursing facility placement absent enrollment into the New Choices Waiver program; or
 - vi. Have previously been enrolled in the New Choices Waiver but were disenrolled from the waiver due to a long term nursing facility admission or due to receipt of a lump sum payment or other financial settlement that resulted in loss of Medicaid financial eligibility. This re-entry after disenrollment is permitted only when there has been no interruption in services equivalent to nursing facility care including equivalent waiver services (paid privately or by another funding source) during the disenrollment period. A new nursing facility level of care assessment is required prior to readmission.

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- *For individuals leaving acute care hospitals, specialty hospitals (non IMD), and Medicare skilled nursing facilities, participation is limited to those receiving a medical, non-psychiatric level of care.*
- *Individuals whose primary condition is attributable to a mental illness are not eligible for participation in the New Choices Waiver.*
- *Individuals who meet the intensive skilled level of care as defined in R414-502 are not eligible for participation in the New Choices Waiver.*
- *Individuals who meet the level of care criteria for admission to an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID) as defined in R414-502 are not eligible for participation in the New Choices Waiver.*

2-2 Nursing Facility Level of Care

1. In determining whether the applicant has mental or physical conditions that can only be cared for in a nursing facility or the equivalent care provided through the New Choices Waiver program, the individual responsible for assessing level of care shall, in accordance with R414-502, document that at least two of the following factors exist:
 - A. Due to diagnosed medical conditions, the individual requires substantial physical assistance with activities of daily living above the level of verbal prompting, supervision, or setting up;
 - B. The attending physician has determined that the individual's level of dysfunction in orientation to person, place, or time requires nursing facility care, or equivalent care provided through a Medicaid home and community-based waiver program; or
 - C. The medical condition and intensity of services indicate that the care needs of the applicant cannot be safely met in a less structured setting, or without the services and supports of a Medicaid home and community-based waiver program.
2. An individual will not be enrolled if it is determined during the eligibility assessment process that the person does not meet the nursing facility level of care criteria or that the health, welfare, and safety of the individual cannot be maintained through the New Choices Waiver program.
3. Individuals who are actively receiving inpatient care in hospitals, nursing facilities, or other licensed Utah medical institutions are not eligible to receive waiver services during the time of their inpatient admission, except as permitted for case management services in two specific circumstances:
 - A. Up to 180 days immediately prior to waiver enrollment for discharge planning case management activities, or
 - B. When an enrolled waiver participant has been admitted to an inpatient setting for temporary care.

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4. All waiver participants must be initially and continuously assessed to meet nursing facility level of care in order to maintain waiver eligibility.

3 NEW CHOICES WAIVER ADMISSION PROCESS

3-1 Application and Assessment

The NCW program office within the Department of Health, Division of Medicaid and Health Financing is the designated entity authorized to receive applications and to perform all screening and intake functions for the NCW program. An application can be requested by calling the NCW program office at (801)538-6155, option 6 or toll free at (800)662-9651, option 6.

There are two different application processes for the NCW program. The process that applies to a particular application is determined by the type of facility the individual is residing in when they submit their application to the NCW program office.

1. For people residing in nursing facilities or other Utah licensed medical institutions (non-IMD):
 - A. Applications will be accepted from those living in nursing facilities or other Utah licensed medical institutions (non-IMD) who meet the minimum eligibility requirements listed in Section 2-1. Applications will be accepted at any time throughout the year until the CMS approved waiver enrollment cap is reached.
 - B. Upon receipt of an application, the NCW program office will perform an initial screening of the application materials to determine if the following minimum eligibility criteria appear to be met:
 - i. The application is complete,
 - ii. The applicant is at least 18 years of age,
 - iii. The applicant has Utah Medicaid financial eligibility in place,
 - iv. The applicant is residing in a qualifying facility type as described in Section 2-1,
 - v. The applicant has satisfied the applicable length of stay requirement in the facility type in which they reside as described in Section 2-1,
 - vi. The applicant has had nursing facility level of care approved through the nursing facility admission process or has supplied medical records sufficient to pass an initial nursing facility level of care screening, and
 - vii. The PASRR determination letter (if applicable) indicates that the applicant is approved for long term nursing facility care.
 - C. If during the screening process any of these minimum criteria are not met, the NCW program office will halt the application process and a denial letter will be generated and sent to the applicant and/or their representative. Hearing rights will be provided.
 - D. If the minimum screening criteria are met, the NCW program office will forward a referral to the waiver case management agency that was selected by the applicant or their representative on the Freedom of Choice Consent Form.

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- E. A registered nurse or licensed physician from the selected case management agency will formally confirm that the nursing facility level of care criteria is met by performing a thorough face to face assessment utilizing the MDS-HC. The deadline for completion of this assessment is within fourteen (14) calendar days of receiving the referral.
 - F. Upon completion of the MDS-HC assessment, the case management agency must complete and submit a Level of Care Determination Form to the NCW program office, indicating whether or not the nursing facility level of care criteria is met. This form is due within one business day following completion of the MDS-HC assessment.
 - G. A licensed social worker and a registered nurse from the case management agency will work with the applicant and any other representatives chosen by the applicant to understand the applicant's strengths, preferences, goals, desires, social needs, support systems, and risk factors.
2. For people residing in licensed assisted living facilities or small health care facilities (Type N), the following application process applies:
- A. Applications will be accepted from those living in licensed assisted living facilities and small health care facilities (Type N) who meet the eligibility requirements listed in Section 2-1.
 - B. Applications will only be accepted during three defined open application periods each year and a limited number of applicants will be processed during each application period. For more information about the tri-annual open application process, refer to Section 3-4 Selection of Entrants to the Waiver.
 - C. Open application periods are as follows:
 - i. July 1 – July 14
 - ii. November 1 – November 14
 - iii. March 1 – March 14
 - D. Upon receipt of an application during the open application period, the NCW program office will perform an initial screening of the application materials to determine if the following minimum eligibility criteria appear to be met:
 - i. The application is complete by the end of the open application period,
 - ii. The application has an official date stamp with a date that falls within the open application period in which it is submitted,
 - iii. The applicant is at least 18 years of age by the end of the open application period,
 - iv. The applicant has Utah Medicaid financial eligibility in place OR has submitted an application to the Department of Workforce Services (DWS) for consideration of Medicaid financial eligibility,
 - v. The applicant is residing in a qualifying facility type as described in Section 2-1,
 - vi. By the end of the open application period, the applicant has satisfied the applicable length of stay requirement in the facility type in which they reside as described in Section 2-1, and
 - vii. The applicant has supplied medical records sufficient to pass an initial nursing facility level of care screening.
 - E. If during the screening process any of these minimum criteria are not met, the NCW program office will halt the application process and a denial letter will be generated and sent to the applicant and/or their representative. Hearing rights will be provided.
 - F. Applications meeting the minimum criteria above will be collected throughout the open application period. At the end of the open application period, the NCW program office will

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determine which of the applicants will proceed to the next step in the application process by following the guidelines found in Section 3-4, Selection of Entrants to the Waiver.

- G. Selected applications will be forwarded to the waiver case management agency that was chosen by the applicant or their representative on the Freedom of Choice Consent Form. Applications not selected will be returned and the applicant or representative will be provided with hearing rights.
- H. A registered nurse or licensed physician from the selected case management agency will formally confirm that the nursing facility level of care criteria is met by performing a thorough face to face assessment utilizing the MDS-HC. The deadline for completion of this assessment is within fourteen (14) calendar days of receiving the referral.
- I. Upon completion of the MDS-HC assessment, the case management agency must complete and submit a Level of Care Determination Form to the NCW program office, indicating whether or not the nursing facility level of care criteria is met. This form is due within one business day following completion of the MDS-HC assessment.
- J. A licensed social worker and the registered nurse from the case management agency will work with the applicant and any other representatives chosen by the applicant to understand the applicant's strengths, preferences, goals, desires social needs, support systems, and risk factors.

3-2 Case Management Agency Notices of Decision

1. Within one business day after completion of the comprehensive needs assessment (MDS-HC), the selected case management agency will send a written notice of decision to the applicant/representative and to the NCW program office. The notice will clearly state the case management agency's decision to accept or decline to provide case management services to an applicant. This notice will include contact information for the NCW program office should the applicant or their representative wish to discuss their options.
2. If an applicant is declined by a case management agency, this does not always mean that the applicant will be denied access to the New Choices Waiver program altogether. In certain circumstances, an applicant/representative may request that their application be forwarded to an alternate case management agency for consideration, if there is another case management agency operating in their county of residence. These requests are managed by contacting the NCW program office.
3. If an applicant is declined by a case management agency for either of the following reasons, the NCW program office will perform a review of the decision and any supporting documentation:
 - A. The case management agency determined that the applicant did not meet nursing facility level of care during the face to face comprehensive assessment process; or
 - B. The face-to-face comprehensive assessment indicated that the applicant's needs exceeded the NCW program's ability to safely serve them.

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4. If the case management agency declines an applicant for either of the two reasons listed above, the case management agency will forward the assessment information to the NCW program office for review. If the NCW program office agrees with the case management agency's determination, the NCW program office will generate and send a denial letter to the applicant/representative denying access to the waiver program altogether. Hearing rights will be provided. If the NCW program office does not agree with the case management agency's determination, the application can be forwarded to another agency of the applicant's choice if another case management agency is available in the applicant's service area.
5. Case management services are required for all participants in the New Choices Waiver program. An eligible applicant who has been declined by every available case management agency in their service area cannot be enrolled on the New Choices Waiver until a case management agency willing to provide services is available. The NCW program office will assist the applicant by identifying all available case management agencies in their service area and by facilitating completion of new Freedom of Choice Consent Forms and referrals to alternate agencies until a willing case management agency is identified or until all possible choices have been exhausted. At the point there are no willing case management agencies, the NCW program office will generate and send a denial letter to the applicant/representative. Hearing rights will be provided.

3-3 Enrollment

1. Once a case management agency has determined that the applicant meets the nursing facility level of care criteria and makes the decision to work with an applicant, they will begin working toward official waiver enrollment. There are two distinct enrollment processes for the NCW program and the process that a particular application goes through is determined by the type of facility they reside in when they submitted their NCW application.
 - A. For applicants residing in nursing facilities or licensed Utah medical institutions (non-IMD):
 - a. The case management agency will assist the applicant to locate a community-based residence that will meet the applicant's needs, preferences, goals and resources. This residence can be the applicant's own home or apartment, the home or apartment of a friend or family member, or an assisted living facility or independent living facility that is enrolled as a provider for the New Choices Waiver program.
 - b. If the applicant needs assistance, the case management agency will help with negotiating a rental agreement for the chosen location. When the rental agreement is completed and signed by all parties, the case management agency must submit it to the NCW program office.
 - c. The NCW program office cannot coordinate NCW enrollment with DWS until the Level of Care Determination Form and a signed rental agreement are received from the case management agency. Both of these items must be sent to the NCW program office by 12:00 noon on the 20th day of the month (or on the last State business day prior to the 20th of the month) in order for official enrollment to take place by the first of the following month.
 - d. When the LOC Determination Form and signed rental agreement are received, the NCW program office will generate and send the 927 form, the signed rental agreement and the

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signed release of information form to the Long Term Care team at the Department of Workforce Services for a separate determination of Medicaid financial eligibility.

- e. Once the approval or denial of Medicaid financial eligibility is determined, DWS will complete and sign section B of the 927 and return it to the NCW program office prior to the last day of the month.
 - f. The NCW program office will notify the case management agency of the Medicaid financial eligibility determination and the applicant's authorization to enroll with the New Choices Waiver upon receipt of an approved 927. The case management agency will notify the applicant and begin planning for the applicant's transition to the NCW program. All enrollments take place on the first day of the month following the completion of the 927 form.
 - g. The final phase in the enrollment process is creation of the person centered comprehensive care plan which must be written within 60 days after completion of the MDS-HC assessment. If the care plan cannot be created within 60 days, a new MDS-HC must be performed and services cannot be authorized until on or within 60 days after the new MDS-HC date. Care plan start dates can fall anytime within the 60-day window, but never earlier than the date the MDS-HC was performed.
- B. For applicants residing in licensed assisted living facilities and small health care (Type N) facilities:
- a. Individuals applying from licensed assisted living or small health care (Type N) facilities are not required to have Medicaid financial eligibility in place at the time of application to the NCW program, but the NCW program office will verify in the screening process that at a minimum, the applicant has submitted a Medicaid financial eligibility application to DWS.
 - b. The NCW program office cannot coordinate with DWS until the LOC Determination Form is received. A rental agreement is not needed at this stage, nor is there a defined deadline day for the LOC Determination Form to be submitted. However, case management agencies are still required to send the LOC Determination Form within one business day of completion of the MDS-HC assessment.
 - c. Upon receipt of the LOC Determination Form from the case management agency, the NCW program office will generate and send the 927 form, a copy of the Pre-enrollment Lease Disclosure Form and signed releases to DWS. The NCW program office may act as a facilitator between the applicant and DWS while DWS determines the applicant's Medicaid financial eligibility in a separate application process.
 - d. Once the approval or denial of Medicaid financial eligibility is determined, DWS will complete and sign section B of the 927 and return it to the NCW program office.
 - e. The NCW program office will notify the case management agency of the financial eligibility determination upon receipt of the 927 form from DWS. If the 927 was approved, the case management agency will assist the applicant with locating a new residence (when applicable), negotiating a new rental agreement and coordinating the start date for waiver services. The case management agency will forward the rental agreement to the NCW program office as soon as it is completed and signed.
 - f. The final phase in the enrollment process is creation of the person centered care plan which must be written within 60 days after completion of the MDS-HC assessment. If the care plan cannot be created within 60 days, a new MDS-HC must be performed and services cannot be authorized until on or within 60 days after the new MDS-HC date. Care plan start dates can

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fall anytime within the 60-day window, but never earlier than the date the MDS-HC was performed.

2. Summary of ultimate requirements that must be completed in full to receive waiver services:

- A. Approval of Medicaid financial eligibility in a separate application process with DWS.
- B. Confirmation that the applicant meets nursing facility level of care criteria based on a face to face MDS-HC assessment by the chosen waiver case management agency.
- C. Development and approval of a waiver comprehensive care plan. The comprehensive care plan must be created within 60 days of the date the MDS-HC assessment was completed. The start date of services on the care plan can fall anytime within the 60-day window, but can be no earlier than the date of the MDS-HC assessment.

3. Reserved Waiver Capacity

The New Choices Waiver program was designed to be a deinstitutionalization program with the original objective being to offer home and community-based options for people wishing to transition out of nursing facilities and Utah licensed medical institutions (non-IMD). In 2012, the waiver was expanded to include a second entry pathway for long term residents of licensed assisted living facilities. In order to ensure the majority of waiver slots are reserved for people wishing to transition out of nursing facilities or other Utah licensed medical institutions (non-IMD), each state fiscal year a minimum of 80% of available waiver slots will be reserved for applicants residing in nursing facilities or other Utah licensed medical institutions (non-IMD).

4. Selection of Entrants to the Waiver

At the beginning of each waiver year (July 1), the NCW program will calculate the total number of available waiver slots. A minimum of 80% of the total number of available waiver slots will be reserved for residents of nursing facilities and other Utah licensed medical institutions (non-IMD).

For applicants residing in nursing facilities or other Utah licensed medical institutions (non-IMD), no selection policies apply beyond the eligibility criteria described in Policy 2-1, Eligibility for Waiver Program. For this group, applications will be not be limited to defined open application periods.

For applicants residing in licensed assisted living facilities or small health care facilities (Type N), the following selection process will be followed:

- A. During three defined open application periods each year, the NCW program will enroll up to 1/3 of the calculated number of available waiver slots that could be filled by people applying from assisted living facilities or small health care facilities (Type N). Each open application period will be 14 days long during which applications will be accepted from all interested assisted living facility or small health care facility (Type N) residents.
- B. Complete applications must be received with an official date stamp that falls within the date range of the open application period. Applications that remain incomplete when the open application

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period ends and applications that do not meet the initial screening criteria listed above will be returned and hearing rights will be provided.

- C. If the number of applications received during an open application period is equal to or less than the number of slots available during that application period, all applications received meeting the minimum screening criteria above will be processed to the next step in the application process.
- D. If more applications are received than there is space available for a particular application period, the NCW program office will rank applicants based on length of stay. (Applicants who have been residing in a qualifying facility type the longest will be given preference.) When this ranking has been completed, the NCW program office will return all applications above the number of available slots for that application period and hearing rights will be provided. The NCW program office will not maintain a waiting list.
- E. In the event there is a length of stay tie at the cut-off point, all applications in the tie meeting the minimum screening criteria will be processed to the next step in the application process. The number of applications accepted above the number of available slots for that open application period will be deducted from the number of applications permitted in the next open application period.
- F. During any of the open application periods, if any of the applicants selected to be processed further end up not qualifying for enrollment or withdraw their application, these slots will not carry over to the next open application period and can be filled by applicants residing in nursing facilities or other Utah licensed medical institutions (non-IMD).

4 Applicant Freedom of Choice of Nursing Facility or New Choices Waiver

1. The New Choices Waiver program is a voluntary home and community-based program that's intended to be one option among others in the range of long term care services. Utah Medicaid recipients meeting the nursing facility level of care criteria and all other New Choices Waiver criteria are afforded the choice of which long term care service delivery system they would like to access. Prior to enrollment in the New Choices Waiver, applicants are advised of their right to choose to receive care provided in a nursing facility (NF) or they may choose to receive services through the New Choices Waiver program.
2. As part of the application packet, the applicant and/or their chosen representative will be advised in writing of all available services and given the opportunity to state which long term care service delivery option they choose to access. The applicant's choice will be documented in writing on the Freedom of Choice Consent Form, signed by the applicant or their representative, and maintained as part of the individual record. A member of the NCW program office staff will verify that this form has been completed and that the applicant has chosen to receive home and community-based services through the New Choices Waiver program before processing the application to the next step in the process.

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3. New Choices Waiver participants are reminded at least annually during their annual comprehensive care plan review that they maintain the right to choose which long term care service delivery option they wish to access and that they have the right to voluntarily disenroll from the New Choices Waiver and enter a nursing facility at any time.

4-1 Participant’s Freedom of Choice of Providers

Each NCW participant will be presented with a Freedom of Choice of Providers form that clearly lists all available services and service providers in their county of residence. The participant will indicate in writing his or her choice of waiver service providers for the services they have been assessed to need and will sign the form to acknowledge that they were given a choice. The case management agency will be responsible for presenting this form and offering choice of providers each time a new service is added to the care plan, anytime the participant requests a different provider, and at each annual care plan review. The case management agency will maintain signed copies of this form in the individual case records.

Freedom of Choice and Conflict Free Case Management

1. Case management services are expected to be provided without conflict of interest. During the care planning process, case managers must counsel their clients and their representatives in this area and assist them to fill out the Conflict Free Case Management Disclosure Form. This form must be completed upon initial enrollment, any time there is a change to the individual case managers that have been assigned to the participant’s case, and at every annual care plan review. During this process if any conflicts of interest are identified, a new case manager and/or a new case management agency must be selected.
2. If a case management agency is enrolled with NCW to provide other waiver services in addition to case management services, they must pay careful attention to conflict of interest rules during the care plan development process. Case management agencies are not permitted to be listed on a participant’s care plan as a provider for any other waiver or non-waiver service except in the following circumstances:
 - A. If a participant has been assessed to need any of the following NCW services and the participant has been provided with a Freedom of Choice Consent Form and has freely selected their case management agency to be the provider of the service(s) without influence, the case management agency is permitted to be listed on the care plan as the provider for the service(s):
 - i. Specialized Medical Equipment and Supplies (T2029)
 - ii. Assistive Technology Devices (T2028)
 - iii. Environmental Accessibility Adaptations (S5165 and T2039)
 - iv. Community Transition Services (T2038)
 - v. Home Delivered Meals (S5170)
 - vi. Transportation- non medical – Public Transit Pass (T2004)

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- B. If it has been determined that the case management agency is the only available provider enrolled to offer other waiver or non-waiver services in a particular geographical region, an exception can be made to permit the participant to select the case management agency as their provider for the other services. The case management agency must provide justification to the NCW program office during the care plan submission process and the NCW program office will perform an analysis to determine whether or not it is appropriate to override the conflict of interest rules.

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

1. When the need arises, participants are separated from the Home and Community Based waiver program through a disenrollment process.
 - A. The disenrollment process is a coordinated effort between NCW staff and case management agencies that are expected to facilitate the following:
 - a. Verification that the disenrollment is appropriate for the waiver participant;
 - b. Movement among waiver programs (when applicable);
 - c. Ensuring effective utilization of waiver program services;
 - d. Effective discharge and transition planning;
 - e. Distribution of information to participants describing all applicable waiver rights; and
 - f. Program quality assurance.

2. All of the various circumstances for which it is permissible for individuals to be disenrolled from the waiver program can be grouped into three distinct disenrollment categories.
 - A. Voluntary disenrollments are cases in which 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 NCW within 10 days from the date of disenrollment. No NCW 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 participants are involuntarily disenrolled from the waiver for any of the following reasons including:

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- a. Death of the Participant;
- b. Participant has been determined to no longer meet the financial requirements for Medicaid program eligibility by the Department of Workforce Services;
- c. Participant enters a skilled nursing facility, and the expected length of stay will exceed 90 days (as verified by a physician).

Pre-Approved involuntary disenrollments require that case managers notify NCW 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 NCW and a second level approval by the BACBS Quality Assurance Unit. Examples of this type of disenrollment include:
 - a. Participant no longer meets the level of care requirements for the Waiver;
 - b. Participant's health and safety needs cannot be met by the Waiver program's services and supports;
 - c. 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;
 - d. Participant has demonstrated non-compliance with a signed health and safety agreement with NCW or the case management agency; or
 - e. Participant's whereabouts are unknown for more than 30 days, and a decision regarding ongoing financial eligibility from the Department of Workforce Services has not been rendered.

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

- A. The case management agency shall compile information to articulate the disenrollment rationale;
- B. This information will then be submitted to NCW for review of the support coordination activities, as well as the disenrollment recommendation;
- C. If NCWS staff concurs with the recommendation, a request for disenrollment approval will be forwarded to the BACBS Quality Assurance Unit for a final decision;
- D. The BACBS 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;
- E. NCW and/or the BACBS 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
- F. The BACBS Quality Assurance Unit will communicate a final disenrollment decision to the NCW.

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

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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.

4-3 Grievances and Appeals

At any time for any reason, waiver applicants, waiver participants and/or their chosen representatives may file a grievance or complaint with their case management agency, the NCW program or with the Constituent Services Office within the Division of Medicaid and Health Financing. Contact information for each of these entities is provided in Section 14 (Contact Information).

1. If a waiver applicant, a waiver participant or their chosen representatives disagree with a decision that has been made regarding their NCW application or regarding their services, providers or any other aspect of their care, they may elect to engage in an informal dispute resolution process by contacting the NCW program.
2. The Division of Medicaid and Health Financing provides an opportunity for a formal Medicaid Fair Hearing upon written request, if an individual is:
 - A. Not given the choice of institutional (NF) care or HCBS waiver services;
 - B. Denied the waiver provider(s) of choice if more than one provider is available to provide the service(s);
 - C. Denied access to the waiver program or to waiver services identified as necessary to prevent institutionalization or given services that are insufficient in amount, duration or frequency to meet the identified need; or
 - D. Experiences a reduction, suspension, or termination of waiver services identified as necessary to prevent institutionalization.
3. The NCW program office will notify the applicant/participant and/or their chosen representative with a Notice of Decision (NOD) if any of the above decisions are made. The NOD will provide instructions for how to request a Medicaid Fair Hearing.
4. A participant who believes they have been wrongly denied choice of services or access to services or providers may request a formal hearing within 30 calendar days from the date written notice is issued or mailed, whichever is later. The participant may elect to continue their waiver services if the participant or provider requests a formal hearing within 10 calendar days after the date of action.
5. The participant is encouraged to use an informal dispute resolution process to bring about a fair solution more quickly but may choose not to use or interrupt the available informal resolution process

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at any time by completing a request for hearing and directing the request be sent to the Division of Medicaid and Health Financing for a formal hearing and determination.

6. An informal dispute resolution process does not change the requirements of the formal fair hearings process. The individual must still file a request for hearing and a request for services to continue within the mandatory time frames established by the Division of Medicaid and Health Financing.

5 PROVIDER PARTICIPATION

5-1 Provider Enrollment

1. Home and community-based waiver services for New Choices Waiver participants are covered benefits only when delivered by a provider enrolled with the State Medicaid Agency to provide the services as part of the NCW program and that are authorized by each participant's chosen case management agency in an approved comprehensive care plan.
2. Any willing provider that meets the qualifications defined in the New Choices Waiver Implementation Plan, Appendix C-2, may enroll at any time to provide a New Choices Waiver service by contacting the NCW program office. The NCW program office will facilitate completion and submission of the required Medicaid provider application. The provider is only authorized to provide the waiver services specified and approved in Attachment A of the Medicaid provider agreement and authorized by a New Choices Waiver case management agency representative in an approved comprehensive care plan

5-2 Provider Reimbursement

1. A unique provider number is issued for each waiver service provider. When submitting claims for reimbursement, the provider must use the proper provider number associated with the waiver that the waiver participant is enrolled in. Claims containing a provider number that is not associated with the proper waiver will be denied.
2. Providers will be reimbursed according to the specified reimbursement rate(s). Units of service must be billed in whole units even if the service was provided for only part of the amount of time specified in the unit definition.
3. Providers may only claim Medicaid reimbursement for services that are ordered by the responsible New Choices Waiver case management agency and for which the provider has a current, signed service authorization form for the individual participant for whom the service is authorized. Service authorizations are valid for a maximum of one year, and must be reissued yearly or when there is a change in the service type, amount, frequency, end date of an existing service or a new service is

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started. The case management agency will supply the service provider with a service authorization form clearly identifying the New Choices Waiver participant, the service requested, the HCPCS billing code, the amount and frequency of the service ordered and the start and end date of the service. Claims must be consistent with the authorized participant, and the amount, frequency and dates ordered by the waiver case management agency in order to be paid. Any services provided that exceed the amount, frequency or dates authorized, or for which there is no current service authorization form will not be reimbursed.

4. With the exception of permitted case management services, providers may not provide services to participants who have been admitted to an inpatient setting.
5. 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 New Choices Waiver State Implementation Plan.
6. Accurate records of each service encounter must be kept by each provider and made available upon request by the NCW program office or any other unit within the Division of Medicaid and Health Financing. Records should include at a minimum:
 - A. The participant's first and last name
 - B. The date of service for each service encounter
 - C. The start and end times for each service encounter
 - D. The service provided (by service title)
 - E. Notes describing the service encounter in detail
 - F. The name(s) of the individual direct service provider(s) who performed the service
 - G. Signature(s) of the individual direct service provider(s)
7. The following are examples of circumstances that are not reimbursable by Medicaid. This is not an all-inclusive list:
 - A. If a waiver participant misses a scheduled appointment, Medicaid cannot be billed for the missed appointment even if the participant did not abide by the provider's cancellation policy. The provider can bill the individual directly for a missed appointment only if it is part of the provider's policy to bill all clients for missed appointments, not just Medicaid recipients. If the provider has such a policy, they are responsible to notify the participant of this policy prior to providing services to the individual.
 - B. Services provided to a NCW participant who was not authorized to receive the service cannot be billed to Medicaid.
 - C. Unused units that have been authorized for one waiver participant cannot be transferred to another waiver participant. If a provider believes that a participant requires more units of service than are authorized on the service authorization form, the provider must contact the assigned case management agency to request an assessment of need.
 - D. Claims submitted for services that were not rendered to the participant are not reimbursable, even if there are unused units remaining.

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E. Any claims paid for services in excess of the amount, duration or frequency listed on the approved care plan or for services that are not listed on the approved care plan for the specific participant will be recovered.

8. Providers are accountable for all terms of agreements as defined in the Utah Department of Health, Division of Medicaid and Health Financing Provider Agreement, which was signed upon enrollment with the New Choices Waiver.

5-3 Standards of Service

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 secure 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.

Breach Reporting/Data Loss

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

5-4 Provider Rights to a Fair Hearing

The Department provides hearing rights to providers who have had any adverse action taken by the Bureau of Authorization and Community-based Services, Division of Medicaid and Health Financing, Utah Department of Health, who submit a written request for a hearing to the agency. Please refer to Utah Department of Health, Division of Medicaid and Health Financing Provider Manual, General Information, Section 1, Chapter 6 – 15, Administrative Review/Fair Hearing. This includes actions relating to enrollment as a waiver provider, contract reimbursement rates, sanctions or other adverse actions related to provider performance, or improper conduct of the agency in performing delegated waiver responsibilities.

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6 AUTHORIZATION OF WAIVER SERVICES

All waiver services must be approved by the NCW program office in order to be eligible for payment. The selected case management agency will submit the individual comprehensive care plan to the NCW program office for review and the approval by an authorized NCW program office representative will constitute prior approval. The case management agency will provide the selected NCW service provider(s) with a New Choices Waiver Adult Residential Services Provider Authorization Form or a New Choices Waiver Service Authorization Form, as applicable. The service authorization form clearly identifies participant's name, Medicaid number, service start and end date, approved waiver service(s), approved number of service units, approved frequency of service and HCPCS code. Units listed on the service authorization form may not exceed units approved by the NCW program office. Any services provided in excess of approved annualized aggregate amounts are not billable to Medicaid. Any paid claims in excess of approved amounts or for services not listed on the approved care plan will be recovered.

7 MDS-HC ASSESSMENT INSTRUMENT / LEVEL OF CARE

The Inter RAI MINIMUM DATA SET - HOME CARE (MDS-HC) is the standard comprehensive assessment instrument used in the New Choices Waiver. It includes all the data fields necessary to measure the participant's level of care as defined in the State's Medicaid nursing facility admission criteria. Registered nurses or licensed physicians are responsible for collecting the needed information and for making the level of care determinations. Assessors must be trained by staff of the NCW program office in the proper application of the MDS-HC instrument and the proper analysis of the MDS-HC data to perform level of care evaluations.

Following completion of the MDS-HC assessment, case management agencies must complete and submit the Level of Care Determination Form and submit it to the NCW program office. The information listed on the Level of Care Determination Form is expected to accurately summarize the findings of the comprehensive MDS-HC assessment.

7-1 Case Management Definition and Scope of Service

Case Management Services are services that assist participants in gaining access to needed waiver services and Medicaid State Plan services, as well as needed medical, social, educational, and other services, regardless of the funding source. Case management consists of the following activities:

1. Complete the initial comprehensive assessment and periodic reassessments to determine the services and supports required by the participant to prevent unnecessary institutionalization;
2. Perform reevaluations of participants' level of care;
3. Complete the initial comprehensive care plan and periodic updates to maximize the participant's strengths while supporting and addressing the identified preferences, goals and needs;

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4. Research the availability of non-Medicaid resources needed by an individual to address needs identified through the comprehensive assessment process and assist the individual in gaining access to these resources;
5. Assist the individual to gain access to available Medicaid State Plan services necessary to address identified needs;
6. Assist the individual to select from available choices, an array of waiver services to address the identified needs and assist the individual to select from the available choice of providers to deliver each of the waiver services including assisting with locating an appropriate home and community-based setting and assisting with negotiation of a rental agreement when needed;
7. Assist the individual to request a fair hearing if choice of waiver services or providers is denied, if services are reduced, terminated or suspended, or if the participant is disenrolled;
8. Monitor to assure the provision and quality of services identified in the individual's care plan;
9. Support the individual/legal representative/family to independently obtain access to services when other funding sources are available;
10. Monitor on an ongoing basis the individual's health and safety status and investigate critical incidents when they occur. At least one (1) telephone or face-to-face contact directly with the waiver participant is required each month and a minimum of one (1) face to face contact with the participant is required every 90 days. When meaningful telephone contact cannot be achieved due to a participant's diminished mental capacity or inability to communicate by phone, in-person contact must be made with the participant monthly;
11. Coordinate across Medicaid programs to achieve a holistic approach to care;
12. Provide case management and transition planning services up to 180 days immediately prior to the date an individual transitions to the waiver program;
13. Provide safe and orderly discharge planning services to an individual disenrolling from the waiver;
14. Perform internal quality assurance activities, addressing all performance measures.
15. Monitor participant medication regimens.

Direct services not included in the list above are not reimbursable under case management. (Examples of non-reimbursable services: transporting clients, directly assisting with packing and/or moving, personal budget assistance, shopping, and any other direct service that is not in line with the approved case management service description.)

In order to facilitate transition, case management services may be furnished up to 180 days prior to transition and providers may bill for this service once the participant enters into the waiver program.

15 units per month or less is the expected typical case management utilization pattern. Plans that include utilization of 16 units or greater will require submission of additional documentation to justify the need for additional services. Plans that include utilization of 26 units or greater will require a second level review by the NCW program office supervisor prior to approval.

Case management agencies may not assign individual case managers to serve a waiver participant when any one or more of the following scenarios exist:

1. The case manager is related to the waiver participant by blood or by marriage,
2. The case manager is related to any of the waiver participant's paid caregivers by blood or by marriage,
3. The case manager is financially responsible for the waiver participant, or

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4. The case manager is empowered to make financial or health-related decisions on behalf of the individual.

Except in remote geographical areas of the state when there are no other case management agency providers available causing an access to care problem, providers who enroll to provide any one or more of the following services for New Choices Waiver are not permitted to be case management providers for New Choices Waiver:

1. Adult residential services,
2. Non-medical transportation services (except for monthly public transit passes),
3. Financial management services,
4. Attendant care services,
5. Respite care services, and
6. Adult day health services.

7-2 Participant – Centered Care Planning

As a component of the NCW application process, each applicant or designated representative will be provided with a list of rights and responsibilities, including protections related to abuse, neglect and exploitation.

Furthermore, during the assessment and care planning process, the waiver case management agency will review participant rights and responsibilities with each participant and/or their representative and will provide avenues through which to notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation. Each participant and/or representative will be provided with a copy of their rights and responsibilities and with contact information to notify appropriate authorities or entities.

The care plan is driven by the NCW participant. It is developed based upon the assessed needs, strengths, goals, preferences and desired outcomes of the participant. The participant, representative, primary paid care givers, the participant’s case management agency and any other individuals of the waiver participant’s choosing including family, friends and/or other caregivers are involved throughout the assessment and planning process and work together as a Person Centered Care Planning (PCCP) team. The case management agency completes the formal assessment process along with the PCCP team and the results are shared with all parties included in this process. The participant or legal representative will be advised of any needs identified during the assessment process and given the opportunity to accept or decline services that would address those needs.

Risk Assessment and Mitigation

The plan will identify the assessed risks while considering the participant’s right to assume some degree of personal risk, and will include resources and/or measures available to reduce risks or identify alternate ways to achieve personal goals.

During the care planning process it is the responsibility of the case manager to monitor for non-compliant HCBS settings as well as to document any human rights restrictions which apply to the participant. This documentation must include information on the restriction, why it is being used, what lesser intrusive

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methods were tried previously (and why they were insufficient to maintain the health and safety of the individual) and a plan to phase-out the use of the intervention/restriction (if possible).

Care Plan Development Timeframe Requirements

1. The case management agency will work with the participant to develop a comprehensive care plan to address the participant's identified needs, goals, preferences and desired outcomes within sixty (60) days of completing an initial MDS-HC and LOC prior to enrollment, and within thirty one (31) days of completing an annual or significant change MDS-HC and Level of Care while enrolled.
2. The start date for wavier services becomes the effective date of the care plan. This date is permitted to fall anytime within the 60 or 31 day range listed above, even if the effective date is retroactive. Under no circumstances can the start date be prior to the date of the MDS-HC assessment date or after the 60 or 31 day range expires.
3. The initial comprehensive care plan cannot be created until all other eligibility criteria for enrollment has been met (including Medicaid financial eligibility). If any of the eligibility criteria remains unmet after the first 60 day MDS-HC assessment window, a new MDS-HC assessment must be performed and waiver services cannot begin until on or within sixty (60) days of the new assessment date. This cycle repeats as each 60 day range passes until full NCW enrollment criteria are met.

Other Care Planning Requirements

1. The case management agency and participant will review the contents of the care plant as part of the PCCP team and the case management agency will submit it to NCW program office for review and approval prior to implementation. The approval of the care plan by the NCW program office will constitute formal authorization to the case management agency of the services to be provided to the participant.
2. The comprehensive care plan will include a statement notifying the participant of their right to appeal to the State Medicaid Agency if they are denied their choice of service providers or if they are denied services that they believe they are eligible to receive. The participant must acknowledge receipt of the notice of decision and right to a fair hearing by signing the comprehensive care plan. The case management agency will be responsible for maintaining a written copy or electronic facsimiles of these plans of care for a minimum period of three years as required by 45 CFR 74.53.
3. The case management agency will review the list of authorized service providers with the participant and complete a Freedom of Choice form acknowledging the participant's selected service providers. The case management agency will maintain this form as part of the participant's records and update it in conjunction with the revision of the comprehensive care plan.
4. The case management agency will provide a service authorization form to the participant selected service providers in accordance with the approved comprehensive care plan. The service authorization form clearly identifies the participant's name, Medicaid number, service start and end date, approved waiver service, approved number of service units, approved frequency of service and HCPCS code. Units listed on the service authorization form may not exceed units approved by the NCW program office on the care plan. Service authorization forms will be updated in conjunction with the comprehensive care plan.

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Care Plan Reviews

The comprehensive care plan is updated at least annually with changes made throughout the year as needed based on the participant's changing needs, requests or based on a significant change in the client's status.

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

1. is not self-limiting;
2. impacts on more than one area of the participant's health status; and
3. requires interdisciplinary review and/or revision of the plan of care.

NOTE: A condition is defined as self-limiting when the condition will normally resolve itself without intervention by case management agency personnel. Generally, if the condition has not resolved within approximately two weeks, staff should begin a comprehensive reassessment.

A full care plan review and update is conducted:

1. When a significant change is consistently noted in two or more areas of decline or two or more areas of improvement,
2. Whenever indicated by the results of a health status change screening,
3. In conjunction with completion of a full comprehensive assessment,
4. At a minimum of annually (no later than by the end of the calendar month of the last care plan and no later than within 31 days of the annual MDS-HC).
5. Anytime during the plan year the waiver participant or the participant's representatives may also request updates or changes to the existing plan outside of annual reviews of the comprehensive care plan. These requests would be addressed directly with the case manager.

All revisions must be reviewed and approved by the NCW program office prior to implementation. The participant must be advised that they have the right to elect to receive services in a Medicaid NF in lieu of continued participation in the waiver.

Comprehensive Care Plan Unit Calculation

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

On an ongoing basis, the designated case management agency is responsible to monitor service utilization for each client for whom the case management agency created a comprehensive care plan. When the case management agency determines that the assessed service needs of a client exceed the amount that has been approved on that client's existing care plan, the case management agency should submit an amendment to increase the number of units to meet the need. Amendments must be made prior to the expiration of the care plan.

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

Providers may not exceed the annualized aggregate of all approved care plan units. Billing in excess of the approved number of units will be subject to recovery of funds by Medicaid.

7-3 Inpatient Hospitalization / Nursing Home Admission

1. Waiver case managers may continue to provide case management services to participants who have entered a nursing home or hospital for up to ninety (90) days after the participant has been admitted, if there is a reasonable expectation that the participant will be able to return to the community within that ninety (90) day time frame. A participant must be disenrolled from the waiver when it is determined that he/she will be in a hospital or nursing facility for greater than ninety (90) days. (See Section 4-2 for disenrollment procedures.)
 - A. HCPCS Code T2024 should be used to bill for any units of case management provided on dates of service in which a participant is an inpatient of a nursing facility or hospital.
2. Participants who have been disenrolled due to exceeding a ninety (90) day stay in a hospital or nursing facility may request to re-enroll upon stabilization of their medical condition,
 - A. If a former participant has remained in the nursing facility or hospital and has received continuous care, he or she may contact their case management agency directly and request a new evaluation without having to complete a new application. The case management agency must complete a full MDS-HC, LOC, rental agreement and comprehensive care plan and submit them to BACBS for approval prior to re-enrollment. Case management agencies must submit paperwork using the guidelines listed in Section 6, Authorization of Waiver Services.
 - B. If a former participant has been discharged from the nursing facility or hospital back to the community, he or she would be required to meet all eligibility requirements and submit a new application in order to be reconsidered for the waiver.
3. The New Choices Waiver cannot pay to hold a participant's room while the participant is away, including during admissions to a hospital or nursing facility.

7-4 Case Management Monitoring

1. Case management monitoring activities are based on the assessed need of the individual participant.
2. At a minimum, the case management agency must make at least one monthly contact directly with the participant either by telephone or in person.
 - A. If a participant's mental capacity or ability to communicate is diminished to the point of being unable to have meaningful telephone contact, a monthly face to face contact with the participant

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will become necessary in order to ensure that the participant's needs are being met. Additional collateral contacts with involved care providers and/or family members may also become necessary for effective monitoring.

3. If a participant is able to have meaningful telephone contact, the case management agency may deem it appropriate based on assessed need to have monthly contact with the participant by telephone. At a minimum, one face to face visit per quarter is required.
4. The case management agency will monitor to assure the provision and quality of services identified in the participant's care plan. This includes ensuring that services are being provided in the amount, frequency and duration ordered in the care plan.
5. The case management agency will monitor on an ongoing basis the participant's health and safety status and initiate appropriate reviews of service needs and care plans as necessary. Case notes should reflect any health or safety issues and activities toward resolution of those issues.
6. The case management agency should be notified any time a participant is away from an adult residential facility overnight.

During routine on-site visits to monitor quality of care, case managers observe residents in their daily environment and interview them to determine overall level of satisfaction with care and to determine whether any restraints, seclusions or other rights restrictions have occurred. Case management agencies are required to notify the NCW program office anytime a participant has been physically or chemically restrained or secluded in a facility, and the SMA is required to notify Licensing.

8 SELF-ADMINISTERED SERVICES

8-1 Definition and Employer Authority

1. Self-administered services (SAS) are a few of the array of services available through the New Choices Waiver that may be authorized to address the assessed needs of the participant. Self-administered services mean service delivery that is provided through a non-agency based provider to a participant who lives in his or her own home or the home of a family member. Participants receiving Adult Residential Services are not eligible for self-administered services. Under the self-administered method, the participant and/or their chosen designee hire individual employees to deliver a waiver service. The participant/participant designee is then responsible to perform the functions of supervising, hiring, assuring that employee qualifications are met, scheduling, assuring accuracy of timesheets, etc. of the individual employee.
2. The self-administered employer authority requires the waiver participant to use a Waiver Financial Management Services (FMS) Agent as an integral component of the waiver services to assist with managing the employer-related financial responsibilities associated with the employer-employee relationship. The Waiver Financial Management Services Agent is a person or organization that assists waiver participants and their representatives, when appropriate, in performing a number of

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employer-related tasks, without being considered the common law employers of the service providers. Tasks performed by the Waiver Financial Management Services Agent include documenting service provider’s qualifications, collecting service provider time records, preparing payroll for participants’ service providers, and withholding, filing, and depositing federal, state, and local employment taxes.

3. Participant employed service providers complete a time sheet for work performed. The participant confirms the accuracy of the time sheet, signs it, and forwards it to the Waiver Financial Management Services for processing. The Waiver Financial Management Agent files a claim for reimbursement through the Medicaid MMIS system and upon receipt of payment, completes the employer-related responsibilities, deducts the established administrative fee, and forwards payment directly to the service provider for the services documented on the time sheet.

8-2 Self- Administered Services Available to Qualified Participants

1. Self –administered services apply only to those participants with identified needs that the case manager has determined to qualify for one or more of the services listed below. These services are the only services available under the self-administered services method:
 - A. Attendant Care Services
 - B. Chore Services
 - C. Homemaker Services
 - D. Respite care – Hourly or Daily

The services listed above are also available through agency based providers.

8-3 Self- Administered Services Case Management Responsibilities

1. Follow all requirements in Attachment B – Special Provisions, Case Management Service Provider Responsibilities for the New Choices Waiver Program.
2. Determine that the participant or participant designee has the ability to understand the risks, rights and responsibilities of receiving services through the Self-Administered Services method and is able to participate in Self- Administered Services.
3. Inform the participant that he or she may choose a designee to assist in the administration of the participant’s services and the responsibilities as an employer. This designation is documented in the PARTICIPANT LETTER OF AGREEMENT.
4. Inform the participant of the ability to combine self-administered services with Agency-Based Services.

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8-4 Self-Administered Services Case Manager Packet

1. The self-administered services case manager packet is a three part packet which includes the instructions, forms and requirements necessary to initiate self-administered services. The case management agency keeps the case management packet and gives the participant and employee packets to the participant/participant designee to be completed and returned to the case management agency.

A. Case Manager Packet

- Case Manager Checklist
- Case Management Responsibilities
- Unit Allocation for Attendant Care
- Service Authorization Form

B. Participant Packet

- Employer Checklist
- Participant Letter of Agreement - requires participant/participant designee signature
- Back Up Service Plan – requires participant/participant designee and case manager signatures
- Utah Criminal History Record Review for Prospective Employees
- Employment Agreement Form –requires employee and participant/participant designee signatures
- New Choices Waiver Provider Code of Conduct – requires employee and participant/participant designee signatures
- Incident Reporting Protocol and Incident Reporting Form

In addition to this packet, the case management agency provides the participant with a packet for the selected FMS agency and a New Choices Waiver Participant Notebook to be used to keep records of the current care plan, employee information, signed agreements, financial management services forms, time sheets, back-up plan, training plans, Provider Code of Conduct and Incident Reporting Protocol.

C. Employee Packet

- Employee Checklist
- Utah Criminal History Record Review for Prospective Employee
- Employment Agreement Form
- State of Utah New Choices Waiver Code of Conduct (including signature page)
- Incident Reporting Protocol and Incident Reporting Form
- Social Security Card (copy)
- Driver License or other photo identification (copy)
- Form W-4
- Form I -9
- Direct Deposit Authorization Form (optional)

2. The case management agency retains completed copies of the following documents for their files:

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- Participant Letter of Agreement
- Back up Service Plan
- Utah Criminal History Record Review for Prospective Employees
- Employment Agreement Form
- New Choices Waiver Provider Code of Conduct, including signed signature page
- Documents required by the Financial Management Services Agency

3. The case management agency reviews the following documents with the participant/participant designee:
 - The requirements, rights and responsibilities of receiving self-administered services as outlined in the PARTICIPANT LETTER OF AGREEMENT.
 - The role and process of the Financial Management Services Agency and assist in the choice of available FMS Agencies.
 - In addition to the PARTICIPANT LETTER OF AGREEMENT, review all State Medicaid Agency documents and forms included in the Participant Packet

8-5 Self- Administered Services Care Planning

1. The case manager works with the participant/participant designee to determine the units of service appropriate to meet the identified service needs and discusses the care plan and service limits.
 - A. Assess the participant's need for Consumer Preparation Services.
 - B. If the participant is eligible for Attendant Care, use the Unit Allocation Form and instructions to assess the level of assistance required. Ensure participant has utilized Medicaid State Plan services to the extent available.
 - C. If the participant is eligible for Chore Services, ensure that no other household member or other entity is capable of performing, responsible to provide, or financially able to pay for the service. In the case of rental property, examine the lease to make sure no one else is responsible to provide Chore Services.
 - D. If the participant is eligible for Homemaker Services, ensure that the person normally responsible for homemaking is temporarily absent or unable to manage the home.
 - E. Once developed, the case manager will submit the care plan to the NCW program office for approval.
2. When all documents, requirements, and care planning are complete, fax or mail the Authorization Form for self-administered services and all required FMS employer and employee forms to the selected FMS Agency:

Morning Star Financial Services
 Fax: 888-657-0874

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9400 Golden Valley Road
Golden Valley, MN 55427

Acumen Fax: 888-249-7023
PO Box 539
Orem, UT 84059-0539

The FMS Provider will notify the case management agency when the employer and employee forms are complete and services can begin.

8-6 Self-Administered Services Ongoing Monitoring:

1. The case management agency is responsible for monitoring the safety and well-being of the participant and the quality and effectiveness of the self-administered service(s) being delivered.
2. The case management agency will monitor the relationship between the participant and the employee(s) and have ongoing contact with the participant/participant designee and employee(s) through the following methods:
 - A. An initial face to face visit with the participant/participant designee and employee within two (2) weeks of start-up of the service. Additional face to face visits with the participant and employee may be required as determined by the case manager.
 - B. Monthly contacts, either by telephone or face to face, as described in Section 7-4.
 - C. An annual reassessment of the care plan to determine changes in condition, reevaluate and adjust the care plan, and offer additional training to the participant and/or employee(s).
 - D. Event based contacts either by telephone or face to face visits, as warranted.
 - E. During each contact assess the participant to assure his or her needs are being met. Document the results of each contact in the case file.
3. The case management agency is responsible for notifying the financial management agent when any of the following occurs:
 - A. The participant is no longer eligible for services.
 - B. A new service is authorized or an existing service is no longer authorized.
 - C. There is a change in the number of units authorized or the frequency of service.
 - D. The participant is deceased.
 - E. There is a change in Case Managers.
 - F. The participant is in the hospital or nursing home.
 - G. The participant has moved.

8-7 Discontinuation of Self-Administered Services

1. Reasons for potential discontinuation of self-administered services include:

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- A. The participant is in the hospital, nursing or rehabilitation facility.
 - B. Voluntary withdrawal.
 - C. The participant or representative fails to provide the required documentation or refuses to follow the service descriptions agreed upon in the care plan.
 - D. There is a determination that funds are being misused or evidence that the service is not being performed.
 - E. There is evidence of abuse, neglect or exploitation of the participant by the employee or designee.
 - F. The participant fails to maintain Medicaid waiver eligibility.
 - G. The participant/participant designee fails to cooperate with the agreed upon care plan; and/or the participant or designee fails to cooperate with authorization changes or rules.
 - H. If the case manager determines that the participant is no longer able to manage the services authorized in the care plan and no participant designee is available, self-administered services will no longer be authorized. The case manager will work with the participant to revise the care plan to order services from the array available through agency based providers. This process will include all aspects of service plan development, including participation by the participant and individuals of his or her choosing and offering choice of providers.
2. Prior to discontinuing services provided by the self-administered services method, the case manager will discuss with the participant the discontinuation of services and will notify the NCW program office. The participant/participant designee will be given written notice and will be given the opportunity to appeal the decision following established appeal procedures.
 3. Denial of self-administered services will not affect continued participation in the New Choices Waiver.

9 INCIDENT REPORTING PROTOCOL

PURPOSE:

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 waiver services. Systematic incident reporting provides a mechanism to assure ongoing monitoring of serious incidents, the provider’s response to incidents and the interventions implemented to prevent reoccurrence. This protocol outlines the responsibilities of New Choices Waiver providers regarding adverse incidents.

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RESPONSIBILITIES OF WAIVER SERVICES PROVIDERS

1. Incidents requiring immediate (same day) notification:

The following types of incidents are considered to be the *most critical* and must be reported immediately (the same day) to the case management agency *and* to the NCW program office. Notification is permissible by telephone or by faxing or emailing an incident report. The NCW program office will accept the New Choices Waiver Incident Report form or the provider's incident report form as written notification. If notifying by telephone, a written incident report must be completed and submitted by the next State business day. An after-hours telephone number is provided at the end of this protocol for notification of this type of incident.

- a) Unexpected or accidental deaths. (This does not include deaths due to natural causes, general system failure or terminal/chronic health conditions.)
- b) Suicide attempts.
- c) An incident or event which is anticipated to receive media, legislative or other form of public scrutiny.
- d) It has been determined that a waiver participant is missing under unexplained or suspicious circumstances.
- e) An event which seriously compromises a working or living environment that results in evacuation of one or more waiver participants. (Gas leak, flooding, roof collapse, lightning strikes, fire, etc.)

2. Incidents requiring notification by the next State business day:

The following types of serious incidents do not require immediate (same day) notification. Residential and other waiver service providers must notify the case management agency *before the end of the next State business day* when any of these types of incidents occur. Notification is permissible by telephone or by faxing or emailing either the New Choices Waiver Incident Report form or the provider's incident report form. If notifying by telephone, a written incident report must follow by the next business day.

- a) Unexpected hospitalizations due to injury, aspiration/choking, or self-injurious behavior.
- b) Any medication or treatment error resulting in marked adverse side effects requiring medical treatment at a clinic, emergency room or hospital.
- c) 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.)
- d) Incidents that involve waste, fraud or abuse of Medicaid funds whether perpetrated by a provider or a recipient of Medicaid services.
- e) Alleged or confirmed incidents of abuse, neglect, or exploitation. These incidents must also be reported to Adult Protective Services or local law enforcement. (UCA 62-A-3-301)

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- f) Activities perpetrated on or by a waiver participant resulting in charges filed by law enforcement.

RESPONSIBILITIES OF WAIVER CASE MANAGEMENT AGENCIES

1. The New Choices Waiver case management agency is responsible for receiving, reviewing, and responding to all incident reports.
2. Upon being notified of any of the types of incidents defined in this protocol, the case management agency shall immediately (on the same day) notify the BACBS New Choices Waiver Policy Specialist (Policy Specialist) by telephone, fax, or email. If notification is provided to the Policy Specialist by telephone, a written report must follow within 24 hours or on the next State business day.
3. If a waiver participant, participant’s family member, or another individual reports an incident to the case manager that occurred while a participant was not receiving services from a NCW provider, the case manager is responsible for completing the incident report and submitting it to the NCW program office.
4. The case management agency must verify that reports of any actual or suspected incidents of abuse, neglect, or exploitation of a waiver participant have been reported to Adult Protective Services or local law enforcement. (UCA 62-A-3-301)
5. The case management agency is responsible for maintaining a record of all incident reports in the participants’ case files. The case management agency will address any identified needs, facilitate a resolution of any causal factors and will follow-up to assure the effectiveness of any new safeguards implemented as a result of the incident.
6. If the Policy Specialist determines that the incident requires further investigation, the Policy Specialist will instruct the case management agency to complete a Critical Incident Investigation form and return it within five (5) business days.
7. When the Policy Specialist determines the investigation is complete, the Policy Specialist will document any findings or corrective action requirements on the BACBS portion of the investigation form. The Policy Specialist will send the case manager a copy of the finalized document, closing the case. In some cases, the Policy Specialist may continue to monitor findings or corrective actions.

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8. Within two (2) weeks after the Policy Specialist informs the case management agency that the investigation has been closed, the CMA 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 disenrollment.

NOTIFICATION TO THE NCW PROGRAM OFFICE

Notification shall be submitted to:

FAX: 801-323-1586

Email: NewChoicesWaiver@utah.gov

From the Salt Lake City area: 801-538-6155, option 6

Outside of Salt Lake City & from neighboring states: 800-662-9651, option 6

After hours, only for the most critical incidents: 801-502-9752

10 SERVICE PROVIDER INTERACTION WITH CASE MANAGEMENT AGENCY

Service providers participating in the New Choices Waiver must adhere to the following requirements covering interactions with the participant selected case management agency and the NCW program office, when applicable.

10-1 Incident reporting as described in section 9-1 of this manual.

10-2 Service Authorization

1. Providers must adhere to all requirements described in section 6 of this manual, Prior Authorization of Waiver Services. Providers may only provide waiver services as ordered by the waiver participant’s case management agency and approved by the NCW Program office. Any concerns regarding ordered services should initially be addressed with the case management agency.
 - A. Providers may only provide waiver services as ordered by the waiver participant’s case management agency and approved by BACBS. Any concerns regarding ordered services should initially be addressed with the case management agency.

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B. The case management agency must provide the service provider with a service authorization form. The form includes the participant's identifying information, the billable HCPCS procedure code, authorized number of units, frequency of service and beginning and ending dates of the service, as well as the case manager's contact information.

- Any billing in excess of prior approved units of service will not be payable and will be recouped.
- Do not provide any services to a waiver participant without first receiving the service authorization form from the case management agency.

10-3 Participant Out of Facility

1. Adult residential services providers must notify the case management agency whenever a participant is out of the facility overnight. This includes:
 - Hospitalizations
 - Vacations
 - Nursing home stays
2. All services must be coordinated through the case management agency in order to ensure maximum benefit, care plan adherence and continued waiver eligibility.
3. Adult residential services providers should not accept a waiver participant who has been hospitalized or has been in the nursing facility on an extended stay basis back into their facility without first contacting their case manager to determine if they are still New Choices Waiver eligible. New Choices Waiver is not responsible for payment if the participant is not currently eligible.

11 CLAIMS AND REIMBURSEMENT

11-1 Time Limit to Submit Claims

All claims and adjustments for services must be received by Medicaid within 12 months from the date of 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 12 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. Payment will be made for Medicare/Medicaid Crossover claims only if claims are submitted within six months from the date of Medicare payment stated on the Medicare Explanation of Medical Benefits (EOMB). Code of Federal Regulations 42 (CFR), Section 447.45(d) (1). Utah Administrative Code, Rule R414-25x.

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11-2 Calculating Claims Using TN Modifier

When using the TN rural enhancement modifier for a claim, providers should bill the total eligible amount to be reimbursed (base amount and 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 then pays the actual billed amount up to the Maximum Allowable Rate X 1.75.

11-3 Use of “TN” Rural Enhancement Modifier

The use of the TN rural enhancement modifier is authorized in the New Choices 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 rate 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 except Weber County, Davis County, Salt Lake County, and Utah County.

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

- A. The case management agency must authorize use of the rural enhancement rate at the time the services are ordered.
- B. The location assigned as the provider’s normal base of operation must be in a county designated as rural;
- C. The location from which the service provider begins the specific trip must be in a county designated as rural;
- D. The location where the service is provided to the waiver participant must be in a county designated as rural; and
- E. 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 multiple Medicaid participants, each leg of the trip will be treated as an independent trip for purposes of qualifying for the rural enhancement (i.e. each leg must involve a direct travel distance of 25 miles or more).

2. Uniform Authorization of the Rural Enhancement Rate

- A. It is the responsibility of the case management agency to authorize any provider to bill for services using the rural enhancement code modifier. The case management agency will complete the Service Authorization Form and send it to the service provider to be maintained in their files as proof of service authorization. The case management agency will maintain a copy of the written authorization form that includes authorization for enhanced billing in their files as well as submit a copy to the NCW program office.
- B. .

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C. The NCW program office 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 provider and the case management agency will be notified by the NCW program office. Recoupment will be made for any inappropriate use of the rural enhancement rate.

3. When possible, providers must coordinate service delivery to minimize the use of the TN modifier by combining multiple service encounters in a single trip. Waiver case managers must take into account the opportunity to coordinate service delivery among waiver participants served by a common provider when scheduling services as part of plan of care implementation.

12 SERVICE PROCEDURE CODES

The New Choices Waiver HCPCS codes can be found on the Medicaid website at the following location:

<http://health.utah.gov/ltc/NC/NCPProviders.htm>

Providers must refer to the service authorization form provided by the assigned case management agency for each waiver participant to know the HCPCS code that can be billed.

13 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 62A-3-305 and State Rule R510-302.

1. 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.
2. 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. That law enforcement agency shall initiate an investigation in cooperation with Adult Protective Services.
3. 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.
4. Any person who willfully fails to report suspected abuse, neglect, or exploitation of a vulnerable adult is guilty of a class B misdemeanor.

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5. Under circumstances not amounting to a violation of Section 76-8-508, a person who threatens, intimidates, or attempts to intimidate a vulnerable adult who is the 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.
6. 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.
7. An adult is not considered abused, neglected, or a vulnerable adult for the reason that the adult has chosen to rely solely upon religious, nonmedical forms of healing in lieu of medical care.

14 CONTACT PHONE NUMBERS

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| Adult Protective Services (DHS/DAAS) | <p style="text-align: center;">Adult Protective Services Salt Lake County 1-801-538-3567 All other counties 1-800-371-7897</p> <p>Please be prepared to offer the following information: <i>(note: all information is not necessary, but helpful)</i></p> <ul style="list-style-type: none"> • Name, address, and phone number of victim. • Identifying information of the victim such as: birth date, social security number, age, ethnicity.... • Name, address, and phone number of alleged perpetrator (if applicable). • Identifying information regarding alleged perpetrator (if applicable). • Your name, phone number and address. • Provide information on any disability, health problem or mental illness. • Reason for concern (alleged abuse, neglect or exploitation). | |
| Disenrollment | <p style="text-align: center;">Utah Department of Health Division of Medicaid and Health Financing NCW Program Office PO Box 143112 Salt Lake City Utah 84114-3112 Fax: 801-323-1586</p> | |
| Medicaid Constituent Services | Tracy Barkley | Phone: 1-801-538-6417 Toll Free: 1-877-291-5583 Email: tbarkley@utah.gov |

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| Health Program Representatives | http://health.utah.gov/umb/documents/hpr.php | |
| Incident Reporting | <p align="center">Utah Department of Health Division of Medicaid and Health Financing NCW Program Office Attn: New Choices Waiver Incident Reporting PO Box 143112 Salt lake City Utah 84114-3112 Fax: 801-323-1586</p> | |
| Medicaid ACO Health Plans | Healthy U | Phone: 1-888-271-5870 1-801-587-6480 http://uuhsc.utah.edu/uhealthplan/healthyU/members.html |
| | Molina | Phone: 1-888-483-0760 www.molinahealthcare.com |
| | Select Access | Phone: 1-800-662-9651 www.ihc.com |
| | Health Choice Utah | Phone: 1-877-358-8797 www.healthchoiceutah.com |
| Medicaid Client Education | http://health.utah.gov/medicaid/provhtml/clients.htm | |
| Medicaid Information Line | 801-538-6155 or 1-800-662-9651 http://health.utah.gov/medicaid | |
| New Choices Waiver Program Office | Salt Lake City area: 1-801-538-6155, option 6 Outside of the Salt Lake City area and in neighboring states: 1-800-662-9651, option 6 Fax: 1-801-323-1586 | |
| | Email: newchoiceswaiver@utah.gov : www.health.utah.gov/ltc | |
| Request for Hearing | <p>Utah Department of Health Director's Office / Formal Hearings Division of Medicaid and Health Financing PO Box 143105 Salt Lake City Utah 84114-3105 Fax: 801-536-0143</p> | |

14-1 New Choices Waiver Level of Care Determination Form

Name: _____ DOB: _____ Medicaid ID: _____
 Initial Assessment Annual Reassessment Substantial change in health status Other _____

(a) Due to diagnosed medical conditions, the individual requires substantial physical assistance with daily living activities above the level of verbal prompting, supervising, or setting up. (Please rate the amount of assistance required for each activity):

| | Does not meet factor (a) | | | Meets factor (a) | | |
|-------------------------|--------------------------|---|--------------------------|--------------------------|--------------------------|-------------------------------|
| | Performs Independently | Independent with assistive device or set up | Prompting or Supervision | Minimal Physical Assist | Moderate Physical Assist | Complete Dependence on others |
| a. Bathing/Showering: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Grooming/Hygiene: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Dressing/Undressing: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Eating/Self feeding: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Transferring: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Toileting: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Mobility/Ambulation: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Bed Mobility: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

(b) The attending physician has determined that the individual’s level of dysfunction in orientation to person, place, or time requires nursing facility care; or equivalent care provided through a Medicaid Home and Community-Based Waiver program. Please rate your assessment of the individual’s care requirement:

- a. Level of dysfunction in orientation to person: N/A Requires NF care Does not require NF care
- b. Level of dysfunction in orientation to place: N/A Requires NF care Does not require NF care
- c. Level of dysfunction in orientation to time: N/A Requires NF care Does not require NF care

If your assessment indicates that the individual may meet this factor, please verify this with the physician or through applicable medical records.

Name of verifying physician: _____

Verification obtained by: _____ Date: _____

Physician verification is not required to confirm your assessment of the following:

- d. Impaired decision making ability: None Mild Moderate Severe
- e. Impaired communication ability: None Mild Moderate Severe
- f. Impaired memory recall: None Short-term Long-term Procedural
- g. Does the client experience periods of confusion that have potential to endanger the client or others? Yes No

(c) The medical condition and intensity of services indicate that the care needs of the individual cannot be safely met in a less structured setting, or without the services and supports of a Medicaid Home and Community-Based Waiver program. List the medical diagnoses, treatments, therapies and programs necessary for the health and safety of this client. This area should not include a reiteration of any ADL assistance identified in section (a).

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A minimum of 2 out of the 3 factors listed above are required to determine that an individual meets nursing facility level of care.

- Based upon the assessment dated _____, this individual has been determined to meet nursing facility level of care.
- Based upon the assessment dated _____, this individual has been determined to NOT meet nursing facility level of care.

Notes: _____
 RN Name: _____ Signature: _____ Date: _____

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15-3 New Choices Waiver Incident Reporting Form

| | | |
|--|---|--|
| CLIENT'S NAME : | DOB: _____/_____/_____ | <p><u>Please check the incident type below.</u></p> <p><i>The following incidents require immediate (same day) notification:</i></p> <p><input type="checkbox"/> Unexpected or accidental death</p> <p><input type="checkbox"/> Suicide attempt (does not include threats only)</p> <p><input type="checkbox"/> Incident expected to receive media, legislative or public scrutiny</p> <p><input type="checkbox"/> Compromised work or living environment requiring evacuation</p> <p><input type="checkbox"/> Person missing under suspicious or unexplained circumstances (Time of last known whereabouts: _____)</p> <p><i>The following incidents require notification within 24 hours or on the next business day:</i></p> <p><input type="checkbox"/> Injury (includes burns, choking, brain trauma, fractures, etc.)</p> <p><input type="checkbox"/> Abuse (physical or sexual)</p> <p><input type="checkbox"/> Neglect (caregiver neglect or self-neglect)</p> <p><input type="checkbox"/> Exploitation (by somebody in a relationship of trust)</p> <p><input type="checkbox"/> Waste, fraud or abuse of Medicaid funds</p> <p><input type="checkbox"/> Human rights violation</p> <p><input type="checkbox"/> Medication/treatment errors resulting in marked adverse side effects</p> <p><input type="checkbox"/> Law enforcement involvement resulting in charges being filed</p> <p><input type="checkbox"/> Other type of incident causing concern for safety</p> |
| FACILITY OF RESIDENCE NAME: | DATE OF INCIDENT: | |
| (<input type="checkbox"/> N/A – not living in a facility) | TIME OF INCIDENT: | |
| CLIENT'S MAILING ADDRESS: | | |
| WAS THE FAMILY/RESPONSIBLE PERSON NOTIFIED? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | Does this client have a legal guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No Guardian's name: _____ | |
| LAW ENFORCEMENT NOTIFIED? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Date: _____ | APS NOTIFIED? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Date: _____ | |
| NARRATIVE DESCRIPTION OF INCIDENT | | |
| 1. Location of incident: 2. What happened? 3. How was it discovered? 4. Immediate actions taken: | | |

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| <p>5. Any precipitating events? (Illnesses, med changes, etc.)</p> <p>6. Will there be any new safeguards as a result of this incident?</p> | <p><u>Please answer the following 5 questions:</u></p> <p>1. Did the person sustain an injury as a result of the incident? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>2. Was the person treated in the ER and released the same day? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>3. Was the person admitted to the hospital? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>4. If 'yes' to #3, was the hospital admission directly related to the injury or was it for another medical reason or both? <input type="checkbox"/>Injury <input type="checkbox"/>Another medical reason <input type="checkbox"/>Both</p> <p>5. Is/was the person receiving hospice care? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> |
|---|---|

| | | | |
|---|---------------------------|-----------------------|---|
| Provider Representative's Signature: | Phone & Email: | Title: | Date forwarded to case manager: |
| Case Manager's Signature: | Phone & Email: | Date Notified: | Date forwarded to BACBS: |
| BACBS Representative's Signature: | Phone & Email: | Date notified: | Date forwarded to SMA QA Unit: <input type="checkbox"/> N/A |

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**Medicaid Home and Community Based Program Disenrollment Notice
Disenrollment Form DPF-1
(See section 4-2 of this manual for policy and procedures for disenrollment)**

| | |
|---|------------------------|
| Program Name: | |
| Program Contact Person: | Phone: |
| Address: | |
| Client Name: | Medicaid ID#: |
| Phone: | |
| Legal Guardian Name/Family Member: (if applicable) | |
| Phone: | |
| Client Address: | |
| Current Residence while enrolled in program (Check): <input type="checkbox"/> Home <input type="checkbox"/> Apartment <input type="checkbox"/> Supervised Apartment <input type="checkbox"/> Assisted Living <input type="checkbox"/> Independent Living Facility <input type="checkbox"/> Other: (list) | |
| Date of enrollment: | Date of disenrollment: |
| Voluntary disenrollment: | |
| Client: Chose to voluntarily disenroll from this program (Notify DMHF within 10 days of disenrollment) | |
| Clients new address: (if known) | |
| Clients new phone number: (if known) | |
| Pre-Approved Involuntary Disenrollment: | |
| Client: Was disenrolled from the New Choices Waiver for the following reason: <input type="checkbox"/> Death of the participant; <input type="checkbox"/> Participant has been determined to no longer meet the financial requirements for Medicaid program eligibility by the Department of Workforce Services; | |

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|--|------------------------|
| <input type="checkbox"/> Participant enters a skilled nursing facility and the expected length of stay will exceed 90 days (as verified as a physician) ; Date of Admission to SNF: _____ Name of SNF: _____ | |
| Medicaid Home and Community Based Program Disenrollment Notice of Intent Disenrollment Form DPF-2 | |
| Program Name: | |
| Program Contact Person: | Phone: |
| Address: | |
| Client Name: | Medicaid ID#: |
| Phone: | |
| Legal Guardian Name/Family Member: (if applicable) | |
| Phone: | |
| Client Address: | |
| Current Residence while enrolled in program (Check): <input type="checkbox"/> Home <input type="checkbox"/> Apartment <input type="checkbox"/> Supervised Apartment <input type="checkbox"/> Assisted Living <input type="checkbox"/> Nursing Facility <input type="checkbox"/> ICF/ID <input type="checkbox"/> Other: (list) | |
| Date of enrollment: | Date of disenrollment: |

Special Circumstance involuntary disenrollments:

- 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 meet minimal safety standards;
- Participant has demonstrated non-compliance with a signed health and safety agreement with NCW or the case management agency; Participant, or their legal representative (when applicable), requests a transfer of the participant from one Medicaid waiver program directly to another waiver program; or
- Participant's whereabouts are unknown for more than 30 days, and a decision regarding ongoing financial eligibility from the department of workforce Services has not been rendered Summarize Program interventions to rectify the identified problem, prior to the intended disenrollment decision: (submit corroborating documents)

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**Division of Medicaid and Health Financing Decision Notice for Special Circumstance Involuntary
Home and Community Based Program Disenrollment
Disenrollment Form DPF-3**

| | |
|--|---|
| Program Name: | |
| Program Contact Person: | Phone: |
| Address: | |
| Client Name: | Medicaid ID#: |
| Phone: | |
| Legal Guardian Name/Family Member: (if applicable) | |
| Phone: | |
| Client Address: | |
| Current Residence while enrolled in program (Check): | |
| <input type="checkbox"/> Home | <input type="checkbox"/> Apartment |
| <input type="checkbox"/> Assisted Living | <input type="checkbox"/> Nursing Facility |
| <input type="checkbox"/> Other: (list) | <input type="checkbox"/> Supervised Apartment |
| <input type="checkbox"/> ICF/ID | |
| Date of enrollment: | Date of disenrollment: |

The (case management agency) is recommending disenrolling the client from the New Choices Waiver based on the following:

- 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 meet minimal safety standards;
- Participant has demonstrated non-compliance with a signed health and safety agreement with NCW or the case management agency;
- Participant, or their legal representative (when applicable), requests a transfer of the participant from one Medicaid waiver program directly to another waiver program; or
- Participant's whereabouts are unknown for more than 30 days, and a decision regarding ongoing financial eligibility from the department of workforce Services has not been rendered.