

Utah Medicaid Provider Manual	Home and Community Based Waiver Services New Choices Waiver
Division of Medicaid and Health Financing	Updated January 2016

**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 or assisted living facilities 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 “statewideness” requirements in subsection 1902(a)(1) of the Social Security Act, and
- 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 Statewideness

Under the waiver of Statewideness, the State is permitted to provide covered waiver services to eligible individuals who reside anywhere in the state, subject to the availability of case management services.

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:

BACBS	Bureau of Authorization and Community-based Services
CMA	Case Management Agency
CMS	Centers for Medicare and Medicaid Services
DMHF	Division of Medicaid and Health Financing
HCBS	Home and Community-Based Services

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LOC Level of Care

NCW New Choices Waiver -- the Medicaid 1915(c) HCBS Waiver Program that was developed to provide Utah Medicaid recipients living long term in a nursing facility or a licensed assisted living facility the supportive services that they need to live safely in a home or community-based setting. Services may be provided in a participant's residence, a family member's residence, or an assisted or independent living facility, that has directly contracted with the New Choices Waiver.

MDS-HC Minimum Data Set for Home Care serves as the standard comprehensive assessment instrument used in the New Choices Waiver

NF Nursing facility

SAS Self-administered services is a service delivery method where the participant and/or their chosen designee hire individual employees to deliver a waiver service.

SFY State fiscal year

SMA State Medicaid Agency

1 - 2 CMS Approved Waiver Implementation Plan

- A. The State Implementation Plan for the New Choices Waiver, approved by CMS, serves as the State's 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.
- B. 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, the Waiver State Implementation Plan should be referenced.
- C. In the event provisions of this manual are found to be in conflict with the State Implementation Plan, the State Implementation Plan will take precedence.

2 SERVICE AVAILABILITY

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

2 – 1 Eligibility for Waiver Program

- A. Home and community-based New Choices Waiver services are covered benefits only for Utah Medicaid recipients who at the time of admission:
 - 1. are at least 18 years old, and;

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2. one of the following four (4) scenarios describes their current situation:
 - a) are receiving Medicaid reimbursed nursing facility care on an extended stay basis of 90 days or more;
 - b) are receiving Medicare or Medicaid reimbursed care in a licensed Utah medical institution other than a Medicaid certified nursing facility (that is not an Institution for Mental Disease) 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;
 - c) are receiving Medicaid reimbursed services through another of Utah's 1915 (c) waivers and have been identified in need of immediate (or near immediate) nursing facility placement absent enrollment into the New Choices Waiver program; or
 - d) are residing in a licensed assisted living facility on an extended stay basis of 180 days or more.

- *In the case of acute care hospitals, specialty hospitals, and Medicare skilled nursing facilities, participation is limited to individuals who are admitted for the purpose of receiving a medical, non-psychiatric level of care more acute than the Medicaid nursing facility level of care provided in R414-502.*
- *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 provided 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 provided in R414-502 are not eligible for participation in the New Choices Waiver.*

B. 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; the individual responsible for assessing level of care shall, in accordance with R414-502, document that at least two of the following factors exist:

1. 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;
2. 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 the New Choices Waiver; or
3. 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 the New Choices Waiver

C. An individual will not be enrolled if it is determined during the eligibility assessment process that the health, welfare, and safety of the individual cannot be maintained through the New Choices Waiver program.

D. Inpatients of hospitals or nursing facilities are not eligible to receive waiver services (except as specifically permitted for case management discharge planning in the 180-day period before discharge).

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2 - 2 Applicant Freedom of Choice of Nursing Facility or New Choices Waiver

- A. Utah Medicaid recipients who meet the eligibility requirements of the New Choices Waiver may choose to receive services in a nursing facility (NF) or through the New Choices Waiver.
- B. A pre-enrollment review of eligibility will be completed by a representative from the Bureau of Authorization and Community-based Services. The applicant or their chosen representative will be advised of available services and given the opportunity to choose to receive services through a NF or the New Choices Waiver. The applicant's choice will be documented in writing on the New Choices Waiver Freedom of Choice Consent Form, signed by the applicant or their representative, and maintained as part of the individual record.
- C. New Choices Waiver participants have the option to choose institutional (NF) care at any time and voluntarily disenroll from the New Choices Waiver.

2 - 3 New Choices Waiver Participants' Freedom of Choice of Service Providers

- A. The 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 and will sign the form to acknowledge that they were given a choice. The case management agency will be responsible for maintaining a signed copy of this notice in their case records.

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

- A. When the need arises, participants are separated from the Home and Community Based waiver program through a disenrollment process.
 - 1. The disenrollment process is a coordinated effort between NCW staff within the DMHF (hereafter referred to as NCW) and case management agencies that are expected to facilitate the following:
 - i. Verification that the disenrollment is appropriate for the waiver participant;
 - ii. Movement among waiver programs (when applicable);
 - iii. Ensuring effective utilization of waiver program services;
 - iv. Effective discharge and transition planning;
 - v. Distribution of information to participants describing all applicable waiver rights; and
 - vi. Program quality assurance.
- B. 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.
 - 1. Voluntary disenrollments are cases in which participants, or their legal representative (when applicable), choose to initiate disenrollment from the waiver. Disenrollments are also

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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.

2. Pre-Approved involuntary disenrollments are cases in which participants are involuntarily disenrolled from the waiver for any of the following reasons including:
 - i. Death of the Participant;
 - ii. Participant has been determined to no longer meet the financial requirements for Medicaid program eligibility by the Department of Workforce Services;
 - iii. Participant enters a skilled nursing facility, and the expected length of stay will exceed 90 days (as verified by a physician); or
 - iv. 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.

3. 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:
 - i. Participant no longer meets the level of care requirements for the Waiver;
 - ii. Participant's health and safety needs cannot be met by the Waiver program's services and supports;
 - iii. Participant has demonstrated non-compliance with the agreed upon care plan and is unwilling to negotiate a plan of care that meets minimal safety standards;
 - iv. Participant has demonstrated non-compliance with a signed health and safety agreement with NCW or the case management agency; or

 - v. Participant's whereabouts are unknown for more than 30 days, and a decision regarding

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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 Action (NOA) and right to fair hearing information.

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

2 - 5 Fair Hearings

- A. The State Medicaid Agency provides an eligible individual applying for or receiving waiver services an opportunity for a hearing upon written request, if the eligible individual is:
 1. Not given the choice of institutional (NF) care or HCBS waiver services.
 2. Denied the waiver provider(s) of choice if more than one provider is available to render the service(s).
 3. Denied access to waiver services, that they are eligible to receive, identified as necessary to prevent institutionalization.
- B. An eligible individual and the individual's legal representative, as applicable, will receive a written Notice of Agency Action from BACBS if the individual is denied a choice of institutional or New Choices Waiver program, or subsequently found ineligible for the waiver program.

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- C. An eligible individual and the individual's legal representative, as applicable, will receive a written Notice of Agency Action from BACBS if the individual is denied access to the provider of choice for a covered waiver service. The Notice of Agency Action delineates the individual's right to appeal the decision.
- D. An aggrieved participant may request a formal hearing within 30 calendar days from the date written notice is issued or mailed, whichever is later. The State Medicaid Agency may reinstate services for participants or suspend any adverse action for providers if the aggrieved person requests a formal hearing not more than ten calendar days after the date of action.
- E. The participant is encouraged to utilize an informal dispute resolution process to expedite equitable solutions but may forgo or interrupt the available informal resolution process at any time by completing a request for hearing and directing the request be sent to the State Medicaid Agency for a formal hearing and determination.
- F. An informal dispute resolution process does not alter the requirements of the formal fair hearings process. The individual must still file a request for hearing and a request for continuation of services within the mandatory time frames established by the State Medicaid Agency. An informal dispute resolution must occur prior to the deadline for filing the request for continuation of service and/or the request for formal hearing or be conducted concurrent with the formal hearing process.

3 PROVIDER PARTICIPATION

3 - 1 Provider Enrollment

- A. 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 New Choices Waiver and authorized by a New Choices Waiver case management agency.
- B. 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 BACBS. BACBS 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.

3 - 2 Provider Reimbursement

- A. A unique provider number is issued for each of the waiver Service Providers. When submitting claims for reimbursement, the Provider must use the proper provider number associated with the waiver for the waiver participant receiving the services. Claims containing a provider number that is not associated with the proper waiver will be denied.
- B. Providers will be reimbursed according to the specified reimbursement rate(s). Units of service must be billed in whole units as listed in the rate table, even if the service was provided for only part of the amount of time specified in the unit definition. (See rate table)

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C 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 service authorization form. Service authorizations are valid for a maximum of one year, and must be reissued yearly. The case management agency will supply the service provider with a service authorization form clearly identifying the New Choices Waiver 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 amount, frequency and dates ordered by the waiver case management agency in order to be paid. Any services provided that exceed the amount or frequency authorized, or for which there is no current service authorization form will not be reimbursed. Any claims inaccurately paid will be subject to recoupment.

D. 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.

3 - 3 Standards of Service

Providers must adhere to service standards and limitations described in this manual, the terms and conditions of the Medicaid provider agreement, and the terms and conditions of the New Choices Waiver Implementation Plan.

Data Security & Privacy

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

Breach Reporting/Data Loss

Providers must report to NCW, 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.

3 - 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

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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.

4 PRIOR AUTHORIZATION OF WAIVER SERVICES

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

5 MDS-HC ASSESSMENT INSTRUMENT / LEVEL OF CARE

The Inter RAI MINIMUM DATA SET - HOME CARE (MDS-HC) serves as 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 responsible for collecting the needed information and for making the level of care determinations are trained by staff of the State Medicaid Agency in the proper application of the MDS-HC instrument and the proper analysis of the MDS-HC data to perform level of care evaluations.

6 NEW CHOICES WAIVER ADMISSION PROCESS

6-1 Application and Assessment

- A. Applications will be accepted from those who meet the minimum eligibility requirements listed in Section 2-1. Applications may be obtained by contacting the Bureau of Authorization and Community-based Services.
- B. Upon initial determination of eligibility to apply for the New Choices Waiver, a representative from the Bureau of Authorization and Community-based Services will provide the applicant with information regarding available waiver case management agencies in the applicant's county. The applicant's choice will be documented on the Freedom of Choice form and the completed application will be sent to the selected case management agency. An application will not be considered complete until all requested documentation is received.
- C. A registered nurse from the selected case management agency will complete a thorough assessment utilizing the MDS-HC within fourteen (14) calendar days of receiving the referral. A Level of Care Determination Form will be completed immediately following the MDS-HC assessment (within 14 days) and will be submitted to BACBS.

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- D. A licensed social worker from the case management agency will work with the registered nurse to determine social needs, support systems, and risk factors.

6-2 Admission Determination

- A. Upon completion of the comprehensive needs assessment, the selected case management agency will provide BACBS, as well as the applicant, with a notice of determination clearly stating 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 BACBS and a statement directing the applicant to contact BACBS should they wish to discuss their options.
- B. Eligible applicants who have been declined by a case management agency may request that their application be forwarded to an alternate case management agency for review, if there is another case management agency operating in their county of residence.
- C. An eligible applicant who has been declined by every available case management agency cannot be enrolled on the New Choices Waiver until a case management agency willing to provide services is available.

6 - 3 Enrollment

- A. Once a case management agency has made the decision to work with an applicant, they will assist the applicant to locate a residence that will meet the applicant's needs. This residence can be the applicant's own home, a family member's home, another type of housing or an assisted or independent living facility that has enrolled to be a provider for the New Choices Waiver.
- B. The case management agency will assist the applicant with obtaining a rental agreement for the chosen location and submitting this to BACBS. For applicants living in nursing facilities, the rental agreement must be received by BACBS by 12:00 noon on the twentieth (20th) of the month or the last State working day prior to the twentieth (20th) of the month. This deadline does not apply to rental agreements submitted for applicants living in assisted living facilities.
- C. BACBS will submit the 927 form and rental agreement to the Long Term Care team at the Department of Workforce Services for determination of financial eligibility.
- D. Workforce Services will determine financial eligibility and approve or deny the 927 form prior to the last day of the month, for applicants living in nursing facilities. Approval or denial of 927 forms for applicants living in assisted living facilities may take longer. Once the determination of financial eligibility has been made, Workforce Services will sign section B of the 927 and return it to BACBS.
- E. BACBS will notify the case management agency of the applicant's authorization to enroll with the New Choices Waiver upon receipt of a signed 927 form. The case management agency will notify the applicant and begin planning for the applicant's discharge from the nursing facility or transition to the NCW within the assisted living facility.
- F. All enrollments from nursing facilities take place on the first day of the month following the completion of the 927 form. Enrollments from assisted living facilities may take place any day of the month following completion of the 927 form.

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7 CASE MANAGEMENT

7 - 1 Case Management Encounters

To better focus primary attention on providing the specific level of case management intervention needed on an individualized basis, as determined during the initial and ongoing comprehensive needs assessment process, the individual comprehensive care plan will be the vehicle through which the level of assessed need for case management will be detailed in terms of amount, duration and frequency.

- A. The case management agency will develop a comprehensive care plan to address the participant's identified needs 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.
- B. The case management agency will review the contents of the care plan with the participant and submit it to BACBS prior to implementation. The approval of the care plan by BACBS will constitute formal authorization to the case management agency of the services to be provided to the participant.
- C. 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 3 years as required by 45 CFR 74.53.
- D. 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.
- E. 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 service units, approved frequency of service and HCPCS code. **Units listed on the service authorization form may not exceed units approved by BACBS.** Service authorization forms will be updated in conjunction with the comprehensive care plan.
- F. The comprehensive care plan must be revised at least annually and when a significant change in condition occurs.
- G. Subsequent revision of the participant's comprehensive care plan as a result of an annual re-assessment or a significant change in the participant's health, welfare, or safety requires proper notice to the participant as described above in C. In addition, 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.
 1. A significant change is defined as a major change in the participant's status that:
 - A. is not self-limiting;

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- B. impacts on more than one area of the participant's health status; and
- C. 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 waiver personnel. Generally, if the condition has not resolved within approximately two weeks, staff should begin a comprehensive reassessment.

- 2. A comprehensive reassessment is required if a significant change is consistently noted in two or more areas of decline or two or more areas of improvement.

H. 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.

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 - 2 Inpatient Hospitalization / Nursing Home Admission

- A. 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 2-4 for disenrollment procedures.)
 - 1. 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.
- B. 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,
 - 1. 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

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submit them to BACBS for approval prior to re-enrollment. Case management agencies must submit paperwork using the guidelines listed in section 6-3.

2. 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.
- C. 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.

7-3 Level of Care

- A. The level of care (LOC) determination will be made by the registered nurse from the case management agency in accordance with R414-502-3. The LOC determination is based on the MDS-HC assessment and must be completed within fourteen (14) days of the MDS-HC. The LOC Determination Form must be submitted to BACBS upon completion. All participants must be initially and continuously assessed to meet Nursing Facility Level of Care in order to maintain waiver eligibility. A participant must be disenrolled from the waiver if they are assessed as no longer meeting Nursing Facility Level of Care.

7-4 Case Management Monitoring

- A. Case management monitoring activities are based on the assessed need of the individual participant.
- B. At a minimum, the case management agency must make at least one monthly contact directly with the participant either by telephone or in person.
1. If a participant's mental capacity is diminished to the point of being unable to have meaningful telephone contact, a monthly face to face contact with the participant 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.
- C. 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.
- D. 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.
- E. 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.
- F. The case management agency should be notified any time a participant is away from an adult residential facility overnight.

8 SELF-ADMINISTERED SERVICES

8-1 Definition and Employer Authority

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- A. Self-administered services (SAS) are 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 means 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.
- B. 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 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.
- C. 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

- A. 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:
 - 1 Attendant Care Services
 - 2 Chore Services
 - 3 Homemaker Services
 - 4 Respite care – Hourly
 - 5 Respite Care – Daily

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

8 - 3 Self- Administered Services Case Management Responsibilities:

- A. Follow all requirements in Attachment B – Special Provisions, Case Management Service Provider Responsibilities for the New Choices Waiver Program.
- B. 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.

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- C. 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.
- D. Inform the participant of the ability to combine self-administered services with Agency-Based Services.

8 - 4 Self-Administered Services Case Manager Packet

A. 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 CMA keeps the case management packet and gives the participant and employee packets to the participant/participant designee to be completed and returned to the CMA.

1. Case Manager Packet

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

2. 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 CMA 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.

3. 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)

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B. The CMA retains completed copies of the following documents for their files:

- 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

C. The CMA 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.
1. 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

A. 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.

1. Assess the participant's need for Consumer Preparation Services.
2. 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.
3. 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.
4. 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.
5. Once developed, the case manager will submit the care plan to BACBS for approval.

B. 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
 9400 Golden Valley Road
 Golden Valley, MN 55427

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AcumenFax: 888-294-7023
 PO Box 539
 Orem UT 84059-0539

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

8 - 6 Self-Administered Services Ongoing Monitoring:

- A. The CMA 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.
- B. The CMA 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:
 - 1. 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.
 - 2. Monthly contacts, either by telephone or face to face, as described in Section 7-4.
 - 3. 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).
 - 4. Event based contacts either by telephone or face to face visits, as warranted.
 - 5. 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.
- C. The CMA is responsible for notifying the financial management agent when any of the following occurs:
 - 1 The participant is no longer eligible for services.
 - 2 A new service is authorized or an existing service is no longer authorized.
 - 3 There is a change in the number of units authorized or the frequency of service.
 - 4 The participant is deceased.
 - 5 There is a change in Case Managers.
 - 6 The participant is in the hospital or nursing home.
 - 7 The participant has moved.

8- 7 DISCONTINUATION OF SELF-ADMINISTERED SERVICES

- A. Reasons for potential discontinuation of self-administered services include:
 - 1 The participant is in the hospital, nursing or rehabilitation facility.
 - 2 Voluntary withdrawal.
 - 3 The participant or representative fails to provide the required documentation or refuses to follow the service descriptions agreed upon in the care plan.

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- 4 There is a determination that funds are being misused or evidence that the service is not being performed.
- 5 There is evidence of abuse, neglect or exploitation of the participant by the employee or designee.
- 6 The participant fails to maintain Medicaid waiver eligibility.
- 7 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.
- 8 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.

B. 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 BACBS. The participant/participant designee will be given written notice and will be given the opportunity to appeal the decision following established appeal procedures.

C. Denial of self-administered services will not affect continued participation in the New Choices Waiver.

9 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.

9 – 1 Incident Reporting

A. All negative incidents involving a waiver participant must be reported to the case management agency utilizing the New Choices Waiver incident reporting form as soon as possible, but no later than the first business day after the incident has occurred. This is in addition to APS reporting requirements and does not negate the individual providers' obligation to report when the incident involves abuse, neglect or exploitation. Negative incidents may include, but are not limited to:

1. Unexpected or accidental deaths. (This does not include deaths due to natural causes, general system failure or terminal/chronic health conditions.)
2. Suicide attempts.
3. An incident or event which is anticipated to receive media, legislative or other form of public scrutiny.
4. It has been determined that a waiver participant is missing under unexplained or suspicious circumstances.
5. 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.)
6. Unexpected hospitalizations due to injury, aspiration/choking, or self-injurious behavior.
7. Any medication or treatment error resulting in marked adverse side effects requiring medical treatment at a clinic, emergency room or hospital.
8. 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.)

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9. Incidents that involve waste, fraud or abuse of Medicaid funds whether perpetrated by a provider or a recipient of Medicaid services.
10. 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)
11. Activities perpetrated on or by a waiver participant resulting in charges filed by law enforcement.

(Please see the "Incident Reporting Protocol" for additional information regarding reporting time frames.)

9 – 2 Service Authorization

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.

1. 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 units of 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 subject to recoupment.
- Do not provide any services to a waiver participant without first receiving the prior authorization form from the case management agency.

9 – 3 Participant Out of Facility

A. 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

B. All services must be coordinated through the case management agency in order to ensure maximum benefit, care plan adherence and continued waiver eligibility.

C. Do not accept a waiver participant who has been hospitalized or has been in the nursing facility on an **extended stay basis** back into your 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 they are not currently eligible.

10 CLAIMS AND REIMBURSEMENT

10 - 1 Timely Filing of Claims

All claims and adjustments for services must be received by Medicaid within twelve 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

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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.

10 - 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.

10-3 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.

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

1. The case management agency must authorize use of the rural enhancement rate at the time the services are ordered.
2. The location assigned as the provider’s normal base of operation must be in a county designated as rural;
3. The location from which the service provider begins the specific trip must be in a county designated as rural;
4. The location where the service is provided to the waiver participant must be in a county designated as rural; and
5. 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).

B. Uniform Authorization of the Rural Enhancement Rate

1. 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 in their files as well as submit a copy to BACBS.
2. If the initial authorization was verbal, the case management agency will follow up with a written

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service authorization that includes the authorization for rural enhanced reimbursement. The case management agency will maintain a copy of the written authorization form in their case files and submit a copy of any Authorization Forms that include authorization for enhanced billing to BACBS.

3. BACBS 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 BACBS. Recoupment will be made for any inappropriate use of the rural enhancement rate.
- C. 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.

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11 SERVICE PROCEDURE CODES

The HCPCS procedure codes listed below are covered by Medicaid for the New Choices Waiver Program.

WAIVER SERVICE	HCPCS CODE	UNIT OF SERVICE
Case Management	T1016	per unit (15 min)
Pre-enrollment and Inpatient Case Management	T2024	per unit (15 min)
Homemaker services	S5130	per hour
Adult Day Care (Adult Day Health)	S5102	per day
Habilitation Services	T2017	per hour
Respite Care Services		
<ul style="list-style-type: none"> Respite care services 	S5150	per hour
<ul style="list-style-type: none"> Respite care services, daily (six hours or more within a day) 	S5151	per day
<ul style="list-style-type: none"> Respite care services-Out of Home/Room and Board Included 	H0045	per day
Adult Residential Services		
<ul style="list-style-type: none"> Adult Host Homes 	S5140	per day
<ul style="list-style-type: none"> Assisted Living Facilities 	T2031	per day
<ul style="list-style-type: none"> Licensed Community Residential Care 	T2033	per day
<ul style="list-style-type: none"> Certified Residential Care 	T2016	per day
Attendant Care Services	S5125	per unit (15 min)
Caregiver Training	S5115	per unit (15 min)
Chore Services	S5120	per unit (15 min)
Environmental Accessibility Adaptations		
<ul style="list-style-type: none"> Home Modifications 	S5165	per episode
<ul style="list-style-type: none"> Vehicle Modifications 	T2039	per episode
Home Delivered Meals	S5170	per meal
Community Transition Services	T2038	per service

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Medication Administration Assistance Service		
<ul style="list-style-type: none"> Medication Reminder Systems (not face to face) 	S5185	per month
<ul style="list-style-type: none"> Medication Set Up 	H0034	per unit (15 min)
Personal Emergency Response Systems		
<ul style="list-style-type: none"> Personal emergency response systems purchase, rental & repair 	S5162	each
<ul style="list-style-type: none"> Personal emergency response systems response center service 	S5161	per month
<ul style="list-style-type: none"> Personal emergency response system installation, testing & removal, base 	S5160	each
Specialized medical equipment/supplies/assistive technology	T2029	each
Transportation- Non- Medical		
<ul style="list-style-type: none"> Transportation -Non-Medical- mile 	S0215	per mile
<ul style="list-style-type: none"> Transportation -Non-Medical – one way trip 	T2003	one way trip
<ul style="list-style-type: none"> Public Transit Pass 	T2004	month
Personal Budget Assistance	H0038	per unit (15 min)
Assistive Technology Devices	T2028	per Item
Supportive Maintenance (Home Health Aide) Services (Extended State Plan Service)	T1021	per hour
Consumer Preparation Services	S5108	per unit (15 min)
Financial Management Services*	T2040	per month

*Financial Management Services Reimbursement

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

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12 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.
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.

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13 CONTACT PHONE NUMBERS

Adult Protective Services (DHS/DAAS)	<p 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). 	
Disenrollments	<p align="center">Utah Department of Health Division of Medicaid and Health Financing Bureau of Authorization and Community-based Services Attn: New Choices Waiver Disenrollment Staff PO Box 143112 Salt Lake City Utah 84114-3112 Fax: 801-323-1586</p>	
HPR - Constituent Services	Tracy Barkley	Phone: 1-801-538-6417 Toll Free: 1-877-291-5583 Email: tbarkley@utah.gov
Health Program Representatives	<p align="center">http://health.utah.gov/umb/documents/hpr.php</p>	
Incident Report Form	<p align="center">Utah Department of Health Division of Medicaid and Health Financing Bureau of Authorization and Community-based Services Attn: New Choices Waiver Incident Reporting PO Box 143112 Salt lake City Utah 84114-3112 Fax: 801-323-1586</p>	
Medicaid Health Plans	Healthy U Customer Service: Molina Customer Service:	Phone: 1-888-271-5870 1-801-587-6480 http://uuhsc.utah.edu/uhealthplan/healthyU/members.html Phone: 1-888-483-0760 www.molinahealthcare.com Phone: 1-800-662-9651

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	Select Access Customer Service:	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 Contact Information		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	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	

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14 **Attachment A – Authorized Provider Services**

ENROLLMENT 1915(c) HCBS NEW CHOICES WAIVER

Provider Name: _____

Effective Date: _____

<p>*FOR DMHF USE ONLY:*</p> <p>Provider #:</p> <p>Category of Service:</p>

PROVIDER is authorized to participate in the following waiver services (Mark all that apply):

(X)	New Choices Waiver Service	*FOR DMHF USE ONLY* MEDICAID PROVIDER TYPE
	ADULT DAY CARE	
	ADULT RESIDENTIAL SERVICES *	
	ASSISTIVE TECHNOLOGY DEVICES	
	ATTENDANT CARE SERVICES	
	CAREGIVER TRAINING	
	CASE MANAGEMENT *	
	CHORE SERVICES	
	CONSUMER PREPARATION SERVICES	
	ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS	
	FINANCIAL MANAGEMENT SERVICES	
	HABILITATION	
	HOME DELIVERED MEALS	
	HOMEMAKER SERVICES	
	COMMUNITY TRANSITION SERVICES	
	MEDICATION REMINDER SERVICES	
	NON-MEDICAL TRANSPORTATION	
	PERSONAL BUDGET ASSISTANCE	
	PERSONAL EMERGENCY RESPONSE SYSTEM	
	RESPIRE	
	SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES	
	SUPPORTIVE MAINTENANCE (HOME HEALTH AIDE) SERVICES	

* Attachment B, "Special Provisions Agreement", must be completed to become a provider for these waiver services.

Provider is available to provide services in the following counties:

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(Please circle all that apply.)

STATEWIDE

- | | | | |
|-----------------|------------------|-----------------|-------------------|
| Beaver County | Box Elder County | Cache County | Carbon County |
| Daggett County | Davis County | Duchesne County | Emery County |
| Garfield County | Grand County | Iron County | Juab County |
| Kane County | Millard County | Morgan County | Piute County |
| Rich County | Salt Lake County | San Juan County | Sanpete County |
| Sevier County | Summit County | Tooele County | Utah County |
| Uintah County | Utah County | Wasatch County | Washington County |
| Wayne County | Weber County | | |

Note: This form is not an authorization for payment. No provider may bill for services rendered to a New Choices Waiver participant without having an appropriate, current service authorization form signed by both the provider and the New Choices Waiver Case Management Agency representative. The service authorization form will identify the specific service requested, the service start and end dates, the amount and frequency of the service ordered and the HCPCS billing code. Providers may not bill nor will Medicaid pay for services that do not fall within the authorized start and end dates, that exceed the amount and frequency authorized or that have an unauthorized HCPCS code. These services must be authorized by the Case Management Agencies on the comprehensive care plan.

The undersigned Provider Representative requests enrollment as a provider of Medicaid 1915(c) HCBS waiver services identified in this Attachment.

Signature of Provider Representative

Date

The Division of Medicaid and Health Financing, Bureau of Authorization and Community-based Services, certifies that the above provider meets all qualifications listed in Appendix C-3 of the New Choices Waiver State Implementation Plan for the covered services authorized in this agreement and assures the contract provider is continuously certified / licensed throughout the period of the agreement. The undersigned Bureau of Authorization and Community-based Services Representative also certifies that the above designated category of service and provider type are accurate.

Signature of Representative

Date

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15 ATTACHMENT B – SPECIAL PROVISIONS

15 – 1 Attachment B - Adult Residential Service

**ATTACHMENT B
SPECIAL PROVISIONS**

RESPONSIBILITIES OF ADULT RESIDENTIAL SERVICES PROVIDERS UNDER THE NEW CHOICES HOME AND COMMUNITY- BASED SERVICES WAIVER

The Home and Community-Based Services (HCBS) New Choices Waiver Program (Waiver Program) is a Medicaid sponsored program administered through the Utah Department of Health, Division of Medicaid and Health Financing, Bureau of Authorization and Community-based Services. The Waiver Program was developed to provide Medicaid recipients who have been residing long term in a nursing facility or assisted living facility with the option of receiving long term care services in home and community based settings.

The Waiver Program is intended to be utilized in conjunction with other formal and informal support systems and contributes to the health, safety and welfare of the targeted population. Home and Community-Based Services are an element of the State Medicaid Plan and must operate in accordance with all established federal and state requirements for both HCBS waivers and the overall Medicaid program. Adult Residential Services are one component of this coordinated long term care service delivery system. The roles of providers of HCBS Waiver Services must be clearly defined in order to ensure waiver participants' needs are identified and services are provided to support successful community placement.

To participate in the New Choices Waiver Program as an Adult Residential Service provider, the provider will:

1. Provide at least three meals per day.
2. Provide 24 hours a day, seven days a week, general monitoring and emergency response services.
3. Provide assistance with ADLs in accordance with my facility licensure and participant's waiver care plan.
4. Provide assistance for physical transfers as needed and as licensure allows.
5. Provide assistance to evacuate the building if necessary in accordance with licensure standards.
6. Provide housekeeping services, including personal laundry, in compliance with identified needs established in the waiver care plan.
7. Provide medication assistance in accordance with my facility licensure and the participant's assessed needs as established in the waiver care plan.
8. Provide general nursing care in accordance with facility licensure.

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9. Participate in care plan development with the case management agency and encourage resident and/or their representative to participate.
10. Interact with the resident's chosen case management agency to resolve concerns that may arise and in order to coordinate third party services.
11. Provide services as identified in the care plan.
12. Make planned social and recreational activities available to waiver participants in order to enhance their quality of life and provide a homelike setting.
13. Operate in accordance with all established federal and state requirements applicable to my facility licensure.
14. Understand that room and board are not covered by the New Choices Waiver and are not a Medicaid benefit. I am responsible for establishing these rates and they will be paid directly to the facility by the individual waiver participant or their representative. Medicaid is not responsible for payment of room and board.
15. Accept the Medicaid reimbursement rate as payment in full for a Medicaid covered service. Neither the resident nor their families will be billed additional costs for these covered services.
16. Not bill for Adult Residential Services on days that the waiver participant is not in the facility, and will notify the case management agency of such occurrences i.e. hospitalization.
17. Notify the participant's case management agency should I have concerns regarding client safety and/or believe that their needs can no longer be met at the facility.
18. Notify the waiver participant's chosen case management agency within twenty four hours of any negative incident involving the participant. The facility will utilize a standardized Incident Reporting Form, provided by the Bureau of Authorization and Community-based Services, to make these notifications.
19. Develop an individualized tracking form to ensure that Medicaid reimbursed Adult Residential Waiver Services are provided to each waiver recipient in accordance with their waiver care plan.
20. Furnish data requested by the Bureau of Authorization and Community-based Services to satisfy federal reporting requirements or to administer the Medicaid program, including data the Bureau of Authorization and Community-based Services determines necessary to evaluate the New Choices Waiver program as a component of the State Medicaid Agency's long term care network.

Type or print **PROVIDER** name

Type or print name of corporation

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PROVIDER address

Telephone number

PROVIDER signature

Date

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ATTACHMENT B - SPECIAL PROVISIONS

15 – 2 Attachment B-2, Adult Residential Service, Certified IL Facilities and Homes

**ATTACHMENT B-2
SPECIAL PROVISIONS, ADULT RESIDENTIAL SERVICES
CERTIFIED INDEPENDENT LIVING FACILITIES AND HOMES**

**RESPONSIBILITIES OF INDEPENDENT LIVING SERVICES PROVIDERS UNDER THE NEW
CHOICES HOME AND COMMUNITY-BASED SERVICES WAIVER**

The Home and Community-based Services (HCBS) New Choices Waiver Program (Waiver Program) is a Medicaid program administered through the Utah Department of Health, Division of Medicaid and Health Financing, Bureau of Authorization and Community-based Services (BACBS). The Waiver Program is designed to provide people who meet nursing facility level of care and who have been residing long term in a nursing facility or assisted living facility the option of receiving supportive services in a home or community-based setting.

The Waiver Program is intended to be used in conjunction with other formal and informal support systems and contributes to the health, safety and welfare of the targeted population. Home and Community-based Services are an element of the State Medicaid Plan and must operate in accordance with all established federal and state requirements for both HCBS waivers and the overall Medicaid program. Adult Residential Services are one component of this coordinated long term care service delivery system. The roles of providers of HCBS waiver services must be clearly defined in order to ensure waiver clients' needs are identified and services are provided to support successful community placement.

To participate in the New Choices Waiver Program as an Independent Living Services Provider, the provider will:

1. Prepare at least three meals per day.
2. Provide 24 hours a day, seven days a week, general monitoring and emergency response services. Providers must have staff on site that are reachable at all times and must be able to respond quickly in the case of emergency. Providers must develop and employ formal safety plans for each New Choices Waiver client that includes daily status checks. Personal Emergency Response Systems will only be authorized if the system is linked to provider staff.
3. Provide assistance to evacuate the building if necessary.
4. Provide housekeeping services, in compliance with identified needs specified in the waiver service authorization form. Housekeeping includes general cleaning and laundry services, including personal laundry, provided on a schedule specifically designed to meet each client's individually assessed needs.
5. Participate in care plan development with the case management agency and encourage the client and/or their representative to participate.

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6. Interact with the client's chosen case management agency to resolve concerns that may arise and to coordinate third party services.
7. Provide services as identified in the waiver care plan.
8. Make planned social and recreational activities available to clients in order to enhance their quality of life and provide a homelike setting.
9. Operate in accordance with independent living certification requirements. BACBS will perform annual on-site certification inspections to ensure ongoing compliance.
10. Understand that room and board are not covered by the New Choices Waiver and are not a Medicaid benefit. Independent Living Services Providers are responsible for establishing room and board charges and will be paid directly by the client or their representative.
11. Accept the Medicaid reimbursement rate as payment in full for a Medicaid covered service. Neither the client nor their families will be billed additional costs for these covered services.
12. Not bill for Adult Residential Services on days that the waiver client is not in the facility, and will notify the case management agency of such occurrences, e.g. hospitalization.
13. Notify the client's case management agency of concerns regarding client's safety or if you believe that their needs can no longer be met in the independent living facility or home.
14. Notify the client's chosen case management agency and, if required, BACBS of any negative incident involving the client, in accordance with New Choices Waiver Incident Reporting Protocol. This protocol is outlined in the New Choices Waiver Provider Manual, Section 16-2. Develop an individualized tracking form to ensure that Medicaid reimbursed Adult Residential Services are provided to each waiver client in accordance with their waiver care plan.
15. Furnish data requested by the Bureau of Authorization and Community-based Services to satisfy federal reporting requirements or to administer the Medicaid program, including data the BACBS determines necessary to evaluate the Home and Community-based Waiver program as a component of the State Medicaid Agency's long term care network.
16. Refrain from marketing directly to waiver clients, potential clients or their representatives.

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Type or print provider name

Type or print name of corporation

Provider address

Telephone number

Provider Signature

Date

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15 – 2 Attachment B - Case Management Services

ATTACHMENT B SPECIAL PROVISIONS

RESPONSIBILITIES OF CASE MANAGEMENT SERVICES PROVIDERS UNDER THE NEW CHOICES HOME AND COMMUNITY- BASED SERVICES WAIVER

The Home and Community-Based Services (HCBS) New Choices Waiver Program (NCW Program) is a Medicaid sponsored program administered through the Utah Department of Health, Division of Medicaid and Health Financing, Bureau of Authorization and Community-based Services. The NCW program must operate in accordance with all established federal and state requirements for both HCBS waivers and the overall Medicaid program. The Waiver Program was developed to provide Medicaid recipients who have been residing long term in a nursing facility or assisted living facility with the option of receiving long term care services in home and community based settings.

The waiver program is intended to be utilized in conjunction with other formal and informal support systems and contributes to the health, safety and welfare of the targeted population. Home and Community-Based Services are an element of the State Medicaid Plan and must operate in accordance with all established federal and state requirements for both HCBS waivers and the overall Medicaid program. Case management services are one component of this coordinated long term care service delivery system. The roles of providers of HCBS waiver services must be clearly defined in order to ensure waiver participants' needs are identified and services are provided to support successful community placement.

To participate in the New Choices Waiver Program as a case management service provider, the provider will:

1. Complete initial **comprehensive assessment utilizing the MDS-HC** as well as periodic (annual and at significant change) reassessments to determine the services and support required by participants.
2. Evaluate participant **level of care** upon participant application, annually, and in the event of a significant change in health status.
3. Assist participants with identifying non-Medicaid resources that may meet their needs.
4. Assist participants with accessing Medicaid State Plan services.
5. Develop a **comprehensive care plan** based on assessed needs and available resources regardless of the funding source. Update care plans annually and as needed to address changing needs.
6. Assist participants with selecting waiver service providers, from the list of providers developed by the Bureau of Authorization and Community-based Services, that would best meet his/her individual needs.
7. Obtain approval from the Department of Health, Division of Medicaid and Health Finance, Bureau of Authorization and Community-based Services prior to implementing the comprehensive care plan.

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8. Educate participants on their right to free choice of providers and services. Reinforce and support participant's choices.
9. Assist participant with requesting a fair hearing if choice of waiver services or service providers is denied.
10. Monitor waiver service providers to insure that services are being provided according to the assessed need documented in the comprehensive care plan.
11. Monitor on an ongoing basis the participant's health and safety status. Initiate appropriate reviews of needs and care plan as indicated.
12. Coordinate services across all Medicaid programs to achieve a holistic approach to care.
13. Face to face contact with client must be made based on assessed need. This contact must be made quarterly at a minimum.
14. Adhere to the **New Choices Disenrollment Protocol** when it appears any waiver participant may require disenrollment participant from the program.
15. Provide discharge and transition planning services to individuals to ensure their health and safety whenever the case management agency provides 30 day notice to a participant.
16. Perform internal quality assurance activities.
17. Provide case management and transition planning services up to 180 days immediately prior to the date a participant transitions to the waiver program. (Medicaid cannot be billed for these services until after the participant enters into the waiver program and has begun to receive waiver services.
18. Receive and maintain a record of incident reports, as per protocol, relating to waiver participants.
19. Follow the New Choices Waiver Incident Reporting Protocol. Respond to concerns and incidents reported by participant and/or service providers regarding participant's health, safety and/or welfare.
20. Direct marketing to consumers by a Case Management Agency is prohibited. Case Management Agencies may develop educational information that will be distributed to waiver applicants by the Bureau of Authorization and Community-based Services.
21. All forms utilized for the New Choices Waiver must be approved by the Bureau of Authorization and Community-based Services prior to dissemination to participants.

Type or print **PROVIDER** name

Type or print name of corporation

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PROVIDER address

Telephone number

PROVIDER signature

Date

16-1 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).

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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16 - 2 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.

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 Bureau of Authorization and Community – based Services (BACBS). Notification is permissible by telephone or by faxing or emailing an incident report. BACBS 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.

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- 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)
- 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 (CMA) 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 CMA 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 BACBS.
4. The CMA 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 CMA is responsible for maintaining a record of all incident reports in the participants’ case files. The CMA 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 CMA 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.
8. Within two (2) weeks after the Policy Specialist informs the CMA 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 BACBS

Notification shall be submitted to:

FAX: 801-323-1586

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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



New Choices Waiver

Incident Report 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> <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?</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><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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16 – 3 DISENROLLMENT

Purpose:

The disenrollment process is a coordinated effort between NCW and case management agencies that is expected to facilitate the following:

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

Procedure:

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

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.

Steps for notification include:

- a) **Written** notification shall be provided by the case management agency to the New Choices Waiver program
- b) Notification shall be submitted to:

Utah Department of Health
Division of Medicaid and Health Financing
Bureau of Authorization and Community-based Services
Attn: New Choices Waiver
PO Box 143112
Salt Lake City, Utah 84114-3112
FAX: 801-323-1586

- c) The case management agency will use Form DPF-1 for notification to New Choices Waiver BACBS.

Written notification shall be provided to New Choices waiver BACBS within ten days of a voluntary disenrollment.

- d) A New Choices waiver review is not required prior to a voluntary disenrollment.

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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- Death of the participant;
- Participant has been determined to no longer meet the financial requirements for Medicaid program eligibility by the Department of Workforce Services;

Participant enters a skilled nursing facility and the expected length of stay will exceed 90 days (as verified by a physician, Pre-Approved involuntary disenrollments require case managers to notify NCW within 10 days from the date of disenrollment. No NCW prior review or approval of the decision to disenroll is required, as the reasons for preapproved 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.

Steps for notification include:

- Written** notification shall be provided to New Choices Waiver by the case management agency
- Notification shall be submitted to:

Utah Department of Health, Division of Medicaid and Health Financing
Bureau of Authorization and Community-based Services
Attn: New Choices Waiver
PO Box 143112
Salt Lake City, Utah 84114-3112
FAX: 801-323-1586

- Case management agencies will use Form DPF-1 for notification to NCW within forty-eight (48) hours of a preapproved involuntary disenrollment.
- Notification shall be provided to NCW within 48 hours of discharge.
- A NCW review is not required prior to the disenrollment.

3. **Special Circumstance Involuntary 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:

- 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 CMA;
- 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.
The special circumstance disenrollment review process will consist of the following activities:

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- g) The case management agency shall compile information to articulate the disenrollment rationale;
- h) This information will then be submitted to NCW for review of the support coordination activities, as well as the disenrollment recommendation;
- i) If NCW staff concurs with the recommendation, a request for disenrollment approval will be forwarded to the BACBS Quality Assurance Unit for a final decision;
- j) 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;
- k) 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
- l) 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 Action (NOA) and right to fair hearing information.

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

Steps for notification include:

- a. **Written** notification shall be provided to NCW by the case management agency from which special circumstance involuntary disenrollment is being proposed.
- b. Notification shall be submitted to:

Utah Department of Health, Division of Medicaid and Health Financing
Bureau of Authorization and Community-based Services
Attn: New Choices Waiver
PO Box 143112
Salt Lake City, Utah 84114-3112
FAX: 801-323-1586

- c. New Choices Waiver case management agencies must notify NCW of proposed special circumstance, involuntary disenrollments at the earliest point possible when considering a participant for involuntary disenrollment. Upon receipt, NCW will log the receipt of the disenrollment notice, and will begin responding within 5 working days.
- d. Case management agencies will utilize Form DPF-2 for notification to NCW.

NCW will provide a notice of decision (Form DPF-3) to the CMA within **thirty days** of receipt of the notification.

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- e. New Choices Waiver case management agencies must notify NCW of proposed special circumstance, **imminent danger**, and involuntary disenrollments as soon as issues requiring immediate intervention are identified. NCW will assist in the coordination to expedite the process to assure appropriate program placement is achieved.
- f. Cases in which a client or others in the community are in **immediate jeopardy** will require telephonic prior-authorization to be granted by BACBS Quality Assurance Unit.
- The New Choices Waiver case management agency will contact NCW by telephone, 801-538-6155 (option 6) or 800-662-9651 (option 6).
 - The following information will be required for telephonic prior-authorizations:
 - a description of the current situation placing the client or others in immediate jeopardy;
 - a description of measures currently being employed to prevent a further deterioration of the situation;
 - a description of the program's intent regarding permanent disenrollment versus providing a temporary placement due to an acute problem.
 - In cases in which immediate jeopardy situations arise outside of regular business hours (Monday - Friday 8:00 a.m. - 5:00 p.m.); post-authorization will be required. The case management agency shall obtain post-authorization on the **first** business day after the occurrence.

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**Medicaid Home and Community Based Program Disenrollment Notice
Disenrollment Form DPF-1**

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; <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:_____

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**New Choices Waiver Home and Community Based Program
Special Circumstance Involuntary 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 CMA;
- 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"/> 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:

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 CMA;
- 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.