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

Contents

1 GENERAL POLICY

Under section 1915(c) of the Social Security Act, a State may request approval through the federal Centers for Medicare and Medicaid Services (CMS) to "waive" certain statutory requirements in order to use Medicaid funds for an array of home and community-based medical assistance services provided to eligible recipients as an alternative to institutional care. The State of Utah has requested Medicaid reimbursed home and community-based waiver services for individuals who are currently residing long term in nursing facilities, assisted living facilities, small health care (Type N) facilities or other licensed Utah medical institutions, except for institutions for mental disease (IMD) and wish to receive supportive services in a home or community-based setting, and who but for the provision of such services, would require nursing facility placement. On April 1, 2007, the Division of Medicaid and Health Financing received approval from CMS to begin operating the New Choices Waiver. The approval includes waivers of:

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

Waiver of Comparability

In contrast to Medicaid State Plan services requirements, under a waiver of comparability, the State is permitted to provide covered waiver services to eligible individuals who meet the State's criteria for Medicaid reimbursement in a nursing facility (NF), and "waiver services" need not be comparable in amount, duration, or scope to services covered under the State Plan. However, each year the State must demonstrate that the waiver is a "cost-neutral" alternative to institutional (NF) services. This means that, in the aggregate, the total annual Medicaid expenditures for waiver recipients, including their State Plan services, cannot exceed the estimated Medicaid expenditures had those same recipients received Medicaid-funded NF services.

Waiver of Institutional Deeming Requirements

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

1-1 Acronyms and Definitions

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

BLTSS Bureau of Long Term Services and Supports

CMS Centers for Medicare and Medicaid Services

DMHF Division of Medicaid and Health Financing

HCBS Home and Community Based Services

IMD Institution for Mental Disease

LOC Level of Care

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

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

NF Nursing Facility

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

SFY State Fiscal Year (July 1 – June 30)

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

SMA State Medicaid Agency

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

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

1-2 CMS Approved Waiver State Implementation Plan

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

2. This manual does not contain the full scope of the Waiver State Implementation Plan. To understand the full scope and requirements of the New Choices Waiver program, refer to the Waiver State Implementation Plan.

3. If anything written in this manual is found to be in conflict with the State Implementation Plan, the State Implementation Plan will take precedence.

2 SERVICE AVAILABILITY

1. Home and community-based waiver services are covered benefits only when provided:

    A. to an individual who meets the eligibility criteria defined in the CMS approved Waiver State Implementation Plan;

    B. pursuant to a written and approved comprehensive care plan.

2-1 Eligibility for Waiver Program

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

- *For individuals leaving acute care hospitals, specialty hospitals (non IMD), and Medicare skilled nursing facilities, participation is limited to those receiving a medical, non-psychiatric level of care.*

- *Individuals whose primary condition is attributable to a mental illness are not eligible for participation in the New Choices Waiver.*
- *Individuals who meet the intensive skilled level of care as defined in R414-502 are not eligible for participation in the New Choices Waiver.*
- *Individuals who meet the level of care criteria for admission to an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID) as defined in R414-502 are not eligible for participation in the New Choices Waiver.*
- *Individuals with a complex set of health and/or safety needs who cannot be safely served in a home and community-based setting will not be eligible for participation in the New Choices Waiver.*

2-2 Nursing Facility Level of Care

1. In determining whether the applicant has mental or physical conditions that can only be cared for in a nursing facility or the equivalent care provided through the New Choices Waiver program, the individual responsible for assessing level of care shall, in accordance with R414-502, document that at least two of the following factors exist:

    A. Due to diagnosed medical conditions, the individual requires substantial physical assistance with activities of daily living above the level of verbal prompting, supervision, or setting up;

    B. The attending physician has determined that the individual's level of dysfunction in orientation to person, place, or time requires nursing facility care, or equivalent care provided through a Medicaid home and community-based waiver program; or

    C. The medical condition and intensity of services indicate that the care needs of the applicant cannot be safely met in a less structured setting, or without the services and supports of a Medicaid home and community-based waiver program.

2. An individual will not be enrolled if it is determined during the eligibility assessment process that the person does not meet the nursing facility level of care criteria or that the health, welfare, and safety of the individual cannot be maintained through the New Choices Waiver program.

3. Individuals who are actively receiving inpatient care in hospitals, nursing facilities, or other licensed Utah medical institutions are not eligible to receive waiver services during the time of their inpatient admission, except as permitted for case management services in two specific circumstances:

    A. Up to 180 days immediately prior to waiver enrollment for discharge planning case management activities, or

    B. When an enrolled waiver participant has been admitted to an inpatient setting for temporary care.

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

3 NEW CHOICES WAIVER ADMISSION PROCESS

3-1 Application and Assessment

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

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

1. For people residing in nursing facilities or other Utah licensed medical institutions (non-IMD):

    A. Applications will be accepted from those living in nursing facilities or other Utah licensed medical institutions (non-IMD) who meet the minimum eligibility requirements listed in Section 2-1. Applications will be accepted at any time throughout the year until the CMS approved waiver enrollment cap is reached.

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

face to face assessment utilizing the MDS-HC. The deadline for completion of this assessment is within fourteen (14) calendar days of receiving the referral.

F. Upon completion of the MDS-HC assessment, the case management agency must complete and submit a Level of Care Determination Form to the NCW program office, indicating whether or not the nursing facility level of care criteria is met. This form is due within one business day following completion of the MDS-HC assessment.
G. A licensed social worker and a registered nurse from the case management agency will work with the applicant and any other representatives chosen by the applicant to understand the applicant's strengths, preferences, goals, desires, social needs, support systems, and risk factors.
H. New Choices Waiver applications will be denied when an applicant refuses to consent to quality assurance monitoring of assessments and service coordination.

2. For people residing in licensed assisted living facilities or small health care facilities (Type N), the following application process applies:
    A. Applications will be accepted from those living in licensed assisted living facilities and small health care facilities (Type N) who meet the eligibility requirements listed in Section 2-1.
    B. Applications will only be accepted during three defined open application periods each year and a limited number of applicants will be processed during each application period. For more information about the tri-annual open application process, refer to Section 3-4 Selection of Entrants to the Waiver.
    C. Open application periods are as follows:
        i. July 1 – July 14
        ii. November 1 – November 14
        iii. March 1 – March 14
    D. Upon receipt of an application during the open application period, the NCW program office will perform an initial screening of the application materials to determine if the following minimum eligibility criteria appear to be met:
        i. The application has an official date stamp with a date that falls within the open application period in which it is submitted,
        ii. The applicant is at least 18 years of age by the end of the open application period,
        iii. The applicant has Utah Medicaid financial eligibility in place OR has submitted an application to the Department of Workforce Services (DWS) for consideration of Medicaid financial eligibility,
        iv. The applicant is residing in a qualifying facility type as described in Section 2-1,
        v. By the end of the open application period, the applicant has satisfied the applicable length of stay requirement in the facility type in which they reside as described in Section 2-1, and
        vi. The applicant has supplied medical records sufficient to pass an initial nursing facility level of care screening. The applicant has supplied additional documentation requested by the NCW program needed to screen for eligibility within 5 business days.
    E. If during the screening process any of these minimum criteria are not met, the NCW program office will halt the application process and a denial letter will be generated and sent to the applicant and/or their representative. Hearing rights will be provided.
    F. Applications meeting the minimum criteria above will be collected throughout the open

application period. At the end of the open application period, the NCW program office will determine which of the applicants will proceed to the next step in the application process by following the guidelines found in Section 3-4, Selection of Entrants to the Waiver.

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

3-2 Case Management Agency Notices of Decision

1. Within one business day after completion of the comprehensive needs assessment (MDS-HC), the selected case management agency will send a written notice of decision to the applicant/representative and to the NCW program office. The notice will clearly state the case management agency's decision to accept or decline to provide case management services to the applicant. This notice will include contact information for the NCW program office should the applicant or their representative wish to discuss their options.

2. If an applicant is declined by a case management agency, this does not always mean that the applicant will be denied access to the New Choices Waiver program altogether. In certain circumstances, an applicant/representative may request that their application be forwarded to an alternate case management agency for consideration, if there is another case management agency operating in their county of residence. These requests are managed by contacting the NCW program office. The NCW program office will advise applicants (or representatives) whether or not the circumstances permit selection of an alternate case management agency.

3. If an applicant is declined by a case management agency for any of the following reasons, the NCW program office will perform a review of the decision and any supporting documentation:

    A. The case management agency determined that the applicant did not meet nursing facility level of care during the face to face comprehensive assessment process;
    B. The case management agency determined that the applicant's primary condition is attributable to mental illness;
    C. The case management agency determined that the applicant is eligible for admission to an

intermediate care facility for people with intellectual disabilities; or

D. The face-to-face comprehensive assessment indicated that the applicant has complex health and/or safety needs that exceed the NCW program's ability to safely serve them.

4. If the case management agency declines an applicant for any of the four reasons listed above, the case management agency will forward the assessment information to the NCW program office for review. If the NCW program office agrees with the case management agency's determination, the NCW program office will generate and send a denial letter to the applicant/representative denying access to the waiver program altogether and the applicant will not be permitted to select an alternate case management agency. Hearing rights will be provided. If the NCW program office does not agree with the case management agency's determination, the application can be forwarded to another agency of the applicant's choice if another case management agency is available in the applicant's service area.

5. Case management services are required for all participants in the New Choices Waiver program. An eligible applicant who has been declined by every available case management agency in their service area cannot be enrolled on the New Choices Waiver until a case management agency willing to provide services is available. The NCW program office will assist the applicant by identifying all available case management agencies in their service area and by facilitating completion of new Freedom of Choice Consent Forms and referrals to alternate agencies until a willing case management agency is identified or until all possible choices have been exhausted. At the point there are no willing case management agencies, the NCW program office will generate and send a denial letter to the applicant/representative. Hearing rights will be provided.

3-3 Enrollment

1. Once a case management agency has determined that the applicant meets the nursing facility level of care criteria and makes the decision to work with an applicant, they will begin working toward official waiver enrollment. There are two distinct enrollment processes for the NCW program and the process that a particular application goes through is determined by the type of facility they reside in when they submitted their NCW application.

   A. <u>For applicants residing in nursing facilities or licensed Utah medical institutions (non-IMD):</u>
      a. The case management agency will assist the applicant to locate a community-based residence that will meet the applicant's needs, preferences, goals and resources. This residence can be the applicant's own home or apartment, the home or apartment of a friend or family member, a licensed assisted living facility, a small health care facility (Type N), a community residential treatment facility or an independent living facility. All facility-based residential options are limited to facilities that are enrolled as providers for the New Choices Waiver program.
      b. Because payment for room and board is the responsibility of New Choices Waiver clients, a rental agreement must be negotiated between the client (or their representative) and the residence that they have chosen. If the applicant needs assistance, the case management agency will help with negotiating a rental agreement for the chosen location. When the rental

agreement is completed and signed by all parties, the case management agency must submit it to the NCW program office.

c. The NCW program office cannot coordinate NCW enrollment with DWS until the Level of Care Determination Form, Notice of Decision Letter, signed 114AR release form and a signed rental agreement are received from the case management agency. All of these items must be sent to the NCW program office by 12:00 noon on the 20th day of the month (or on the last State business day prior to the 20th of the month) in order for official enrollment to take place by the first of the following month.
d. When the all required documents are received, the NCW program office will generate and send the 927 form, the signed rental agreement and the signed 114AR release form to the Long Term Care team at the Department of Workforce Services for a separate determination of Medicaid financial eligibility.
e. Once the approval or denial of Medicaid financial eligibility is determined, DWS will complete and sign section B of the 927 and return it to the NCW program office prior to the last day of the month.
f. The NCW program office will notify the case management agency of the Medicaid financial eligibility determination and the applicant's authorization to enroll with the New Choices Waiver upon receipt of an approved 927. The case management agency will notify the applicant and begin planning for the applicant's transition to the NCW program. All enrollments for hospital and nursing facility applicants take place on the first day of the month following the completion of the 927 form. If enrollment (and move out of the hospital/nursing facility) must be delayed due to a change in the applicant's health status or for any other reason, the case management agency must notify the NCW program office right away. For all delayed enrollments, the case management agency must continue to communicate regularly with the NCW program office and shall not enroll the applicant or move them out of the hospital/nursing facility until clearing it again with the NCW program office first.
g. The final phase in the enrollment process is creation of the person centered comprehensive care plan through the person-centered care planning (PCCP) process. The case management agency shall convene a PCCP meeting with the client and anybody else that the client wishes to be present. This meeting must take place prior to the implementation of the initial care plan. Initial care plans must be written and have an effective date that is within 60 days after completion of the MDS-HC assessment. If the care plan cannot be created within 60 days, a new MDS-HC must be performed and services cannot be authorized until on or within 60 days after the new MDS-HC date. Care plan start dates can fall anytime within the 60-day window, but never earlier than the date the MDS-HC was performed or earlier than the date of NCW enrollment.

B. For applicants residing in licensed assisted living facilities and small health care (Type N) facilities:
   a. Individuals applying from licensed assisted living or small health care (Type N) facilities are not required to have Medicaid financial eligibility in place at the time of application to the NCW program, but the NCW program office will verify that a Medicaid financial eligibility application has been submitted to DWS within 30 days of the level of care assessment performed by the case management agency. Individuals must establish financial eligibility for Medicaid within 180 days following the first level of care assessment performed by a case management agency. If either of the above requirements are not met within the specified time frames, the

application will be denied and hearing rights provided.

b. The case management agency must submit a completed LOC Determination Form within one day of completion of the MDS-HC assessment. The LOC Determination Form, a Notice of Decision Letter and a signed 114AR release form must be received by the NCW program office in order for the NCW program office to proceed to the next step of coordinating with DWS. (For ALF and Type N applicants, a rental agreement is not needed at this stage, nor is there a defined deadline day of the month for the required forms to be submitted. However, case management agencies must strive to submit the required forms within one business day of completion of the MDS-HC assessment in order to avoid delaying the earliest possible enrollment date.
c. Upon receipt of the required forms from the case management agency, the NCW program office will generate the 927 form and send it to DWS along with a copy of the Pre-enrollment Lease Disclosure Form from the application and the signed 114 AR release form. The NCW program office may act as a facilitator between the applicant and DWS while DWS determines the applicant's Medicaid financial eligibility in a separate application process.
d. Once the approval or denial of Medicaid financial eligibility is determined, DWS will complete and sign section B of the 927 form and return it to the NCW program office.
e. The NCW program office will notify the case management agency of the financial eligibility determination upon receipt of the 927 form from DWS. If the 927 was approved, the case management agency will assist the applicant with locating a new residence (when applicable), negotiating a new rental agreement and coordinating the start date for waiver services. The case management agency will forward the rental agreement to the NCW program office as soon as it is completed and signed.
f. The final phase in the enrollment process is creation of the person centered care plan through the person-centered care planning (PCCP) process. The case management agency shall arrange a PCCP meeting with the client and anybody else that the client wishes to be present and this meeting must take place prior to the implementation of the initial care plan. Initial care plans. Initial care plans must be written and have an effective date within 60 days after completion of the MDS-HC assessment. If the care plan cannot be created within 60 days, a new MDS-HC must be performed and services cannot be authorized until on or within 60 days after the new MDS-HC date. Care plan start dates can fall anytime within the 60-day window, but never earlier than the date the MDS-HC was performed or earlier than the date of NCW enrollment.

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

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

3. Reserved Waiver Capacity

The New Choices Waiver program was designed to be a deinstitutionalization program with the

original objective being to offer home and community-based options for people wishing to transition out of skilled nursing facilities and other Utah licensed medical institutions (non-IMD).

In 2012, the waiver was expanded to include a second entry pathway for long term residents of licensed assisted living facilities and small health care (Type N) facilities. In order to ensure the majority of waiver slots are reserved for people wishing to transition out of nursing facilities or other Utah licensed medical institutions (non-IMD), each state fiscal year a minimum of 80% of available waiver slots will be reserved for applicants residing in nursing facilities or other Utah licensed medical institutions (non-IMD).

4. Selection of Entrants to the Waiver

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

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

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

A. During three defined open application periods each year, the NCW program will enroll up to 1/3 of the calculated number of available waiver slots that could be filled by people applying for the non-reserved slots including people who are applying from assisted living facilities or small health care facilities (Type N). Each open application period will be 14 days long during which applications will be accepted from interested assisted living facility or small health care facility (Type N) residents. Open application period date ranges are listed on the following website:

https://medicaid.utah.gov/ltc/nc/

B. Complete applications must be received with an official date stamp that falls within the date range of the open application period. The official date stamp can be a fax date stamp, a secure email date stamp, a USPS postmark date stamp or a date stamp that is placed on an application by the Utah Department of Health when an application has been hand delivered to the NCW program office. If an application is incomplete when it is received and remains incomplete 5 business days after a request for additional information, the application will be denied and hearing rights provided. Applications that do not meet the initial screening criteria listed above will be denied and hearing rights will be provided.

C. If the number of applications received during an open application period is equal to or less than the number of slots available during that application period, all applications received meeting the minimum screening criteria above will be processed to the next step in the application process.

D. If more applications are received than there is space available for a particular application period, the NCW program office will rank applicants based on length of stay.

(Applicants who have been residing in a qualifying facility type the longest will be given preference.) When this ranking has been completed, the NCW program office will return all applications above the number of available slots for that application period and hearing rights will be provided. The NCW program office will not maintain a waiting list.

E. In the event there is a length of stay tie at the ranking cut-off point, all applications in the tie meeting the minimum screening criteria will be processed to the next step in the application process. The number of applications accepted above the number of available slots for that open application period will be deducted from the number of applications permitted in the next open application period.

F. If any of the applicants selected to be processed further in the July and November open application periods are determined ineligible for enrollment or withdraw their application, these slots may be filled from applications received from individuals residing in licensed assisted living facilities and small health care (Type N) facilities during the final open application period in the current fiscal year, March 1-14.

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

1. The New Choices Waiver program is a voluntary home and community-based program that's intended to be one option among others in the range of long term care services. Utah Medicaid recipients meeting the nursing facility level of care criteria and all other New Choices Waiver criteria are afforded the choice of which long term care service delivery system they would like to access. Prior to enrollment in the New Choices Waiver, applicants are advised of their right to choose to receive care provided in a nursing facility (NF) or they may choose to receive services through the home and community-based New Choices Waiver program.

2. As part of the application packet, the applicant and/or their chosen representative will be advised in writing of all available services and given the opportunity to state which long term care service delivery option they choose to access. The applicant's choice will be documented in writing on the Freedom of Choice Consent Form, signed by the applicant or their representative, and maintained as part of the individual record. A member of the NCW program office staff will verify that this form has been completed and that the applicant has chosen to receive home and community-based services through the New Choices Waiver program before processing the application to the next step in the process.

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

4-1 Participant's Freedom of Choice of Providers

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

Freedom of Choice and Conflict Free Case Management

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

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

    A. Until March 1, 2019, if a client has been assessed to need goods and/or services through any of the following NCW services the case management agency may purchase the goods and/or service(s) from a non-Medicaid retailer or other entity and then receive direct Medicaid reimbursement through the usual and customary claims reimbursement process to pay the non-Medicaid retailer or other entity. For these instances, it is permitted for the case management agency to be listed on the care plan as a pass-through payment entity in order to ensure access to care:

        i. Assistive Technology Devices (T2028)
        ii. Environmental Accessibility Adaptations (S5165 and T2039)
        iii. Community Transition Services (T2038)
        iv. Transportation- non medical – Public Transit Pass (T2004)
        v. Specialized Medical Equipment (T2029)

    B. By March 1, 2019, Utah will implement the use of a financial transaction services contractor to pay for goods and services purchased from retail stores, general contractors or other entities not directly enrolled as Medicaid providers. Starting March 1, 2019, case management agencies will not be permitted to act as pass-through payment agents for the above listed services, except as provided in section 4-1-C.

    C. If it has been determined that the case management agency is the only willing, qualified provider enrolled to offer other paid waiver or non-waiver services in a particular geographical

region, an exception can be made to permit the client to select the case management agency as their provider for the other services. The case management agency must provide justification to the NCW program office during the care plan submission process and the NCW program office will perform an analysis to determine whether or not it is appropriate to override the conflict of interest rules.

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

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

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

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

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

    A. Voluntary disenrollments are cases in which participants, or their representative (when applicable), choose to initiate disenrollment from the waiver.

Refusal to participate in quality assurance monitoring is considered voluntary disenrollment.
Disenrollments are also considered voluntary when the waiver participant enters a skilled nursing facility for a stay of less than 90 days and chooses not to transition back to the original waiver program. This includes cases in which the participant transitions to another waiver program from the skilled nursing facility.

Voluntary disenrollments require that case managers notify NCW within 10 days from the date of disenrollment using the DPF-1 form. The DPF-1 form must be signed by the participant or their designated representative, if applicable. NCW prior review or approval of the decision to disenroll is not required.

Additional documentation will be maintained by the case management agency that describes the participant's intent to disenroll from the waiver program. This documentation should also outline discharge planning activities completed by the case manager with the waiver participant as part of the disenrollment process.

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

a. Death of the Participant;

b. Participant has been determined to no longer meet the financial requirements for Medicaid program eligibility by the Department of Workforce Services;
c. Participant enters a skilled nursing facility, and the expected length of stay will exceed 90 days (as verified in writing by a physician).
d. Participant enters a skilled nursing facility and the actual length of stay has reached 90 days or more. (A physician's statement is not required for this circumstance.)

Pre-Approved involuntary disenrollments require that case managers notify NCW within 10 days from the date of disenrollment using a DPF-1 form. Prior review or approval of the decision to disenroll is not required. Documentation will be maintained by the case management agency, detailing the discharge planning activities completed with the waiver participant as part of the disenrollment process when appropriate.

C. Special circumstance 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 BLTSS Quality Assurance Unit. Examples of this type of disenrollment include:

a. Participant no longer meets the level of care requirements for the New Choices Waiver;
b. Participant's health and safety needs cannot be met by the waiver program's services and supports;
c. Participant has demonstrated non-compliance with the agreed upon care plan and is unwilling to negotiate a plan of care that meets minimal safety standards;
d. Participant has demonstrated non-compliance with a signed health and safety agreement with NCW or the case management agency; or
e. Participant's whereabouts are unknown for more than 30 days, and a decision regarding ongoing financial eligibility from the Department of Workforce Services has not been rendered.

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

A. The case management agency shall compile all applicable log notes, records and other information to support that supports the disenrollment request;
B. This information will then be submitted to the NCW program office along with a completed DPF-2 form detailing specific discharge plans to address each of the client's assessed needs;
C. If after reviewing the submitted documents the NCW program office agrees with the disenrollment recommendation and believes the discharge planning activities are sufficient to meet the client's assessed needs, a request for disenrollment approval will be forwarded to the BLTSS Quality Assurance Unit for a final decision;
D. The BLTSS Quality Assurance Unit will review and assure that the disenrollment request is appropriate, that adequate discharge planning is in place to meet the client's assessed needs and that all Medicaid State Plan, waiver services, non-waiver services and other available services/resources have been fully utilized in an effort to meet the participant's needs prior to disenrollment being requested;

E. The NCW program office and/or the BLTSS Quality Assurance Unit may facilitate meetings with appropriate parties, as needed, to complete the review and make an appropriate final decision on the proposed disenrollment; and
F. The BLTSS Quality Assurance Unit will communicate a final disenrollment decision to the NCW program office.

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

The case management agency will initiate discharge planning activities sufficient to assure a smooth transition to an alternate Medicaid program and/or to other services. Discharge planning activities shall be documented in the client's case record within the case management agency. If the client (or representative) files an appeal with the Medicaid Fair Hearings Office, the case management agency will continue to serve the client and maintain all NCW standards (including updating the comprehensive care plan when appropriate) throughout the hearing process and until a decision is reached.

If an individual who has been disenrolled from the NCW program through the special circumstance involuntary disenrollment process later reapplies to the NCW program, the NCW program office will review records from their current place of residence and any other relevant information to determine whether the circumstances causing the disenrollment have been resolved. If the NCW program office determines that the circumstances causing the individual's disenrollment continue to exist, the application will be denied and hearing rights will be provided.

4-3 Grievances and Appeals

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

1. If a waiver applicant, a waiver client or their chosen representative(s) disagree with a decision that has been made regarding their NCW application or regarding their services, providers or any other aspect of their care, they may elect to engage in an informal dispute resolution process by contacting the Complaints and Grievances Coordinator with the NCW program office at (800)662-9651, option 6.

2. The Division of Medicaid and Health Financing provides an opportunity for a Fair Hearing upon written request, if an individual is:

   A. Not given the choice of institutional (NF) care or HCBS waiver services;

B. Denied the waiver provider(s) of choice if more than one provider is available to provide the service(s);

C. Denied access to the waiver program or to waiver services identified as necessary to prevent institutionalization or given services that are insufficient in amount, duration or frequency to meet the identified need; or

D. Experiences a reduction, suspension, or termination of waiver services that the waiver client or their representative believes they are eligible to receive.

3. The NCW program office will notify the applicant and/or their chosen representative with a Notice of Decision (NOD) if the applicant is denied access to the waiver program. The NOD will provide instructions for how to request a Medicaid Fair Hearing.

4. The Case Management Agency will notify the participant and/or their chosen representative with a Notice of Decision (NOD) if an enrolled participant experiences any of the other situations described above. The NOD will provide instructions for how to request a Medicaid Fair Hearing.

5. A participant who believes they have been wrongly denied choice of services or access to services or providers may request a Fair Hearing within 30 calendar days from the date listed on the NOD. The participant may elect to continue their waiver services if the participant or provider requests a hearing within 10 calendar days after the date of action.

6. The participant is encouraged to use the informal dispute resolution process to bring about a fair resolution more quickly, but the informal dispute resolution process is not required and a client or their representative may bypass or interrupt the informal dispute resolution process by completing a request for hearing and sending it to the Division of Medicaid and Health Financing.

7. The choice to engage in the informal dispute resolution process does not change the timely filing requirements of the Fair Hearings process. If a client wishes to go before the Hearings Office, a request for hearing must be submitted within the mandatory timeframes established by the Division of Medicaid and Health Financing.

PROVIDER PARTICIPATION

5-1 Provider Enrollment

1. Home and community-based waiver services for New Choices Waiver participants are covered benefits only when delivered by a provider enrolled with the State Medicaid Agency to provide the services as part of the NCW program and that are authorized by each participant's chosen case management agency in an approved comprehensive care plan.

2. Any setting in which services were not being provided under an approved state plan, waiver or demonstration as of March 1, 2014 must be in compliance with regulations for the HCBS Settings Rule by the effective date of the program (the time the state submits a claim for Federal HCBS reimbursement).
3. 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 submitting a provider enrollment application through the PRISM Provider Portal. Information about how to access the Provider Portal can be found on the Utah Medicaid website: https://medicaid.utah.gov/

4. Providers are only authorized to provide the waiver services specified and approved in the provider's Attachment A within the PRISM Provider Portal. The service area for each NCW service the provider enrolls to offer is limited to the counties specified for that specific service in the same Attachment A. Services cannot be provided to NCW clients until the services (including amount, frequency and duration) are authorized by a New Choices Waiver case management agency representative in an approved comprehensive care plan. Providers shall not initiate services for a NCW client until the provider has an approved written service authorization from the client's chosen waiver case management agency.

5-2 Provider Reimbursement

1. A unique provider number is issued for each waiver service provider. When submitting claims for reimbursement, the provider must use the proper provider number associated with the waiver that the waiver participant is enrolled in. Claims containing a provider number that is not associated with the proper waiver will be denied.

2. Providers will be reimbursed according to the specified reimbursement rate(s).

3. Direct service providers may only claim Medicaid reimbursement for services that are ordered by the responsible New Choices Waiver case management agency and for which the provider has a current, signed service authorization form for the individual participant for whom the service is authorized. Service authorizations are valid for a maximum of one year, and must be reissued yearly or when there is a change in the service type, amount, frequency, or end date of an existing service or a new service is started. The case management agency will supply the service provider with a service authorization form clearly identifying the New Choices Waiver participant, the service requested, the HCPCS billing code, the amount and frequency of the service ordered and the start and end date of the service. Claims must be consistent with the authorized participant and the HCPCS code(s), amount, frequency and dates ordered by the waiver case management agency. Claims paid for services provided that exceed the amount, frequency or dates authorized, or for HCPCS codes (services) for which there is no approved service authorization form will be subject to a recovery of funds. Case management agencies may be held financially responsible for issuing a service authorization form to a provider that does not match the HCPCS code, service scope, start and end date, number of service units, frequency of service, and/or provider name listed on an individual's approved care plan with an end date of July 1, 2019 or later.

4. With the exception of permitted case management services, providers may not provide services to participants who have been admitted to any inpatient setting including but not limited to a hospital, skilled nursing facility, specialty behavioral health hospital, or rehabilitation facility.

5. All providers must adhere to service standards and limitations described in this manual, the terms and conditions of the Medicaid provider agreement, the terms and conditions of Attachments A and B for each service type and the terms and conditions of the New Choices Waiver State Implementation Plan.

6. Accurate records of each service encounter must be kept by each provider (including case management agencies) and made available upon request by the NCW program office or any other unit within the Division of Medicaid and Health Financing. Records should include at a minimum:

   A. The participant's first and last name
   B. The date of service for each service encounter
   C. The start and end times for each service encounter
   D. The service provided (by service title)
   E. Notes describing the service encounter in detail
   F. The name(s) of the individual direct service provider(s) who performed the service
   G. Signature(s) of the individual direct service provider(s)

7. The following are examples of circumstances that are not reimbursable by Medicaid. This is not an all-inclusive list:

   A. If a waiver participant misses a scheduled appointment, Medicaid cannot be billed for the missed appointment even if the participant did not abide by the provider's cancellation policy. The provider can bill the individual directly for a missed appointment only if it is part of the provider's policy to bill all clients for missed appointments, not just Medicaid recipients. If the provider has such a policy, they are responsible to notify the participant of this policy prior to providing services to the individual.
   B. Services provided to a NCW participant who was not authorized to receive the service cannot be billed to Medicaid.
   C. Unused units that have been authorized for one waiver participant cannot be transferred to another waiver participant. If a provider believes that a participant requires more units of service than are authorized on the service authorization form, the provider must contact the assigned case management agency to request an assessment of need.
   D. Claims submitted for services that were not rendered to the participant are not reimbursable, even if there are unused units remaining.
   E. Any claims paid for services in excess of the amount, duration or frequency listed on the approved care plan or for services that are not listed on the approved care plan for the specific participant will be recovered.

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

5-3 Standards of Service

Data Security & Privacy

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

Breach Reporting/Data Loss

Providers must report to the NCW program, either by email or telephone, any breach or loss of PHI/PII. This report should be completed not more than 24 hours after the provider knows, or should have reasonably known about the breach. The provider must also submit a report in writing/by email to NCW within 5 business days of the breach. The provider will also cooperate with any investigation of the breach or data loss.

5-4 Provider Rights to a Fair Hearing

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

5-5 Provider Non-Compliance

Contract Termination

The State Medicaid Agency may terminate the provider's New Choices Waiver contract in accordance with R414-22, Administrative Sanction Procedures and Regulations, after giving the provider 30 days advance written notice for either of the following reasons:

1. The State Medicaid Agency detects a pattern of non-compliance with general Utah Medicaid provider standards

2. The State Medicaid Agency detects a pattern of non-compliance with NCW policies, procedures and/or provisions.
3. The State Medicaid Agency detects significant misconduct or substantial evidence of misconduct that violates requirements of the Medicaid waiver program.

The provider will be given hearing rights for any adverse actions taken by the State Medicaid Agency.

Examples of conduct that constitute patterns of non-compliance include but are not limited to:

a) Abuse, neglect or exploitation of waiver clients;
b) Isolating individuals from the broader community and non-compliance with the HCBS Settings Final Rule
c) Inaccurate level of care assessment documentation;
d) Billing Medicaid in excess of the amount, duration and frequency of services that have been authorized;
e) Billing Medicaid for services not provided;
f) Inadequate or non-existent record keeping;
g) Repeatedly tardy care plan submission;
h) Billing Medicaid for case management services provided by individuals that do not meet the minimum qualifications of RN or SSW licensure (or equivalent or higher licensure);
i) Not maintaining minimum provider qualifications such as required business license or certification;
j) Acts of direct marketing to prospective or currently enrolled NCW clients or their representatives;
k) Acts of coercion or manipulation of client freedom of choice rights;
l) Acts of offering or receiving incentives or kick-backs to or from other providers or entities in an effort to manipulate client freedom of choice rights;
m) Lack of adequate provider representation at annual mandatory provider trainings and/or completion of required provider trainings;
n) Billing NCW clients or their representatives for services covered by Medicaid

If the State Medicaid Agency discovers conduct that constitutes a pattern of non-compliance, or discovers that a single violation of general Medicaid or NCW policy has occurred, but elects not to terminate the provider's New Choices Waiver contract, the State Medicaid Agency may instead:

a) Require the provider to repay any overpayments;
b) Complete additional training;
c) Submit a Corrective Action Plan;
d) Submit to additional monitoring activities in order to avoid contract termination;
e) Withhold payment in accordance with R414-1-31, Withholding of Payments; or
f) Suspend referrals of new clients until the provider has met established compliance targets or has established an approved Corrective Action Plan.

Corrective Action Plan

The State Medicaid Agency may request the provider submit a Corrective Action Plan to address individual instances or patterns of non-compliance with general Medicaid or NCW policy. A Corrective Action Plan may take any of several forms. It may include training, revised provider agency

policies/procedures, additional staff, different staffing patterns, etc. Technological solutions may be implemented to alert for timeliness of home visits, levels of care and service plans, etc. Each Corrective Action Plan must measure the impact to determine whether it was effective. If not, other interventions should be explored. The State Medicaid Agency may require additional monitoring activities to assure the effectiveness of interventions.

Assuring Freedom of Choice

New Choices Waiver affords clients the fundamental right to select their preferred provider for NCW services assessed to be needed and to select the preferred provider for Medicaid State Plan services. This selection is to be made without coercion or undue influence. Providers may not influence prospective or current clients' Freedom of Choice in any way and are prohibited from direct marketing activities. Examples of direct marketing include, but are not limited to, unsolicited direct marketing activities to prospective NCW clients during inpatient stays; unsolicited direct marketing to health care settings where prospective NCW clients may reside; and unsolicited direct marketing to health care providers/entities. Providers may not enter into formal or informal contracts/agreements with other entities or quid pro quo arrangements that have the effect of influencing or manipulating Freedom of Choice. Outside of excellent NCW service provision which would naturally garner recognition, marketing strategies shall be limited to indirect marketing (materials such as brochures and business cards that individuals can access at their preference.)

Providers may not approach prospective or currently enrolled NCW clients or their representatives unless the client or representative explicitly requests information from the provider for the purposes of exploring available provider options. When approached by prospective or currently enrolled NCW clients or their representatives who need general information about the NCW program or assistance with the application process, the provider may refer the inquirer to the NCW Program Office helpline for information or the provider may assist but shall make it expressly clear that the individual has the right to select any available waiver provider or change their provider at any time. Providers may not require a prospective client or their representative to select a particular provider, including themselves, in exchange for assistance with understanding the NCW program services or assistance with the application process. Any assistance provided by case management agencies to prospective clients or their representatives prior to receipt of a referral from the NCW Program Office is not reimbursable under the NCW program.

Providers may not offer financial incentives or other enticements or otherwise persuade a prospective or currently enrolled NCW client to choose or transfer to the provider or to an individual case worker for case management services. If a case manager leaves employment with one NCW case management provider and becomes employed with another NCW case management provider, that case manager shall not advise clients on their existing NCW caseload to switch to the new case management agency in order to keep that case manager. Provider may not require NCW clients to select a certain waiver or non-waiver provider for other services listed on the person-centered care plan.

The State Medicaid Agency shall engage in surveillance and monitoring activities to assure that individual Freedom of Choice is afforded. Instances of violation of Freedom of Choice may be addressed with a series of restrictions concluding with contact termination. The State Medicaid Agency may withhold authorization to serve additional NCW clients for 90 days after the first violation; for 180 days after the second violation; and shall terminate the provider's New Choices Waiver contract following the third violation. The provider will be given hearing rights for any adverse actions taken by the State Medicaid Agency.

6 AUTHORIZATION OF WAIVER SERVICES

All waiver services must be approved by the NCW program office in order to be eligible for payment. The selected case management agency will submit the individual comprehensive care plan to the NCW program office for review and the approval by an authorized NCW program office representative will constitute prior approval. The case management agency will provide the selected NCW service provider(s) with a New Choices Waiver Adult Residential Services Provider Authorization Form or a New Choices Waiver Service Authorization Form, as applicable. The service authorization form clearly identifies participant's name, Medicaid number, service start and end date, approved waiver service(s), approved number of service units, approved frequency of service and HCPCS code. Units listed on the service authorization form may not exceed units approved by the NCW program office. Any services provided in excess of approved annualized aggregate amounts are not billable to Medicaid. Any paid claims in excess of approved amounts or for services not listed on the approved care plan will be recovered. Case management agencies may be held financially responsible for issuing a service authorization form to a provider that does not match the HCPCS code, service scope, start and end date, number of service units, frequency of service, and/or provider name listed on an individual's approved care plan with an end date of July 1, 2019 or later.

7 MDS-HC ASSESSMENT INSTRUMENT / LEVEL OF CARE

The Inter RAI MINIMUM DATA SET - HOME CARE (MDS-HC) is the standard comprehensive assessment instrument used in the New Choices Waiver. It includes all the data fields necessary to measure the participant's level of care as defined in the State's Medicaid nursing facility admission criteria. Registered nurses or physicians licensed in Utah are responsible for collecting the needed information and for making the level of care determinations. Every RN or physician assessor must receive MDS-HC training provided by designated State level staff prior to administering the MDS-HC for the first time.

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

7-1 Participant – Centered Care Planning

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

Furthermore, during the assessment and person-centered care planning process, the waiver case management agency will review participant rights and responsibilities with each participant and/or their representative and will provide avenues through which to notify appropriate authorities or entities when

the participant may have experienced abuse, neglect or exploitation. Each participant and/or representative will be provided with a copy of their rights and responsibilities and with contact information to notify appropriate authorities or entities.

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

Risk Assessment and Mitigation

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

During the care planning process it is the responsibility of the case manager to monitor for non-compliant HCBS settings as well as to document any human rights restrictions which apply to the participant. This documentation must include information on the restriction, why it is being used, what lesser intrusive methods were tried previously (and why they were insufficient to maintain the health and safety of the individual) and a plan to phase-out the use of the intervention/restriction (if possible).

Care Plan Development Timeframe Requirements

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

Other Care Planning Requirements

1. The case management agency and participant will review the contents of the care plant as part of the PCCP team and the case management agency will submit it to NCW program office for review and approval prior to implementation. The approval of the care plan by the NCW program office will constitute formal authorization to the case management agency of the services to be provided to the

participant.

2. The comprehensive care plan will include a statement notifying the participant of their right to appeal to the State Medicaid Agency if they are denied their choice of service providers of if they are denied services that they believe they are eligible to receive. The client or legal representative must acknowledge receipt of their right to a fair hearing by signing the comprehensive care plan. The case management agency will be responsible for maintaining a written copy or electronic facsimiles of these plans of care for a minimum period of three years as required by 45 CFR 74.53.

3. The case management agency will review the list of authorized service providers with the participant and complete a Freedom of Choice form acknowledging the participant's selected service providers. The case management agency will maintain this form as part of the participant's records and update it in conjunction with the revision of the comprehensive care plan.

4. The case management agency will provide a service authorization form to the participant selected service providers in accordance with the approved comprehensive care plan. The service authorization form clearly identifies the participant's name, Medicaid number, service start and end date, approved waiver service, approved number of service units, approved frequency of service and HCPCS code. Units listed on the service authorization form may not exceed units approved by the NCW program office on the care plan. Service authorization forms will be updated in conjunction with changes made to the comprehensive care plan. Case management agencies must also notify providers if a service authorization previously issued has been changed or terminated. Case management agencies may be held financially responsible for issuing a service authorization form to a provider that does not match the HCPCS code, service scope, start and end date, number of service units, frequency of service, and/or provider name listed on an individual's approved care plan with an end date of July 1, 2019 or later.

5. The New Choices Waiver Program Office is responsible for conducting quality assurance monitoring. Quality assurance is conducted through various activities and aims to assess the quality of services provided to waiver participants and evaluate adherence to policy.

   Through observational audits the New Choices Waiver Program Office will assess the provision of case management, assessments, and person centered care planning. In addition to the purpose of quality assurance stated above, observational audits will also allow the New Choices Waiver Program Office to increase internal understanding of interactions between waiver participants and case management agencies.

   Participation in the observational audit, by the waiver participant and case management agency, is a requirement of waiver enrollment. Refusal to participate by the waiver participant is considered voluntarily disenrollment. Information gathered through the observational audit may be used to determine a waiver participant's initial and ongoing eligibility; an application may be denied based on information collected through the observation. A provider may be subject to corrective action based on information gathered through quality assurance monitoring.

Care Plan Reviews

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

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

1. is not self-limiting;

2. impacts on more than one area of the participant's health status; and
3. requires interdisciplinary review and/or revision of the plan of care.

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

A full care plan review and update is conducted:

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

Significant Change Care Plans

All significant change care plans requesting the addition of a new service(s) to an existing approved care plan must be submitted to the New Choices Waiver Program Office either before or within 30 days of the start date of the new service.

Significant change care plans submitted to correct errors to existing services or for other reasons will still be considered for approval, if they are submitted within 60 days of the care plan's expiration date. Examples include:

1. Errors in the amount or frequency of services requested
2. Errors in the provider's name
3. Errors in the HCPCS Code or service title
4. Inadvertent omission of a service

Requests to amend an expired care plan can be submitted within the 90 days following the care plan expiration date. Requests for an amendment to care plans that are more than 90 days after the care plan's expiration date will be denied.

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

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 should be submitted prior to the expiration of the care plan. Requests for an amendment to an expired care plan must be submitted within the 90 days following the care plan expiration date, or the request will be denied.

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

1. Waiver case managers may continue to provide case management services to participants who have entered a nursing home or hospital for up to ninety (90) days after the participant has been admitted, if there is a reasonable expectation that the participant will be able to return to the community within that ninety (90) day timeframe. A participant must be disenrolled from the waiver when it is determined by a physician that the expected length of stay in a hospital or nursing facility will exceed 90 days or if the actual length of stay has reached 90 days. (See Section 4-2 for disenrollment procedures.)

    A. HCPCS Code T2024 should be used to bill for any units of case management provided on dates of service in which a participant is an inpatient of a nursing facility or hospital.

2. Participants who have been disenrolled due to exceeding a ninety (90) day stay in a hospital or nursing facility may request to re-enroll upon stabilization of their medical condition,

    A. If a former participant has remained in the nursing facility or hospital and has received continuous care, he or she may contact their case management agency directly and request a new evaluation without having to complete a new application. The case management agency must

complete a full MDS-HC, LOC Determination Form, rental agreement, PCCP addendum and comprehensive care plan and submit them to BLTSS for approval prior to re-enrollment. Case

management agencies must submit paperwork using the guidelines and deadlines listed in Section 6, Authorization of Waiver Services. Case management agencies should not initiate waiver services until an approved 927 is received listing a NCW re-enrollment date for the client.

B. If a disenrolled waiver client experiences an interruption in nursing facility or equivalent care during the time of disenrollment from the NCW program, the individual will be required to submit a new application and reestablish that they meet all waiver eligibility criteria as specified in Section 2 and Section 3 of this manual in order to re-enroll in the NCW program.

3. Adult Residential Services providers may not bill for dates of service when the waiver client is away from the facility for full 24-hour days. The New Choices Waiver does not cover “room holds” for time periods when a waiver client is away, including during vacations, admissions to a hospital or nursing facility or any other absence of one or more 24-hour day. (A 24-hour day begins and ends at midnight.)

7-3 Case Management Monitoring

1. Case management monitoring activities are based on the assessed need of the individual participant.

2. At a minimum, the case management agency must make at least one monthly contact directly with the participant either by telephone or in person.

   A. If a participant’s mental capacity or ability to communicate is diminished to the point of being unable to have meaningful telephone contact, a monthly face to face contact with the participant will become necessary in order to ensure that the participant’s needs are being met. Additional collateral contacts with involved care providers and/or family members may also become necessary for effective monitoring.

3. If a participant is able to have meaningful telephone contact, the case management agency may deem it appropriate based on assessed need to have monthly contact with the participant by telephone. At a minimum, one face to face visit per quarter is required.

4. The case management agency will monitor to assure the provision and quality of services identified in the participant’s care plan. This includes ensuring that services are being provided in the amount, frequency and duration ordered in the care plan.

5. The case management agency will monitor on an ongoing basis the participant’s health and safety status and initiate appropriate reviews of service needs and care plans as necessary. Case notes should reflect any health or safety issues and activities toward resolution of those issues.

6. The case management agency should be notified any time a participant is away from an adult residential facility overnight.

During routine on-site visits to monitor quality of care, case managers observe residents in their daily environment and interview them to determine overall level of satisfaction with care and to determine

whether any restraints, seclusions or other rights restrictions have occurred. Case management agencies are required to notify the NCW program office anytime a participant has been physically or chemically restrained or secluded in a facility, and the NCW program office is required to notify Licensing.

8 SELF-ADMINISTERED SERVICES

8-1 Definition and Employer Authority

1. Self-administered services (SAS) are a few of the array of services available through the New Choices Waiver that may be authorized to address the assessed needs of the participant. Self-administered services mean service delivery that is provided through a non-agency based provider to a participant who lives in his or her own home or the home of a family member. Participants receiving Adult Residential Services are not eligible for self-administered services. Under the self-administered method, the participant and/or their chosen designee hire individual employees to deliver a waiver service. The participant/participant designee is then responsible to perform the functions of supervising, hiring, assuring that employee qualifications are met, scheduling, assuring accuracy of timesheets, etc. of the individual employee.

2. The self-administered employer authority requires the waiver participant to use a Waiver Financial Management Services (FMS) Agent as an integral component of the waiver services to assist with managing the employer-related financial responsibilities associated with the employer-employee relationship. The Waiver Financial Management Services Agent is a person or organization that assists waiver participants and their representatives, when appropriate, in performing a number of employer-related tasks, without being considered the common law employers of the service providers. Tasks performed by the Waiver Financial Management Services Agent include documenting service provider's qualifications, collecting service provider time records, preparing payroll for participants' service providers, and withholding, filing, and depositing federal, state, and local employment taxes.

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

8-2 Self- Administered Services Available to Qualified Participants

1. Self –administered services apply only to those participants with identified needs that the case manager has determined to qualify for one or more of the services listed below. These services are the only services available under the self-administered services method:

A. Attendant Care Services
B. Chore Services
C. Homemaker Services
D. Respite care – Hourly

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

8-3 Self- Administered Services Case Management Responsibilities

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

2. Determine that the participant or participant designee has the ability to understand the risks, rights and responsibilities of receiving services through the Self-Administered Services method and is able to participate in Self- Administered Services.

3. Inform the participant that he or she may choose a designee to assist in the administration of the participant's services and the responsibilities as an employer. This designation is documented in the PARTICIPANT LETTER OF AGREEMENT.

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

8-4 Self-Administered Services Case Manager Packet

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

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

   B. Participant Packet
      - Employer Checklist
      - Participant Letter of Agreement - requires participant/participant designee signature
      - Back Up Service Plan – requires participant/participant designee and case manager signatures
      - Utah Criminal History Record Review for Prospective Employees

- Employment Agreement Form –requires employee and participant/participant designee signatures
- New Choices Waiver Provider Code of Conduct – requires employee and participant/participant designee signatures
- Incident Reporting Protocol and Incident Reporting Form

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

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

2. The case management agency retains completed copies of the following documents for their files:
- Participant Letter of Agreement
- Back up Service Plan
- Utah Criminal History Record Review for Prospective Employees
- Employment Agreement Form
- New Choices Waiver Provider Code of Conduct, including signed signature page
- Documents required by the Financial Management Services Agency

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

8-5 Self- Administered Services Care Planning

1. The case manager works with the participant/participant designee to determine the units of service appropriate to meet the identified service needs and discusses the care plan and service limits.

   A. Assess the participant's need for Consumer Preparation Services.

   B. If the participant is eligible for Attendant Care, use the Unit Allocation Form and instructions to assess the level of assistance required. Ensure participant has utilized Medicaid State Plan services to the extent available.

   C. If the participant is eligible for Chore Services, ensure that no other household member or other entity is capable of performing, responsible to provide, or financially able to pay for the service. In the case of rental property, examine the lease to make sure no one else is responsible to provide Chore Services.

   D. If the participant is eligible for Homemaker Services, ensure that the person normally responsible for homemaking is temporarily absent or unable to manage the home.

   E. Once developed, the case manager will submit the care plan to the NCW program office for approval.

2. When all documents, requirements, and care planning are complete, fax or mail the Authorization Form for self-administered services and all required FMS employer and employee forms to the selected FMS Agency:

   Morning Star Financial Services
   Fax: 888-657-0874
   9400 Golden Valley Road
   Golden Valley, MN 55427

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

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

8-6 Self-Administered Services Ongoing Monitoring:

1. The case management agency is responsible for monitoring the safety and well-being of the participant and the quality and effectiveness of the self-administered service(s) being delivered.

2. The case management agency will monitor the relationship between the participant and the employee(s) and have ongoing contact with the participant/participant designee and employee(s) through the following methods:

A. An initial face to face visit with the participant/participant designee and employee within two (2) weeks of start-up of the service. Additional face to face visits with the participant and employee may be required as determined by the case manager.
B. Monthly contacts, either by telephone or face to face, as described in Section 7-4.
C. An annual reassessment of the care plan to determine changes in condition, reevaluate and adjust the care plan, and offer additional training to the participant and/or employee(s).
D. Event based contacts either by telephone or face to face visits, as warranted.
E. During each contact assess the participant to assure his or her needs are being met. Document the results of each contact in the case file.

3. The case management agency is responsible for notifying the financial management agent when any of the following occurs:

A. The participant is no longer eligible for services.
B. A new service is authorized or an existing service is no longer authorized.
C. There is a change in the number of units authorized or the frequency of service.
D. The participant is deceased.
E. There is a change in Case Managers.
F. The participant is in the hospital or nursing home.
G. The participant has moved.

8-7 Discontinuation of Self-Administered Services

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

A. The participant is in the hospital, nursing or rehabilitation facility.
B. Voluntary withdrawal.
C. The participant or representative fails to provide the required documentation or refuses to follow the service descriptions agreed upon in the care plan.
D. There is a determination that funds are being misused or evidence that the service is not being performed.
E. There is evidence of abuse, neglect or exploitation of the participant by the employee or designee.
F. The participant fails to maintain Medicaid waiver eligibility.
G. The participant/participant designee fails to cooperate with the agreed upon care plan; and/or the participant or designee fails to cooperate with authorization changes or rules.
H. If the case manager determines that the participant is no longer able to manage the services authorized in the care plan and no participant designee is available, self-administered services will no longer be authorized. The case manager will work with the participant to revise the care plan to order services from the array available through agency based providers. This process will include all aspects of service plan development, including participation by the participant and individuals of his or her choosing and offering choice of providers.

2. Prior to discontinuing services provided by the self-administered services method, the case manager will discuss with the participant the discontinuation of services and will notify the NCW program office. The participant/participant designee will be given written notice and will be given the opportunity to appeal the decision following established appeal procedures.

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

9 Incident Reporting Protocol

PURPOSE:

Waiver programs must provide adequate and appropriate services that safeguard the health and welfare of all enrolled participants. Waiver programs must also assure financial accountability for funds expended for waiver services. Systematic incident reporting provides a mechanism to assure ongoing monitoring of serious incidents, the provider's response to incidents and the interventions implemented to prevent reoccurrence. This protocol outlines the responsibilities of New Choices Waiver providers regarding adverse incidents. Failure to comply with the NCW Incident Reporting Policy and/or the NCW Program Office's request for information during reporting/investigation activities may be addressed with a corrective action plan; withholding of payments in accordance with R414-1-31, Withholding of Payments; and/or holds on authorization to serve additional NCW participants in accordance with R414-22-4, Grounds for Sanctioning Providers.

RESPONSIBILITIES OF WAIVER SERVICES PROVIDERS

1. All negative events experienced by NCW participants must be reported by NCW service providers to the participant's case management agency within 24 hours of discovery by sending an incident report to the case management agency's designated incident reporting fax or email. This contact information and the NCW Incident Report Form can be found at the NCW website: https://medicaid.utah.gov/ltc/nc-providers/

2. In cases where the negative event and/or the timing of reporting falls on a weekend or holiday, reporting the negative event by the next business day is permissible.

3. Reportable negative events include, but are not limited to:
   a) Death, regardless of the circumstances

b) Changes in medical or functional status
c) Falls with or without injury
d) ER treatment for any reason
e) Hospital admission for any reason
f) Mental health decline
g) Suicide attempt
h) The start of or discontinuation of hospice or home health services
i) A move to a skilled nursing facility
j) Any negative event that occurs at the client's place of residence or that occurs while the client is in the community
k) Incidents expected to receive media, legislative or public scrutiny
l) Compromised living environment requiring evacuation
m) Person missing at least 24 hours or, regardless of the amount of time missing, under suspicious or unexplained circumstances
n) Injury including burns, choking, brain trauma, fractures, aspiration and self-injurious behavior
o) Abuse (physical or sexual)
p) Neglect (caregiver neglect or self-neglect)
q) Exploitation (including theft of medication)
r) Waste, fraud or abuse of Medicaid funds (to include actions perpetrated by either participant and/or providers)
s) Human rights violation
t) Medication/treatment error, including inappropriate medication use while the medication is in control of the provider, participant or other individual
u) Law enforcement involvement
v) Substance abuse
w) PHI/PII security breach
x) Other type of incident causing concern for health and safety

4. Reportable negative events are broadly defined so case management agencies can address any identified needs, facilitate a resolution of any causal factors and follow-up to assure the effectiveness of any new safeguards implemented as a result of the event.

5. Waiver services providers are required to promptly respond to case management agency requests for information, reports, summary of safeguards implemented and any process improvements implemented by the service provider.

RESPONSIBILITIES OF WAIVER CASE MANAGEMENT AGENCIES

1. The New Choices Waiver case management agency is responsible for receiving, reviewing, and responding to all incident reports. Incident reports should be reviewed and sufficient information gathered to determine if the incident meets the criteria of a possible Critical Incident.

2. Upon being notified of any of the following types of incidents defined in this section as a possible Critical Incident, the case management agency shall notify the NCW Program Office within 24 hours by telephone, fax, or email. If notification is provided to the NCW Program Office by telephone, a written report must follow within 24 hours or on the next State business day. Possible Critical Incidents include:

    a. Unexpected or accidental death
    b. Suicide attempt (Suicide attempts do not include suicidal thoughts or threats without actions)
    c. Incident expected to receive media, legislative or public scrutiny
    d. Compromised work or living environment requiring evacuation
    e. Person missing at least 24 hours, or regardless of the amount of time missing, under suspicious or unexplained circumstances
    f. Injury (includes burns, choking, brain trauma, fractures, aspiration and self-injurious behavior
    g. Abuse (physical or sexual)
    h. Neglect (caregiver neglect or self-neglect)
    i. Exploitation (including theft of medication)
    j. Waste, fraud, or abuse of Medicaid funds (to include actions perpetrated by either participant and/or providers)
    k. Human rights violation
    l. Medication/treatment errors resulting in marked adverse side effects (includes inappropriate medication use while the medication is in control of the provider, participant or other individual)
    m. Law enforcement involvement resulting in charges being filed (to include events where charges are filed against participant and/or staff)
    n. Other type of incident causing concern for health and safety
    o. Substance abuse requiring medical treatment
    p. PHI/PII security breach

3. In cases where the incident and/or the timing of reporting falls on a weekend or holiday, reporting the incident by the next business day is permissible.

4. If a waiver participant, participant's family member, or another individual reports an incident to the case manager that occurred while a participant was not receiving services from a NCW provider, the case manager is responsible for completing the incident report and submitting it to the NCW program office.

5. The case management agency must verify that reports of any actual or suspected incidents of abuse, neglect, or exploitation of a waiver participant have been reported to Adult Protective Services or local law enforcement. (UCA 62-A-3-301)

6. The case management agency is responsible for maintaining a record of all incident reports in the participants' case files. The case management agency will address any identified needs, facilitate a resolution of any causal factors and will follow-up to assure the effectiveness of any new safeguards implemented as a result of the incident.

7. If the NCW Program Office determines that the incident requires further investigation, the NCW Program Office will instruct the case management agency to complete a Critical Incident Investigation form and return it within ten (10) business days.

8. When the NCW Program Office determines the investigation is complete, the NCW Program Office will document any findings or corrective action requirements on the BLTSS portion of the investigation form. The NCW Program Office will send the case manager a copy of the finalized document, closing the case. In some cases, the NCW Program Office may continue to monitor findings or corrective actions.

9. Within two (2) weeks after the Policy Specialist informs the case management agency that the investigation has been closed, the CMA will notify the client or the client's representative (in person, phone or in writing) of the investigation results and document notification in the client's record. The following types of incidents are excluded from the notification requirement: suicide, death and investigations that conclude with disenrollment.

NOTIFICATION TO THE NCW PROGRAM OFFICE

Notification shall be submitted to:

FAX: 801-323-1586

Email: NewChoicesWaiver@utah.gov

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

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

10 Service Provider Interaction with Case Management Agency

Service providers participating in the New Choices Waiver must adhere to the following requirements

covering interactions with the participant selected case management agency and the NCW program office, when applicable.

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

10-2 Service Authorization

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

A. Providers may only provide waiver services as ordered by the waiver participant's case management agency and approved by BLTSS. Any concerns regarding ordered services should initially be addressed with the case management agency.

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

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

10-3 Participant Out of Facility

1. Adult residential services providers must notify the case management agency whenever a participant is out of the facility overnight. This includes:
    - Hospitalizations
    - Vacations
    - Nursing home stays

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

3. Adult residential services providers should not accept a waiver participant who has been hospitalized or has been in the nursing facility on an extended stay basis back into their facility without first

contacting their case manager to determine if they are still New Choices Waiver eligible. New Choices Waiver is not responsible for payment if the participant is not currently eligible.

11 CLAIMS AND REIMBURSEMENT

11-1 Time Limit to Submit Claims

All claims and adjustments for services must be received by Medicaid within 12 months from the date of service. New claims received past the one year filing deadline will be denied. Any corrections to a claim must also be received and/or adjusted within the same 12 month timeframe. If a correction is received after the deadline, no additional funds will be reimbursed. The one year timely filing period is determined from the date of service or "from" date on the claim. Payment will be made for Medicare/Medicaid Crossover claims only if claims are submitted within six months from the date of Medicare payment stated on the Medicare Explanation of Medical Benefits (EOMB). Code of Federal Regulations 42 (CFR), Section 447.45(d) (1). Utah Administrative Code, Rule R414-25x.

11-2 Calculating Claims Using TN Modifier

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

11-3 Use of "TN" Rural Enhancement Modifier

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

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

    A. The case management agency must authorize use of the rural enhancement rate at the time the services are ordered.
    B. The location assigned as the provider's normal base of operation must be in a county designated as rural;
    C. The location from which the service provider begins the specific trip must be in a county designated as rural;

D. The location where the service is provided to the waiver participant must be in a county designated as rural; and
E. The direct distance traveled by the provider from the starting location of the trip to the waiver participant must be a minimum of 25 miles with no intervening stops to provide waiver or State plan services to other Medicaid participants. When a single trip involves service encounters for multiple Medicaid participants, each leg of the trip will be treated as an independent trip for purposes of qualifying for the rural enhancement (i.e. each leg must involve a direct travel distance of 25 miles or more).

2. Uniform Authorization of the Rural Enhancement Rate

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

   B. The NCW program office is responsible to monitor the Medicaid billing statements to assure providers are appropriately using the rural enhancement rate. In the event of inappropriate use of the rural enhancement rate, the provider and the case management agency will be notified by the NCW program office. Recoupment will be made for any inappropriate use of the rural enhancement rate.

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

11-4 Electronic Visit Verification

Electronic visit verification (EVV) requirements, defined in section 12006 of the 21st Century Cures Act, are effective for Utah Medicaid beginning July 1, 2019. EVV requirements apply to all personal care services and home health care services provided under a 1915 (c) Home and Community Based Waiver.

Choice of reporting systems for EVV are by provider preference, but must meet all federal requirements, including the standards set in the Health Insurance Portability Accountability Act. The State will not implement a mandatory model for use. All provider choice EVV systems must be compliant with requirements of the Cures Act including:

1) type of service performed;
2) individual receiving the service;
3) date of the service;

4) location of service delivery;
5) individual providing the service;

6) time the service begins and ends; and
7) the date of creation of the electronic record.

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

NEW CHOICES WAIVER SERVICES, LIMITS and PROVIDER SPECIFICATIONS

Adult Day Care

Service Definition:

Services generally furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the care plan, in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant.

Limits on the Amount, Frequency or Duration of This Service

Transportation between the participant's place of residence and the adult day care site is not provided as a component of adult day care services and the cost of this transportation is not included in the rate paid to adult day care providers.

Those receiving adult residential services in an assisted living facility, Type N facility or licensed community residential care facility are not eligible for Adult Day Health unless the case management agency assesses a client-specific need that cannot be otherwise met by the facility of residence. Documentation of the identified need must be included in the comprehensive care plan.

Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

Provider Specifications for Service

NCW Service Name: Adult Day Care

HCPCS Billing Code**:** S5102

Billing Modifier: U8

Provider qualifications:

- Must have a current business license;
- Must be a Medicaid provider enrolled to provide NCW Adult Day Care services; and
- Adult Day Care providers must be licensed in accordance with R501-13-1-13; or

- Assisted Living Facility providers must be licensed in accordance with R432-270-29b.

Adult Residential Services

Service Definition:

Supportive services provided in an approved community-based adult residential facility. Supportive services are expected to meet scheduled and unpredictable participant needs and to provide supervision, safety and security in conjunction with residing in a homelike, non-institutional setting.

Adult Residential Services in licensed assisted living facilities and small health care facilities (HCPCS T2031) includes homemaking services, chore services, 24-hour on-site response capability, attendant care services, meal preparation, medication assistance/oversight, social/recreational programming, and nursing/skilled therapy services that are incidental rather than integral to the provision of Adult Residential Services.

Adult Residential Services in licensed assisted living facilities, memory care (HCPCS T2016) includes homemaking services, chore services, 24-hour on-site response capability, attendant care services, meal preparation, medication assistance/oversight, social/recreational programming, memory care services, and nursing/skilled therapy services that are incidental rather than integral to the provision of Adult Residential Services.

Adult Residential Services in licensed community residential facilities (HCPCS T2033) includes meal preparation, behavioral health services, 24-hour on-site response capability, homemaking services, chore services, and social/recreational programming.

Adult Residential Services in certified community residential facilities (independent living facilities, HCPCS H0043) includes homemaking services, meal preparation, 24-hour on-site response capability and daily status checks (or more frequently as deemed appropriate in the comprehensive needs assessment).

All Adult Residential Services no matter the setting includes 24 hour on-site response capability or other alternative emergency response arrangements determined appropriate to meet scheduled or unpredictable participant needs and to provide supervision, safety and security in conjunction with residing in a homelike, non-institutional setting.

Limits on the Amount, Frequency or Duration of This Service:

Separate payment is not made for homemaker services furnished to a participant receiving adult residential services, since these services are integral to and inherent in the provision of adult residential services.

Separate payment is not made for chore services unless an exceptional need is identified in the comprehensive needs assessment that is not specified in the formal lease agreement between the facility and the participant/family as being the responsibility of the facility. Example of an exceptional need: heavy cleaning resulting from hoarding behavior. Documentation of exceptional needs must be submitted with the care plan for approval. Exceptions will not be approved if the chore service is for the costs of general facility maintenance, upkeep or improvement.

Separate payment is not made for attendant care services furnished when the participant is actively receiving care inside the facility or during activities provided by the facility off campus. Attendant care may be provided when a need is identified for participation in off-campus activities not associated with the facility. Examples: personal shopping or accompanying the participant to doctor appointments. Exceptions to the attendant care limitation are made for individuals residing in licensed community residential facilities and independent living facilities because neither type of facility is licensed to perform hands-on assistance with activities of daily living.

Payment is not made for 24-hour skilled care or supervision. Federal financial participation is not available for room and board, for items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. The methodology by which the costs of room and board are excluded from payments for adult residential services is described in Appendix I.

Provider Specifications for Service

NCW Service Name: Adult Residential Services - Utah Licensed Assisted Living Facilities (Type 1 and Type 2) and Utah Licensed Small Health Care (Type N) Facilities

HCPCS Billing Code: T2031

Billing Modifier: U8

Provider qualifications:

- Must have a current business license;
- Must be a Medicaid provider enrolled to provide NCW Adult Residential Services; and
- Assisted living facilities must be licensed in accordance with Utah Administrative Rule R432-270; or
- Small health care (Type N) facilities must be licensed in accordance with Utah Administrative rule R432-300.

Provider Specifications for Service

NCW Service Name: Adult Residential Services – Licensed Assisted Living Facility, Memory Care

HCPCS Billing Code: T2016

Billing Modifier: U8

Provider qualifications:

- Must have a current business license;
- Must be a Medicaid provider enrolled to provide NCW Adult Residential Services; and
- Must be licensed in accordance with Utah Administrative Rule R432-270 and meet the Licensing requirements applicable to secure units (R432-270-16).
-

Provider Specifications for Service

NCW Service Name: Adult Residential Services – Certified Independent Living Facility

HCPCS Billing Code: H0043

Billing Modifier: U8

Provider qualifications:

- Must have a current business license;
- Must be a Medicaid provider enrolled to provide NCW Adult Residential Services; and
- Must satisfactorily pass an on-site certification inspection performed by an official from the New Choices Waiver Program Office prior to enrollment and annually thereafter.

Provider Specifications for Service

NCW Service Name: Adult Residential Services - Licensed Community Residential Care Facility

HCPCS Billing Code: T2033

Billing Modifier: U8

Provider qualifications:

- Must have a current business license;
- Must be a Medicaid provider enrolled to provide NCW Adult Residential Services; and
- Must be a Licensed Residential Treatment Program in accordance with R432-270.

Assistive Technology Devices

Service Definition:

This service under the waiver differs in nature, scope, supervision arrangements, or provider from services in the State plan. Assistive technology device means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. Assistive technology devices includes

(A) The evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;

(B) Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants;

(C) Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;

(D) Coordination and use of necessary interventions, or services with assistive technology devices, such as interventions or services associated with other services in the care plan;

(E) Training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and

(F) Training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.

Devices that can be purchased:

Amplified phones

Digital enhanced cordless telecommunications (DECT) phones

Remote controlled phones with infrared technology

Large print and talking caller ID

Phone headsets

Headset amplifiers and tone control

Large button phones

TDD and TTY

Hearing and Communication:

Communication software

Basic communicators

Picture communicators

Audio and voice recorders

Speech generating devices

Voice amplifiers and synthesizers

Blinking light "doorbell"

Intercom system

Vision impairment adaptations:

Screen readers

Text to speech software

Digital book players

Talking products

Magnifiers

True color floor lamps

Eye drop squeezer

Switches:

Sip and Puff Switches

Sensitive switches

Foot switches

Switch interfaces

Mounting devices

Chin switch

Safety alarms

Other:

Adaptive utensils

Oversized utensil handles

Adaptive cookware

Modified pot handles

Adaptive dishes

Reaching aids

Automatic clock with day and date display

Jar opener

Door knob adapters

Car caddie

Adaptive dressing aids

Button hooks

Adaptive grooming aids

Sock and shoe aids

Long handle grooming aids

Easy grasp key holders and turners

Rolling lotion applicators

Weight sensitive alarms

Non-slip mats

Bedside beverage holders

Burn resistant smoker's apron

Recliner lever extenders

Portable access ramps

Limits on the Amount, Frequency or Duration of This Service:

Service Limit: The maximum allowable cost per assistive technology device is $2,000.00. At the point a waiver participant reaches the service limit, the care coordination team will conduct an evaluation to determine how the individual's health and safety can continue to be assured through authorization for additional service beyond the limit or alternative arrangements that meet the individual's needs while remaining in a community setting.

Provider Specifications for Service

NCW Service Name: Assistive Technology Devices

HCPCS Billing Code: T2028

Billing Modifier: U8

Provider qualifications:

- Must have a current business license; and
- Must be a Medicaid provider enrolled to provide NCW Assistive Technology Devices.

Attendant Care Services

Service Definition:

Attendant care services are those that reinforce an individual's strengths, while substituting or compensating for the absence, loss, diminution, or impairment of a physical or cognitive function. Attendant services incorporate and respond to the participant's preferences and priorities.

Limits on the Amount, Frequency or Duration of This Service:

This service cannot be provided to participants receiving Adult Residential Services or any other waiver service in which the tasks performed are duplicative of the attendant care services.

Provider Specifications for Service

NCW Service Name: Attendant Care Services

HCPCS Billing Code: S5125

Billing Modifier: U8

Provider qualifications:

- Must have a current business license; and
- Must be a Medicaid provider enrolled to provide NCW Attendant Care Services.

Caregiver Training

Service Definition:

Training and counseling services for individuals who provide unpaid support, training, companionship or supervision to participants. For purposes of this service, individual is defined as any person, family member, neighbor, friend, companion or co-worker who provides uncompensated care, training, guidance, companionship, or support to a person served on the waiver. Individuals who are employed to support the participant may not receive this service. Training includes instruction about treatment regimens and other services included in the care plan, use of equipment specified in the care plan, and includes updates as necessary to safely maintain the participant at home. All training the individuals who provide unpaid support to the participant must be included in the participant's care plan. The service covers the costs of registration and training fees associated with formal instruction in areas relevant to participant needs identified in the care plan.

Limits on the Amount, Frequency or Duration of This Service

No limits

Provider Specifications for Service

NCW Service Name: Caregiver Training

HCPCS Billing Code: S5115

Billing Modifier: U8

Provider qualifications:

- Must have a current business license as a formal Caregiver Training provider as applicable; or
- Caregiver Training providers in categories requiring license under State law must comply with licensing requirements contained within R156 or R432; and
- Must be a Medicaid provider enrolled to provide NCW Caregiver Training; and
- Must have demonstrated ability to perform the tasks ordered by the case management agency.

Case Management

Service Definition:

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

a) Complete the initial comprehensive assessment and periodic reassessments to determine the services and supports required by the participant to prevent unnecessary institutionalization;

b) Perform reevaluations of participants' level of care;

c) Complete the initial comprehensive care plan and periodic updates to maximize the participant's strengths while supporting and addressing the identified preferences, goals and needs;

d) Research the availability of non-Medicaid resources needed by an individual to address needs identified through the comprehensive assessment process and assist the individual in gaining access to these resources;

e) Assist the individual to gain access to available Medicaid State Plan services necessary to address identified needs;

f) Assist the individual to select from available choices, an array of waiver services to address the identified needs and assist the individual to select from the available choice of providers to deliver each of the waiver services including assisting with locating an appropriate home and community-based setting and assisting with negotiation of a rental agreement when needed;

g) Assist the individual to request a fair hearing if choice of waiver services or providers is denied, if services are reduced, terminated or suspended, or if the participant is disenrolled;

h) Monitor to assure the provision and quality of services identified in the individual's care plan;

i) Support the individual/legal representative/family to independently obtain access to services when other funding sources are available;

j) Monitor on an ongoing basis the individual's health and safety status and investigate critical incidents when they occur. At least one (1) telephone or face-to-face contact directly with the waiver participant is required each month and a minimum of one (1) face to face contact with the participant is required every 90 days. When meaningful telephone contact cannot be achieved due to a participant's diminished mental capacity or inability to communicate by phone, in-person contact must be made with the participant monthly;

k) Coordinate across Medicaid programs to achieve a holistic approach to care;

l) Provide case management and transition planning services up to 180 days immediately prior to the date an individual transitions to the waiver program;

m) Provide safe and orderly discharge planning services to an individual disenrolling from the waiver;

n) Perform internal quality assurance activities, addressing all performance measures.

o) Monitor participant medication regimens.

Limits on the Amount, Frequency or Duration of This Service

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

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

Provider entities having the capacity to perform case management functions and other waiver or non-waiver services must assure that the functions of the entity are clearly separated and their respective responsibilities well defined. If the case management agency is listed on a comprehensive care plan as the provider for other waiver or non-waiver services, the case management agency must document that there are no other willing qualified providers available to provide the other waiver or non-waiver service(s). The State Medicaid Agency, New Choices Waiver Program Office will review these situations on a case by case basis to determine whether or not to override the conflict of interest.

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

1. the case manager is related to the waiver participant by blood or by marriage,

2. the case manager is related to any of the waiver participant's paid caregivers by blood or by marriage,

3. the case manager is financially responsible for the waiver participant,

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

5. the case manager would benefit financially from the provision of direct care services included in the care plan.

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

By July 1, 2017, Utah will fully implement the use of a Financial Management Service (FMS) entity to pay for goods and services purchased from retail stores, general contractors or other entities not directly enrolled as Medicaid providers. The State will reimburse the FMS entity as an administrative activity.

Provider Specifications for Service

NCW Service Name: Case Management Services

HCPCS Billing Code: T2024 (Pre-enrollment and during post-enrollment inpatient admissions)
T1016 (Post-enrollment)

Billing Modifier: U8

Provider qualifications:

- All providers must initially and continuously employ at least 2 qualified case managers, one with registered nurse (RN) licensure and one with social service worker (SSW) licensure or other licensure that is at least equivalent to or higher than RN and SSW licensure. Providers shall hire additional qualified case managers as their agency's client caseload increases in order to meet workload demands and to maintain quality standards. The State may consider exceptions to the minimum RN and SSW standards in remote geographical areas of the state where access to care issues would exist if not for the exception. These situations will be considered on a case by case basis;
- Must be accredited as a case management agency by the Bureau of Authorization and Community-Based Services;
- Must be a Medicaid provider enrolled to provide NCW Case Management Services; and
- Non-governmental agencies must have a current business license; or
- Must be recognized as a Division of Services for People with Disabilities Entity; or
- Must be recognized as an Area Agency on Aging entity within the State of Utah; or
- Must be recognized as a Center for Independent Living through the State Office of Rehabilitation.

Chore Services

Service Definition:

Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as carpet cleaning, pest eradication, cleaning windows and walls, tacking down loose rugs and tiles, lawn mowing, moving heavy items of furniture or snow removal which is necessary in order to provide safe access or egress.

Limits on the Amount, Frequency or Duration of This Service

These services are provided only when neither the participant nor anyone else in the household is capable of performing or financially providing for them, and where no other caregiver, landlord, community/volunteer agency, or third party payer is capable or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, is examined prior to any authorization of service. Additionally this service in not available concurrent with any other waiver service in which the tasks performed are duplicative of chore services.

Provider Specifications for Service

NCW Service Name: Chore Services

HCPCS Billing Code: S5120

Billing Modifier: U8

Provider qualifications:

- Must have a current business license;
- Must be a Medicaid provider enrolled to provide NCW Chore Services; and
- Must have a demonstrated ability to perform the tasks ordered by the case management agency.

Community Transition Services

Service Definition:

Provision of essential household items and services needed to establish and maintain basic living arrangements in a community setting that enable the individual to establish and maintain health and safety. Essential household items include basic furnishings and kitchen and bathroom equipment. This service also includes moving expenses, one-time non-refundable fees to establish utility services and other services essential to the operation of the residence, and services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy. This service may

also be used to replace old depleted household items and furnishings that are necessary to ensure the health and safety of a participant, if the participant is moving from one setting to another.

This service can be accessed for the following events:

1. upon initial waiver enrollment when transitioning to a home or community-based setting, or

2. when an established waiver participant moves to another setting that is determined to better meet the participant's needs, or

3. when an established waiver participant moves to a new setting, to replace old depleted household items or furnishings when assessed to be needed for health and safety.

Limits on the Amount, Frequency or Duration of This Service

Reimbursement for the cost of rent or food is not a covered expense under this service. Reimbursable items are limited to only those household items that are essential.

Storage fees are not covered.

This service cannot be accessed unless a waiver participant is transitioning (moving) from one setting to another.

Reimbursement for the cost of refundable fees or deposits is not a covered expense under this service.

Moving expenses are not covered if the new setting is not determined to better meet the participant's assessed needs.

The maximum allowable cost for this service is $1,000.00. At the point a waiver participant reaches the allowable cost limit, the SMA NCW Unit will conduct an evaluation to determine authorization of any additional service.

Provider Specifications for Service

NCW Service Name: Community Transition Services

HCPCS Billing Code: T2038

Billing Modifier: U8

Provider qualifications:

- Must have a current business license; and
- Must be a Medicaid provider enrolled to provide NCW Community Transition Services.

Consumer Preparation

Service Definition:

Services that assist the participant (or the participant's family or representative, as appropriate) in arranging for, directing and managing services. Serving as the agent of the participant or family, the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services. Practical skills training is offered to enable families and participants to independently direct and manage waiver services. Examples of skills training include providing information on recruiting and hiring employees, managing employees and providing information on effective communication and problem-solving. The service/function includes providing information to ensure that participants understand the responsibilities involved with directing their services. The extent of the assistance furnished to the participant or family is specified in the care plan. This service does not duplicate other waiver services, including case management.

Limits on the Amount, Frequency or Duration of This Service

This service is limited to participants who direct some or all of their waiver services.

Provider Specifications for Service

NCW Service Name: Consumer Preparation Services

HCPCS Billing Code: S5108

Billing Modifier: U8

Provider qualifications:

- Must have a current business license;
- Must be a Medicaid provider enrolled to provide NCW Consumer Preparation Services;
- Individual employee(s) serving NCW clients must be professionals with a bachelor's or a master's degree in social or behavioral health sciences; and
- Individual employee(s) serving NCW clients must demonstrate competence in related topical area(s) of:
    1. Self-determination;
    2. Natural supports; and
    3. Instruction and/or consultation with individuals and families on:

a. Assisting self-sufficiency and
b. Safety.

Environmental Accessibility Adaptations

Service Definition:

Equipment and/or physical adaptations to the individual's residence or vehicle which are necessary to assure the health, welfare and safety of the individual or which enable the individual to function with greater independence in the home and in the community. The equipment/adaptations are identified in the individual's care plan and the model and type of equipment are specified by a qualified individual. The adaptations may include purchase, installation, and repairs. Other adaptation and repairs may be approved on a case by case basis as technology changes or as an individual's physical or environmental needs change. All services shall be provided in accordance with applicable State or local building codes and may include the following:

- Home

Authorized equipment/adaptations such as:

a. Ramps

b. Grab bars

c. Widening of doorways/hallways

d. Modifications of bathroom/kitchen facilities

e. Modification of electric and plumbing systems which are necessary to accommodate the medical equipment, care and supplies that are necessary for the welfare of the individual.

- Vehicle

Authorized vehicle adaptations such as:

1. lifts

2. door modifications

3. steering/braking/accelerating/shifting modifications

4. seating modifications

5. safety/security modifications

Limits on the Amount, Frequency or Duration of This Service

The following are specifically excluded:

a. Adaptations or improvements to the home or vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual;

b. Adaptations that add to the total square footage of the home;

c. Purchase or lease of a vehicle; and

d. Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

The maximum allowable cost per environmental accessibility adaptation is $2,000.00. At the point a waiver participant reaches the service limit, the care coordination team will conduct an evaluation to determine how the individual's health and safety can continue to be assured through authorization for additional service beyond the limit or alternative arrangements that meet the individual's needs while remaining in a community setting.

Provider Specifications for Service

NCW Service Name: Environmental Accessibility Adaptations – Home Modifications

HCPCS Billing Code: S5165

Billing Modifier: U8

Provider qualifications:

- Must have a current business license;
- Must be a Medicaid provider enrolled to provide Environmental Accessibility Adaptations;
- Must demonstrate an ability to perform the tasks ordered by the case management agency; and
- Home modifications installers or repairpersons must have a contractor's license.

Provider Specifications for Service

NCW Service Name: Environmental Accessibility Adaptations – Vehicle Modifications Services

HCPCS Billing Code: T2039

Billing Modifier: U8

Provider qualifications:

- Must have a current business license;
- Must be a Medicaid provider enrolled to provide NCW Environmental Accessibility Adaptations – Vehicle Modifications Services; and
- Must have demonstrated ability to perform the tasks ordered by the case management agency.

Financial Management

Service Definition:

Financial Management Services is offered in support of the self-administered services delivery option. Services rendered under this definition include those to facilitate the employment of individual service providers (employees) by the waiver participant (employer) or designated representative including:

a) Provider qualification verification;

b) Employer-related activities including federal, state, and local tax withholding/payments, unemployment compensation fees, wage settlements, fiscal accounting and expenditure reports;

c) Medicaid claims processing and reimbursement distribution, and

d) Providing monthly accounting and expense reports to the consumer.

Limits on the Amount, Frequency or Duration of This Service

Service is provided to those utilizing Self-Administered Services.

Provider Specifications for Service

NCW Service Name: Financial Management Services

HCPCS Billing Code: T2040

Billing Modifier: U8

Provider qualifications:

- Must be a Certified Public Accountant in accordance with UCA 58-26A and R156-26A;
- Must be a Medicaid provider enrolled to provide NCW Financial Management Services;
- Must have a current business license;

- Must utilize accounting systems that operate effectively on a large scale as well as track individual budgets;
- Must utilize a claims processing system acceptable to the Utah State Medicaid Agency;
- Must establish time lines for payments that meet individual needs within DOL standards;
- Must generate service management, and statistical information and reports as required by the Medicaid program;
- Must develop systems that are flexible in meeting the changing circumstances of the Medicaid program;
- Must provide needed training and technical assistance to clients, their representatives, and others;
- Must document required Medicaid provider qualifications and enrollment requirements and maintain results in provider/employee file;
- Must act on behalf of the person receiving supports and services for the purpose of payroll reporting;
- Must develop and implement an effective payroll system that addresses all related tax obligations;
- Must make related payments as authorized by the case management agency;
- Must generate payroll checks in a timely and accurate manner and in compliance with all federal and state regulations pertaining to “domestic service” workers;
- Must conduct background checks as required and maintain results in employee file;
- Must process all employment records;
- Must obtain authorization to represent the individual/person receiving supports;
- Must prepare and distribute an application package of information that is clear and easy for the individuals hiring their own staff to understand and follow;
- Must establish and maintain a record for each employee and process employee employment application package and documentation;
- Must utilize and accounting information system to invoice and receive Medicaid reimbursement funds;
- Must utilize and accounting and information system to track and report the distribution of Medicaid reimbursement funds;
- Must generate a detailed Medicaid reimbursement funds distribution report to the individual Medicaid recipient or representative semi-annually;
- Must withhold, file and deposit FICA, FUTA and SUTA taxes in accordance with federal IRS and DOL, and state rules;
- Must generate and distribute IRS W-2s, Wage and Tax Statements and related documentation annually to all support workers who meet the statutory threshold earnings amounts during the tax year by January 31st;
- Must file and deposit federal and state income taxes in accordance with federal IRS and state rules and regulations;
- Must assure that employees are paid established unit rates in accordance with the federal and state Department of Labor Fair Labor Standards Act (FLSA);

- Must process all judgments, garnishments, tax levies or any related holds on an employee's funds as may be required by local, state or federal laws;
- Must distribute, collect and process all employee time sheets as summarized on payroll summary sheets completed by the person or his/her representative;
- Must prepare employee payroll checks, at least monthly, sending them directly to the employees;
- Must keep abreast of all laws and regulations relevant to the responsibilities it has undertaken with regard to the required federal and state filings and the activities related to being a Fiscal/Employer Agent;
- Must establish a customer service mechanism in order to respond to calls from individuals or their representative employers and workers regarding issues such as withholding and net payments, lost or late checks, reports and other documentation;
- Must have customer service representatives who are able to communicate effectively in English and Spanish by voice and TTY with people who have a variety of disabilities;
- Must have a Disaster Recovery Plan for restoring software and master files and hardware backup if management information systems are disabled so that payroll and invoice payment systems remain intact; and
- Must regularly file and perform accounting auditing to ensure system accuracy and compliance with general accounting practice.

The monthly payment to the FMS provider can only be made when active financial management services were provided during that month. Payment is not available during inactive periods (such as when there is an interruption in waiver services resulting from an admission to a nursing facility).

Habilitation

Service Definition:

Habilitation Services are active teaching/training therapeutic activities to supply a person with the means to develop or maintain maximum independence in activities of daily living and instrumental activities of daily living, socialization and adaptive skills necessary to reside successfully in home and community-based settings.

Specific services include teaching/retraining the following:

a. daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, , money management and maintenance of the living environment);

b. social skills training in appropriate use of community services; and

c. development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion).

Limits on the Amount, Frequency or Duration of This Service

While it is recognized that observation of skills learned is a critical component of habilitation services, the expectation is that active teaching/training/therapeutic intervention will comprise the majority of each unit of service.

The following are specifically excluded from payment for habilitation services:

a. vocational services,

b. prevocational services,

c. supported employment services,

d. room and board,

e. companion services, and

f. services that are intended to compensate for loss of function such as would be provided by attendant care services.

Provider Specifications for Service

NCW Service Name: Habilitation Services

HCPCS Billing Code: T2017

Billing Modifier: U8

Provider qualifications:

- Must be a Medicaid provider enrolled to provide NCW Habilitation Services;
- Must have a demonstrated ability to perform the tasks ordered on behalf of the waiver client;
- Must have a current business license; and
- For home health agencies, must be a licensed in accordance with R432-700.

Home Delivered Meals

Service Definition:

Home Delivered Supplemental Meal provides a nutritionally sound and satisfying meal to individuals residing in non-facility settings who are unable to prepare their own meals and who do not have a responsible party or volunteer caregiver available to prepare their meals for them.

A meal constitutes a supplemental meal when provided in an amount that meets the nutritional needs of the individual. Each supplemental meal provided shall provide a minimum of 33 1/3 percent of the daily Recommended Dietary Allowances (RDA) and Dietary Reference Intake (DRI) as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences, Institute of Medicine and Mathematica Policy Research, Incorporated.

Limits on the Amount, Frequency or Duration of This Service

Meals provided as part of this service shall not constitute a "full nutritional regimen" (3 meals per day).

Individuals receiving Adult Residential Services are not eligible for this service.

Provider Specifications for Service

NCW Service Name: Home Delivered Meals

HCPCS Billing Code: S5170

Billing Modifier: U8

Provider qualifications:

- Must have a current business license;
- Must be a Medicaid provider enrolled to provide NCW Home Delivered Meals; and
- Must comply with UAC R70-530, Food Protection.

Homemaker Services

Service Definition:

Services consisting of the performance of general household tasks (e.g., meal preparation, grocery shopping, laundry and routine household care including but not limited to cleaning bathrooms, doing dishes, dusting, vacuuming, sweeping, mopping) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.

Limits on the Amount, Frequency or Duration of This Service

This service cannot be provided to participants receiving Adult Residential Services or any other waiver service in which the tasks performed are duplicative of the homemaker services.

Provider Specifications for Service

NCW Service Name: Homemaker Services

HCPCS Billing Code: S5130

Billing Modifier: U8

Provider qualifications:

- Must have a current business license;
- Must be a Medicaid provider enrolled to provide NCW Homemaker Services; and
- Must have a demonstrated ability to perform the tasks ordered by the case management agency.

Medication Administration Assistance Services

Service Definition:

Medication Reminder System (Not Face-To-Face)

Medication Reminder System provides a medication reminder by a third party entity or individual that is not the clinician responsible for prescribing and/or clinically managing the individual, not the entity responsible for the administration of medication, and not the entity responsible for the provision of nursing or personal care or attendant care services. Services involve non face-to-face medication reminder techniques (phone calls, telecommunication devices, medication dispenser devices with electronic alarms which alert the individual and a central response center staffed with qualified individuals).

- Medication Set-Up and Administration

Services of an individual authorized by State law to set-up medications in containers that facilitate safe and effective self-administration when individual dose bubbling packaging by a pharmacy is not available and assistance with self-administration is not covered as an element of another waiver service. Nurses may also assist individuals in the administration of medications as part of a medication maintenance regimen.

Limits on the Amount, Frequency or Duration of This Service

This service is not available to individuals eligible to receive the service through the Medicaid State Plan or other funding source.

Provider Specifications for Service

NCW Service Name: Medication Administration – Medication Reminder System (Not Face-To-Face)

HCPCS Billing Code: S5185

Billing Modifier: U8

Provider qualifications:

- Must have a current business license; and
- Must be a Medicaid provider enrolled to provide NCW Medication Administration Services.

Provider Specifications for Service

NCW Service Name: Medication Administration – Medication Set-Up and Administration Services

HCPCS Billing Code: H0034

Billing Modifier: U8

Provider qualifications:

- Must have a current business license;
- Must be a Medicaid provider enrolled to provide NCW Medication Administration – Medication Set-Up and Administration Services; and
- Must meet and abide by all licensing, supervision and delegation standards for medication set-up and administration found within the Nurse Practice Act, UAC R156-31b.

Non-Medical Transportation

Service Definition:

Service offered in order to enable waiver participants to gain access to non-medical waiver and other community services, activities and resources, as specified by the care plan. Transportation services under the waiver are offered in accordance with the participant's care plan.

Limits on the Amount, Frequency or Duration of This Service

This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, and does not replace them. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized.

Non-Medical transportation is not available for the provision of transportation to medical appointments. Medical appointments are defined as appointments which are covered by the Medicaid state plan, PMHP and/or VA for which medical transportation is available.

Provider Specifications for Service

NCW Service Name: Transportation – Non-Medical - Per One Way Trip

HCPCS Billing Code: T2003

Billing Modifier: U8

Provider qualifications:

- Must have a current business license; and
- Non-Medical Transportation AND Valid Driver's License
- Registered and insured vehicle: UCA 53-3-202, UCA 41-12s-301 to 412
- Medicaid provider enrolled to provide non-medical transportation services. Minimum of $500,000.00 Per Incident Per Occupant Personal Liability Insurance coverage.

Provider Specifications for Service

NCW Service Name: Transportation – Non-Medical - Per Mile

HCPCS Billing Code: S0215

Billing Modifier: U8

Provider qualifications:

- Must have a current business license; and
- Non-Medical Transportation AND Valid Driver's License
- Registered and insured vehicle: UCA 53-3-202, UCA 41-12s-301 to 412
- Medicaid provider enrolled to provide non-medical transportation services. Minimum of $500,000.00 Per Incident Per Occupant Personal Liability Insurance coverage.

Provider Specifications for Service

NCW Service Name: Transportation – Non-Medical – Public Transit Pass

HCPCS Billing Code: T2004

Billing Modifier: U8

Provider qualifications:

- Must be a Medicaid provider enrolled to provide NCW Case Management Services.

Personal Budget Assistance

Service Definition:

Personal budget assistance provides assistance with financial matters, fiscal training, supervision of financial resources, savings, retirement, earnings and funds monitoring, monthly check writing, bank reconciliation, budget management, tax and fiscal record keeping and filing, and fiscal interaction on behalf of the individual.

The purpose of this service is to offer opportunities for waiver participants to increase their ability to provide for their own basic needs, increase their ability to cope with day to day living, maintain more stability in their lives and maintain the greatest degree of independence possible, by providing timely financial management assistance to waiver participants in the least restrictive setting, for those individuals who have no close family or friends willing to take on the task of assisting them with their finances.

Limits on the Amount, Frequency or Duration of This Service

The Personal Budget Assistance provider must assist the waiver participant or the participant's designated representative in reviewing their finances/budget at least monthly, must maintain documentation of this review and must submit the budget review documentation to the Case Management Agency for review on a monthly basis. The services provided in this service will not duplicate FMS services (i.e., tax and fiscal filing).

Representative payee services designated through a mental health authority or through Social Security Administration are excluded from payment under Personal Budget Assistance.

Provider Specifications for Service

NCW Service Name: Personal Budget Assistance

HCPCS Billing Code: H0038

Billing Modifier: U8

Provider qualifications:

- Must have a current business license;
- Must be a Medicaid provider enrolled to provide NCW Personal Budget Assistance; and
- Must demonstrate an ability to perform the tasks ordered by the case management agency.

Personal Emergency Response System

Service Definition:

An electronic device that enables an individual to secure help in an emergency through a connection to a signal response center that is staffed by trained professionals on a 24 hour per day, seven days a week basis.

- Personal Emergency Response Systems (PERS) Response Center Service

Provides ongoing access to a signal response center that is staffed twenty-four hours per day, seven days a week by trained professionals responsible for securing assistance in the event of an emergency.

- Personal Emergency Response System (PERS) Purchase, Rental & Repair

Provides an electronic device of a type that allows the individual to summon assistance in an emergency. The device may be any one of a number of such devices but must be connected to a signal response center.

- Personal Emergency Response System (PERS) Installation, Testing & Removal

Provides installation, testing, and removal of the PERS electronic device by trained personnel.

Limits on the Amount, Frequency or Duration of This Service

No Limits

Provider Specifications for Service

NCW Service Name: Personal Emergency Response System

HCPCS Billing Codes: Purchase, rental, & repair- S5162
Installation, testing, & removal - S5160
Monthly response center service - S5161

Billing Modifier: U8

Provider qualifications:

- Must have a current business license;
- Must be a Medicaid provider enrolled to provide NCW Personal Emergency Response System Services; and
- Personal Emergency Response System equipment suppliers must have FCC registration of equipment placed in the homes of waiver clients; or
- Installers must demonstrate an ability to properly install and test specific equipment being handled; or
- Response Centers must be staffed and in operation 24 hours per day, 7 days per week.

Respite Services

Service Definition:

Care provided to give relief to, or during the absence of, the normal care giver. Respite care may include hourly, daily and overnight support and may be provided in the individual's place of residence, a facility

approved by the State which is not a private residence, or in the private residence of the respite care provider.

Limits on the Amount, Frequency or Duration of This Service

Payments are not made for room and board except when provided as a part of overnight respite care in a facility approved by the State and enrolled as a NCW Respite Care provider. In the case of respite care services that are rendered in a facility overnight, this service will be billed under a specific Respite Care- Overnight, Out of Home, Room and Board Included billing code (H0045). Each Respite Care- Overnight, Out of Home, Room and Board Included episode is limited to a period of 13 consecutive days or less not counting the day of discharge. The number of Respite Care - Overnight, Out of Home, Room and Board Included episodes may not exceed three in any calendar year.

For facility based respite care that is not provided overnight, the provider should bill using the hourly rate (S5150, for less than 6 hours) or the daily rate (S5151, for six hours or more).

Respite care provided in the client's own home or in the private residence of the respite care provider may only be reimbursed using the hourly rate (S5150) or daily rate (S5151).

All instances in which respite care services are delivered for a period of six hours or more within a day shall be billed using a daily rate rather than the hourly rate. A day begins and ends at midnight.

Respite care is not available for those receiving Adult Residential Services.

Provider Specifications for Service

NCW Service Name: Respite Care

HCPCS Billing Codes: Respite Care – Routine (hourly, 5 hours or less) S5150
Respite Care – Routine (daily, 6-hours or more per day) S5151

Billing Modifier: U8

Provider qualifications:

- Must have a current business license;
- Must be a Medicaid provider enrolled to provide NCW Respite Care Services; and
- Adult Day Care providers must be licensed in accordance with R501-12-1; or
- Home Health Agencies must be licensed in accordance with R432-700; or
- Nursing Facilities must be licensed in accordance with R432-150; or
- Assisted Living Facilities must be licensed in accordance with R432-270; or
- Residential Treatment Facilities must be licensed in accordance with R501-19-13.

Provider Specifications for Services

NCW Service Name: Respite Care - Overnight, Out of Home, Room & Board Included

HCPCS Billing Codes: H0045

Billing Modifier: U8

Provider qualifications:

- Must have a current business license;
- Must be a Medicaid provider enrolled to provide NCW Respite Care – Overnight, Out of Home, Room & Board Included; and
- Nursing Facility providers must be licensed in accordance with R432-150; or
- Assisted Living Facility providers must be licensed in accordance with R432-270; or
- Residential Treatment Facilities must be licensed in accordance with R501-19-13.

Specialized Medical Equipment, Supplies and Supplements

Service Definition:

Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service covers items necessary for life support including prescribed nutritional supplements, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan.

Limits on the Amount, Frequency or Duration of This Service

Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation. Coverage includes the costs of maintenance and upkeep of equipment, training the participant or caregivers in the operation and/or maintenance of the equipment or the use of a supply, and the performance of assessments to identify the type of equipment needed by the participant.

Items may only be provided under this service when prescribed by a physician or other appropriate health care provider (such as a physician's assistant or advanced practice registered nurse or other medical care providers with prescriptive authority).

Provider Specifications for Service

NCW Service Name: Specialized Medical Equipment, Supplies and Supplements

HCPCS Billing Code: T2029

Billing Modifier: U8

Provider qualifications:

- Must be a Medicaid provider enrolled to provide NCW Medical Equipment, Supplies and Supplements; and
- Non-durable medical equipment, supplies and supplements providers must have a current business license; or
- Durable medical equipment and supply providers must have a current business license as a DME provider and must have a National Supplier Clearinghouse Letter from CMS.

Supportive Maintenance

Service Definition:

Services defined in 42 CFR 440.70 that are provided when home health aide services furnished under the approved State plan limits are exhausted. The scope and nature of these services do not differ from home health aide services furnished under the State plan. Services are defined in the same manner as provided in the approved State plan. The provider qualifications specified in the State plan apply.

Limits on the Amount, Frequency or Duration of This Service

Supportive maintenance services will only be ordered after full utilization of available State Plan home health services by the participant.

Provider Specifications for Service

NCW Service Name: Supportive Maintenance Services

HCPCS Billing Code: T1021

Billing Modifier: U8

Provider qualifications:

- Must have a current business license;
- Must be a Medicaid provider enrolled to provide NCW Supportive Maintenance; and
- Must be a licensed home health agency in accordance with UAC R432-700.

12 SERVICE PROCEDURE CODES

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

https://medicaid.utah.gov/ltc/nc-providers/

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

13 MANDATORY ADULT PROTECTIVE SERVICES REPORTING REQUIREMENTS

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

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

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

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

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

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

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

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

14 CONTACT PHONE NUMBERS

Adult Protective Services (DHS/DAAS)	**Adult Protective Services** **Salt Lake County 1-801-538-3567** **All other counties 1-800-371-7897** Please be prepared to offer the following information: *(note: all information is not necessary, but helpful)* • Name, address, and phone number of victim. • Identifying information of the victim such as: birth date, social security number, age, ethnicity.... • Name, address, and phone number of alleged perpetrator (if applicable). • Identifying information regarding alleged perpetrator (if applicable). • Your name, phone number and address. • Provide information on any disability, health problem or mental illness. • Reason for concern (alleged abuse, neglect or exploitation).	
Disenrollment	**Utah Department of Health** Division of Medicaid and Health Financing NCW Program Office PO Box 143112 Salt Lake City Utah 84114-3112 Fax: 801-323-1586	
Medicaid Constituent Services	**Tracy Barkley**	Phone: 1-801-538-6417 Toll Free: 1-877-291-5583 Email: tbarkley@utah.gov
Health Program Representatives	https://medicaid.utah.gov/health-program-representatives/	
Incident Reporting	**Utah Department of Health** Division of Medicaid and Health Financing NCW Program Office Attn: New Choices Waiver Incident Reporting PO Box 143112 Salt lake City Utah 84114-3112 Fax: 801-323-1586	
	Healthy U	Phone: 1-888-271-5870

Medicaid ACO Health Plans		1-801-587-6480 http://uuhsc.utah.edu/uhealthplan/healthyU/members.html
	Molina	Phone: 1-888-483-0760 www.molinahealthcare.com
	Select Access	Phone: 1-800-662-9651 www.ihc.com
	Health Choice Utah	Phone: 1-877-358-8797 www.healthchoiceutah.com
Medicaid Client Education	https://medicaid.utah.gov/medicaid-members/	
Medicaid Information Line	801-538-6155 or 1-800-662-9651 https://medicaid.utah.gov/	
New Choices Waiver Program Office	Salt Lake City area: 1-801-538-6155, option 6 Outside of the Salt Lake City area and in neighboring states: 1-800-662-9651, option 6 Fax: 1-801-323-1586	
	Email: newchoiceswaiver@utah.gov: https://medicaid.utah.gov/ltc/nc/	
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	