

## Section 2

### Personal Care Services

#### Traditional Personal Care Services and Employment-related Personal Assistant Services

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## Introduction

This manual is divided into two parts: Traditional Personal Care Services and Employment-related Personal Assistance Services (EPAS). The manual is designed to be used in conjunction with other sections of the Utah Medicaid Provider Manual, such as [Section I: General Information](#)

The information in this manual represents available services when medically necessary. Services may be more limited or may be expanded if the proposed services are medically appropriate and are more cost effective than alternative services.

# PART I – TRADITIONAL PERSONAL CARE SERVICES

## 1 General Information

### 1-1 General Personal Care Policy

Personal care services are an optional Utah Medicaid program authorized by Section 1905(a) (24) of the Social Security Act and 42 CFR § 440.167. Part I of the Personal Care Manual addresses all State Plan covered personal care services with the exception of those services that are provided as part of the Employment-related Personal Assistance Services (EPAS) Program. For information related to EPAS Program services, see Part II of this manual.

The purpose of personal care services is to provide supportive care to members in their place of residence, to maximize independence and to prevent or delay premature or inappropriate institutionalization through providing a range of human assistance that enable persons with disabilities and chronic conditions to accomplish tasks they would normally perform themselves if they did not have a disability.

Personal care services must be administered by agency staff only as ordered by a physician and as stated in the current plan of care.

### HCBS Waiver Personal Care Services

For personal care services that are covered under the HCBS Waivers, please see the appropriate [Utah Medicaid Home and Community Based Waiver Manual](#) for the specific waiver the Medicaid Member is enrolled in.

### 1-2 Fee-For-Service or Managed Care

The Medicaid Provider Manual contains information regarding Medicaid policy and procedures for fee-for-service Medicaid members. The Managed Care Entity (MCE) must provide the services outlined in the applicable Sections as well as the applicable services described in the Utah Medicaid State Plan. However, MCE's may have different prior authorization requirements and post-payment review requirements. Providers who render services to members enrolled in MCE's should contact the MCE or refer to the MCE's manual for

additional information. If a Medicaid member is enrolled in an MCE, they must receive services through that MCE.

At times there are exceptions to MCE coverage. Service exceptions are called “carve-out services,” which may be billed directly to Medicaid on a fee-for-service basis. Medicaid will deny fee-for-service claims submitted directly to the DMHF, unless payment for the service is not the responsibility of the MCE. In such cases the claim is considered for payment under the requirements found in this and other applicable Sections.

To determine if a member is enrolled in an MCE, or if services may be billed to DMHF on a fee-for-service basis, providers must verify member eligibility using one of the following tools: *Eligibility Lookup Tool*, AccessNow (touch tone telephone verification) or, ANSI 270/271, an online service for providers enrolled in the Utah Health Information Network (UHIN). Refer to *Section I: General Information, Chapter 6, Member Eligibility*.

Medicaid members not enrolled in an MCE and not enrolled in DMHF’s Restriction Program, may receive services from any qualified provider who accepts Medicaid.

### 1-3 Acronyms and Definitions

Definitions of terms used in other Medicaid programs are available in the Utah Medicaid Provider Manual, *Section I: General Information*. Definitions specific to the content of this manual are provided below.

#### **Custodial Care Services**

For purposes of these provisions, custodial care is defined as; care that is provided primarily to assist in the activities of daily living, such as bathing, dressing, eating, and maintaining personal hygiene and safety.

#### **EVV**

Electronic Visit Verification

#### **Home Health Aide**

A Certified Nurse Aide who provides services in the home, is referred to as a Certified Home Health Aide for the purposes of this program.

As stated in Utah Administrative Code Rule R432-45: A "Certified nurse aide" means any person who completes a nurse aide training and competency evaluation program (NATCEP) and passes the state certification examination.

#### **Home Health Agency**

A Public agency or private organization which is licensed by the Bureau of Health Facility Licensure and Certification under authority of Utah Code Annotated, Title 26, Chapter 21 **and is certified through the Centers for Medicare and Medicaid Services (CMS).**

**ICF/ID**

Intermediate care facility for individuals with intellectual disabilities.

**IMD**

Institution for mental disease.

**Institution**

Institutions are residential facilities that assume *total* care of the individuals who are admitted.

**Licensed Health Care Professional**

A registered nurse, physician assistant, advanced practice registered nurse, or physician licensed in accordance with Title 58, Occupational and Professional Licensing (Utah Code Annotated) by the Utah Department of Commerce who has the education and experience to assess and evaluate the health care needs of the member.

**Personal Care Aide**

A personal care aide that functions within the constraints of Utah Administrative Code R432-725-14

**Personal Care Agency**

A care agency that consists of two or more individuals providing personal care services, on a visiting basis and is licensed in accordance with Utah Administration Code R432-725

**Personal Care Assessment**

A visit made by a licensed registered nurse initially or at the required time of re-certification to assess the member's functional level, the adaptability of the member's place of residence to the provision of personal care, to determine the capability of the member to participate in their own care and to identify family support systems or individuals willing to assume the appropriate level of responsibility for care when the member is unable to do so.

**Personal Care Service**

- Services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or institution for mental disease.
- Authorized for the individual by a physician in accordance with a plan of care or (at the option of the State) otherwise authorized for the individual in accordance with a plan of care approved by the State.
- Provided by an individual who is qualified to provide such service and who is not a member of the individual's family; and
- Furnished in a home, and at the State's option, in another location.
- For purposes of this section, family member means a legally responsible relative.

**Service Agreement**

A written agreement for services between the member and the personal care provider which outlines how the services are to be provided.

## SMA

State Medicaid Agency

### 1-4 Personal Care Program Requirements

#### A. Program Access

- A physician must prescribe the necessary personal care services.
- Only a Home Health Agency or a Personal Care Agency, as described in [section 1-3](#), may provide personal care services.
- Only a qualified personal care aide, a certified home health aide, a licensed practical nurse, or a registered nurse (performing only personal care level tasks) may provide the personal care services.
- A licensed registered nurse must supervise the provision of personal care services.
- Personal care services are a covered service only for members who receive these services in their residence, not in an institution.
- Initially, a licensed registered nurse must complete a personal care assessment to assess the member's functional level, the adaptability of the member's residence for the provision of personal care, and to identify family support systems or individuals willing to assume the responsibility for care when the member is unable to do so. A licensed registered nurse must also complete a personal care assessment at the required time of recertification or sooner if warranted by a change in the member's condition.

*Note: An additional nurse assessment within a 60 day time period, requires prior authorization.*

#### B. Plan of Care

Personal care services must be delivered according to a written plan of care developed by provider agency staff, in consultation with the physician, and based upon physician orders. The plan of care must include the following:

- Diagnoses related to personal care service needs
- Patient status
  - Mental status
  - Functional limitations
- Service need:
  - Frequency/duration of service
  - Personal care tasks required
  - Equipment required (if applicable)
  - Medications

- Discharge planning or referral
- Other identified appropriate services
- Identification of support systems
  - The parent/guardian is the primary care provider for the minor child and is obligated to provide age-appropriate custodial care for their minor child with disabilities as they would for their typical developing child. Parents are responsible to provide or arrange care for transportation, housework, laundry, shopping, meal preparation, finances, pet care, foot care needs, skin care needs, telephone use and medication management.

The plan must be signed by the licensed registered nurse and incorporated in the Personal Care Agency's permanent record for the member. All changes must be made in writing and signed by the licensed registered nurse or the agency staff receiving the physician's orders. All oral orders must be documented in writing on or before the next plan review.

The certification period for each plan of care is 60 days. Although, a prior authorization may be issued for up to 180 days, a new nursing assessment must be performed and a new plan of care must be created every 60 days and should always have consecutive dates from the previous plan of care unless there has been a break in service.

Agency professional staff must alert the physician promptly of any changes in patient's condition that suggest a need to alter the plan of care.

### **C. Supervision by a Registered Nurse**

The licensed registered nurse must make a supervisory visit to the recipient's residence at least once every 60 days to ensure that care is adequate and provided according to written instructions. The visit may be made either when the aide is present to observe and assist, or when the aide is absent, to assess relationships and determine whether goals are being met.

### **D. Record Keeping**

The Personal Care Agency shall maintain accurate and complete records in accordance with Utah Administrative Code R432-725-13 and in accordance with chapter 4-2 Record Keeping and Disclosure, of the Utah Medicaid Provider Manual [Section I: General Information](#)

## **2 Provider Participation Requirements**

### **2-1 Provider Enrollment**

Refer to the Utah Medicaid Provider Manual, [Section I: General Information](#) for provider enrollment information.



## 2-2 Qualified Personal Care Providers

The individual providing personal care must provide service under the direction of a licensed registered nurse through a Home Health Agency or Personal Care Agency.

Persons qualified to provide personal care must be one of the following:

- Qualified personal care aide
- Certified home health aide
- Licensed practical nurse
- Licensed registered nurse

## 3 Member Eligibility

As stated in *Section I: General Information* of the Utah Medicaid Provider Manual, *Verifying Medicaid Eligibility*, a Medicaid member is required to present the Medicaid Identification Card before each service, and every provider must verify each member's eligibility each time before rendering services. Presentation of the Medicaid Member Card does not guarantee a member continues to be eligible for Medicaid. Verify the member's eligibility, and determine whether the member is enrolled in an MCE, Emergency Only Program, or the Restriction Program; assigned to a Primary Care Provider; covered by a third party; or responsible for a co-payment or co-insurance. Eligibility and health plan enrollment may change from month to month. Retain documentation of the verified eligibility for billing purposes

Verify member eligibility using AccessNow, *Eligibility Lookup Tool*, and ANSI 270/271. For detailed information, call Medicaid Information, or go to the Medicaid website at <https://medicaid.utah.gov/medicaid-online>

**Note:** Medicaid staff makes every effort to provide complete and accurate information on all inquiries. However, federal regulations do not allow a claim payment even if the information given to a provider by Medicaid staff was incorrect.

For more information regarding verifying eligibility, refer to, *Section I: General Information* of the Utah Medicaid Provider Manual, *Verifying Medicaid Eligibility*.

### 3-1 Personal Care Services Eligibility Requirements

Personal care services are available to members who meet the following conditions:

- The member is non-bedbound
- The member is unable to independently perform two or more of the following personal care tasks:
  - Self-administration of medications due to memory lapse
  - Toileting

- Bathing or showering
  - Skin care
  - Ambulation
  - Personal grooming
  - Nutritional requirements, including meal planning, preparation, cleanup, and motivation to eat
- The member needs personal care to:
    - Maintain the capacity to function, delay disease progression, or prevent regression and complications; OR
    - Receive assistance while recovering from an acute condition.

## 4 Program Coverage

### 4-1 Covered Personal Care Services

Personal care services are covered benefits when provided by a Home Health Agency or a Personal Care Agency, as defined in [1-3 Acronyms and Definitions](#) and provided in accordance with current Utah Medicaid policy.

#### Services provided by the personal care provider may include:

- Reminding the patient to take medication, and observing the patient who is able to self-administer medication.
- Providing minimal assistance with, or supervision of, bathing and personal hygiene including shampoo and hair care, non-medical skin care according to the member's plan of care, and shaving (with electric razor only).
- Basic foot care including filing and trimming of nails for patients that have toenails of normal thickness, normal sensation of feet and no history of disease processes that put the patient at high risk for foot complications.
- Providing meal assistance, including meal planning, preparation, feeding if necessary, and cleanup for the individual member.
- Providing oral hygiene, including tooth or denture care.
- Assisting with ambulation, including arm support, use of cane, crutches, walker, wheelchair, or other assistive device.
- Assisting with bladder and bowel requirements or problems, including helping the member to and from the bathroom and assistance with toilet hygiene or assisting non-bedbound patients with bedpan routines. (Assistance with enemas, suppositories, ostomy care, external catheter drainage tubing and bag changing or emptying is not an allowable personal care service).

- Making brief occasional trips outside the home for the member to receive medical examination or treatment, or for shopping to meet the member's health care or nutritional needs.
- Taking proper measures for the patient's safety and comfort, including good hand washing techniques, proper disposal of body waste, and explanation and application of smoking precautions.
- Administering emergency first aid.
- Observing and reporting significant changes in the patient or the home environment.
- Performing household services (if related to a medical need) as are essential to the patient's health and comfort in the home, e.g., changing of bed linens, or rearranging furniture to enable the member to move about more easily in the home.

#### 4-2 Electronic Visit Verification Requirement

Electronic visit verification (EVV) requirements, defined in section 12006 of the 21st Century Cures Act, apply to all personal care services provided under the State Plan or a 1915 (c) Home and Community Based Waiver. Disallowance for claims with incomplete records will not occur until January 1, 2020, for personal care services.

Starting July 1, 2019, the Division of Medicaid and Health Financing will begin to collect and monitor EVV records from personal care providers. The early collection and monitoring of EVV records will give providers an opportunity to test the records submission processes to ensure compliance with the federal requirements prior to the mandatory compliance effective dates.

Providers must select their own EVV service provider and make records available to the State for review upon request on or after July 1, 2019. All systems must be compliant with the 21st Century Cures Act requirements including:

- type of service performed;
- individual receiving the service;
- date of the service;
- location of service delivery;
- individual providing the service
- time the service begins and ends; and
- the date of creation of the electronic record

For more information regarding EVV requirements, please refer to [Utah Administrative Code R414](#) and [Section I: General Information](#) of the Utah Medicaid Provider Manual

### 4-3 Limitations

- Nursing assessments (T1001) are limited to 1 assessment every 60 days. Additional assessments require prior authorization.
- Personal care services (T1019) are limited to 60 hours per month and require prior authorization.
- Providers may not provide personal care services for a member on the same day that Medicaid state plan home health aide services or capitated home health services are provided.
- Regardless of licensing allowances, care providers that are providing services authorized under code T1019, should not provide any care related to patient medical devices and/or supplies, including but not limited to the following items:
  - Any equipment or supplies related to ostomy care
  - External catheter systems, including tubing and/or bag
  - Rectal tubing
  - IV's
  - PICC lines
  - Parenteral lines
  - Enteral feeding tubes
  - Oxygen equipment
  - Any equipment or supplies related to tracheostomy care
  - Ventilators
  - Any equipment or supplies related to wound care
- Utah Medicaid will not reimburse for personal care services if the member's needs exceed the level of care allowable for personal care agencies as determined by current Medicaid policy. If the member's needs exceed allowable personal care services, the agency shall make a referral to a licensed health care professional or an appropriate alternative service provider that can safely meet the level of care required for that member.
- Personal care services should not be confused with services which would more appropriately be provided by persons who provide chore services in the home. Examples of chore services which are clearly not to be regarded as personal care are as follows:
  - Cleaning of floor and furniture in areas not occupied by the member. For example, cleaning of the entire living area if member occupies only one small room.
  - Laundry, other than that incidental to the care of the member. For example, laundering of clothing and bedding for the entire household, as opposed to simple laundering of the member's personal laundry.
  - Care related to the member's pet(s)

## 5 Billing

### 5-1 Personal Care Procedure Codes

#### T1001(SE) Initial and Subsequent Nurse Assessments to Establish Plan of Care

An initial nurse assessment by a licensed registered nurse must be provided for the purpose of assessing the member's needs and functional level and establishing the plan of care, every 60 days.

#### T1019 Personal Care Service

Personal care services, per 1 hour.

#### T1021 Home Health Aide or Certified Nurse Assistant, per visit

Please see the [Utah Medicaid Provider Manual: Home Health Services](#) and the [Coverage and Reimbursement Lookup Tool](#) for policy requirements related to code T1021.

#### Utilization Modifiers

- T1001-SE Utilization Modifier SE is **required** to differentiate personal care assessment from the home health assessment performed in the Home Health State Plan Service category. SE signifies a personal care assessment rate set at 36.69% of the home health assessment base rate. The SE modifier is required to be used on all nursing assessments that are performed for assessing the personal care needs of a Utah Medicaid Member.
- T1019-TN The use of the TN rural enhancement modifier is authorized for the purpose of assuring access in rural areas of the State where providers are required to travel extended distances to deliver services. The rate enhancement adjusts the unit 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 with the exception of Weber, Davis, Salt Lake, and Utah Counties.
- The following limitations are imposed on the use of the rural enhancement for personal care services:
- The location assigned as the provider's normal base of operation must be in a county designated as rural;
  - The location from which the service provider begins the specific trip must be in a county designated as rural;
  - The location where the service is provided to the Medicaid Member must be in a county designated as rural;
  - For single encounter visits, the distance traveled by the provider from the starting location of the trip to the Medicaid Member must be a minimum of 25 miles with no intervening stops to provide services to other Medicaid Members.

- In the case of multiple coordinated visits as part of a single trip, the TN modifier may only be claimed for each specific visit when the travel distance from the previous visit to that visit is 25 or more miles and the rural requirements are met.

For *additional* coverage information, refer to the [Coverage and Reimbursement Lookup Tool](#) on the Medicaid website at: <https://medicaid.utah.gov>

Refer to the Utah Medicaid Provider Manual, [Section I: General Information](#) , for detailed billing instructions.

## 5-2 Medicaid as Payment in Full, Client Billing Prohibited

### Medicaid and MCE

A provider who accepts a member as a Medicaid patient must accept the Medicaid payment as reimbursement in full. If a member has both Medicaid and coverage with a responsible third party, do not collect a co-payment that is usually due at the time of service. The provider may not bill the member for services covered by Medicaid. The payment received from Medicaid is intended to include any deductible, co-insurance, or co-payment owed by the Medicaid member. In addition, the administrative cost of completing and submitting Medicaid claim forms are considered part of the services provided and cannot be charged to Medicaid members.

### Qualified Medicare Beneficiary

Providers who serve Qualified Medicare Beneficiary (QMB) clients must accept the Medicare payment and the Medicaid payment, if any, for co-insurance and deductible as payment in full. Providers may not bill members eligible for the Qualified Medicare Beneficiary Program for any balance remaining after the Medicare payment and the QMB co-insurance and deductible payment from Medicaid. (42 CFR §447.15)

### Providers must follow policies and procedures

Providers must follow policies and procedures concerning, but not limited to: medical services covered; medical service limitations; medical services not covered; obtaining prior authorization; claim submission; reimbursement; and provider compliance, as set forth in all Sections of the Utah Medicaid Provider Manual, Medicaid Information Bulletins, and letters to providers. If a provider does not follow the policies and procedures, the provider may not seek payment from the member for services not reimbursed by Medicaid. This includes services that may have been covered if the provider had requested and obtained prior authorization.

## 5-3 Exceptions to Prohibition on Billing Members

There are certain circumstances in which a provider may bill a Medicaid member. They are: non-covered services, spenddown medical claims, Medicaid cost sharing (co-payments and co-insurance), and broken appointments. The specific policy for each item must be followed before the Medicaid member can be billed. Refer also to [Section I: General Information](#) for more information.

Before collecting a co-payment, confirm the service requires a co-payment and that the member has a co-payment requirement. Give the member a receipt for the co-payment collected. The member is responsible to keep co-payment receipts in case of delayed billings by providers or discrepancies. If a co-payment is not collected at the time of service, the provider may bill the client for it.

#### 5-4 Prior Authorization

Prior authorization may be required for certain services. Failure to obtain prior authorization can result in payment denial by Medicaid. Providers must determine if prior authorization is necessary and obtain authorization *before* providing services. Exceptions can be made, with appropriate documentation, if the service provided meets the requirements listed in chapter 10-3 Retroactive Authorization of the Utah Medicaid Provider Manual, *Section I: General Information* or when a specific grace period is stated in the program specific provider manual.

#### Prior Authorization Certification Period

Prior authorization for personal care services should be requested for 180 days unless the care needs indicate that less time is required. Although a prior authorization may be issued for 180 days, the member must undergo reassessment at least every 60 days. As the prior authorization end date nears, the agency should determine the need for continued care and submit a new prior authorization request. Include all required information and documentation. Reassessments can take place no more than five days prior to, or two days after, the previous certification period expires.

#### Initial Requests:

The Personal Care Agency will be given 10 days from the start of services to submit all required documentation, including the completed "Request for Prior Approval" form, plan of care, and any supporting documentation that would substantiate medical necessity for the requested services. If the request is received more than 10 days after the start of services, the authorization will begin on the day the completed request and all required documentation is received.

#### Re-certification Requests:

A new prior authorization request including "Request for Prior Approval" form, plan of care, and any supporting documentation that would substantiate medical necessity for the requested services will be required every 180 days or sooner if change in authorization is needed. The request for the new certification period must be received within 10 days of the re-certification period start date. Care and service needs and the plan of care must be reviewed and a new prior authorization will be issued if the requested services are approved. If the request is received more than 10 days after the start of the new certification period, the authorization will begin on the day that the completed request and all required documentation is received.

Prior Authorization requests should be faxed to the appropriate number, listed on the prior authorization request form.

### Criteria for Review of Prior Authorization Requests (T1019)

The Medicaid agency will use the following criteria to evaluate prior authorization requests. Criteria include the following:

1. A current prescription for personal care services, by a physician as evidenced in the physician's orders;  
AND
2. Documentation stating the member is non-bedbound; AND
3. Documentation of the patient's inability to perform two or more of the following personal care service tasks:
  - a. Remembering to take self-administered medications
  - b. Elimination, including the use of a urinal, commode, or bedpan
  - c. Bathing or showering, including getting in and out of the tub or shower
  - d. Skin care
  - e. Ambulation, including use of cane, crutches, walker, or wheelchair
  - f. Personal grooming, including oral care, hair care, shaving (with electric razor), dressing, or nail care
  - g. Nutritional requirements, including meal planning, preparation, cleanup, motivation to eat, etc.AND
4. Documentation that the member needs personal care to:
  - a. Maintain capacity to function, delay disease progression, or prevent regression and complications;  
OR
  - b. Receive assistance while recovering from an acute condition
5. Member does not require any of the following *home health aide services*:
  - a. Having urine tested, or urine or stool specimens collected
  - b. Need enemas, external catheter applied or removed, external catheter drainage tubing and bag changed or emptied
  - c. Bag changed on ostomies; active or passive range-of-motion exercises; dry dressings changed

**Note:** If services listed in #5 (Home Health Aide Services) are required, a personal care aide is not the appropriate provider type. Please see the [Utah Medicaid Provider Manual: Home Health Services](#) for home health aide prior authorization requirements.

### Criteria for Review of Prior Authorization Requests for Additional Nurse Assessment Visits (T1001)

If more than one nurse assessment visit is required in a 60-day time period, a completed prior authorization request form should be submitted prior to the service being provided and must include documentation that patient's condition has changed significantly enough to require an additional nurse assessment.



## 5-5 Hearings and Administrative Review

A provider or member may request an administrative hearing to dispute an action taken by the Division of Medicaid and Health Financing (DMHF). Actions taken that may be appealed include, but are not limited to:

- Denial of a prior authorization request.
- Denial of a claim, as indicated by an explanation of benefits or other remittance document issued by Medicaid.

To request a hearing, send a completed hearing request form to the Office of Administrative Hearings. The form must be faxed or postmarked within 30 calendar days from the date DMHF or the MCE sends written notice of its denial or intended action, unless a different time period is indicated on the denial document. Failure to submit a timely request for a hearing constitutes a waiver of the due process right to a hearing. The agency is not required to grant a hearing if the sole issue is a federal or state law requiring an automatic change. Utah Administrative Code R410-14 et seq. sets forth the administrative hearing procedures for Medicaid hearings.

A *Request for Hearing/Agency Action* form (Hearing Request) is available on the Utah Medicaid website at: <https://medicaid.utah.gov/utah-medicaid-forms>, Hearing Request, or a copy may be requested from the Office of Administrative Hearings by calling (801) 538-6576.

Submit the form by mail or fax.

**Mail:**

Division of Medicaid and Health Financing  
Office of Administrative Hearings  
Box 143105  
Salt Lake City, UT 84114-3105

**FAX:** (801) 536-0143

## PART 2 – EMPLOYMENT-RELATED PERSONAL CARE SERVICES

### 1 General Information

#### 1-1 General Policy

Employment-related Personal Assistant Services (EPAS) is an optional Utah Medicaid program authorized by Section 1905(a)(24) of the Social Security Act. Part 2 of the Personal Care Manual addresses State Plan covered EPAS. For information related to traditional personal care services, see Part 1 of this manual.

The manual is designed to be used in conjunction with other sections of the Utah Medicaid Provider Manual, such as *Section I: General Information of the Utah Medicaid Provider Manual (Section I: General Information)* and *the Physician Services Utah Medicaid Provider Manual*.

EPAS provides services to Medicaid participants with disabilities who work and need personal assistance in order to successfully maintain their employment. EPAS may be delivered by a Personal Care Agency licensed to provide personal care services or through the Self-Administered Services (SAS) delivery option. The SAS delivery option allows the Medicaid participant to employ and directly supervise the EPAS employee who meets provider qualifications established by the Medicaid Agency. Medicaid participants who choose to receive EPAS through the SAS delivery option must utilize a Financial Management Service Agency to ensure that the necessary employer related duties and tasks, including managing the EPAS employee's payroll, are properly completed.

#### 1-2 Fee-For-Service or Managed Care

EPAS services are only available on a fee-for-service basis. EPAS is a carve-out service and is not available through MCE's.

#### 1-3 Acronyms and Definitions

##### **Activities of Daily Living (ADLs)**

Basic self-care tasks that people tend to do every day without needing assistance. ADLs include: eating, toileting, dressing, grooming, maintaining continence, bathing, walking and transferring (such as moving from bed to wheelchair).

##### **Assessor**

A Licensed Clinical Social Worker or a Registered Nurse who conducts the required EPAS functional assessment(s) of the Medicaid participants.

##### **BACBS**

Bureau of Authorization and Community Based Services

**Disability**

As defined by established disability criteria according to the Social Security Administration or the Medical Review Board.

**DSPD**

Division of Services for People with Disabilities

**DWS**

Division of Workforce Services

**EPAS**

Employment-related Personal Assistant Services

**EPAS Specialist**

Individual employed by the State Medicaid Agency who provides overall program management and oversight of the EPAS program.

**FMS**

Financial Management Services is the service provided in support of self-administered services that ensures the necessary employer related duties and tasks, including managing the EPAS employee's payroll, are properly completed.

**HCPCS**

Healthcare Common Procedure Coding System

**Instrumental Activities of Daily Living (IADLs)**

These activities are not necessary for fundamental functioning but allow the individual to live independently in a community. IADLs include: meal preparation, ordinary housework and basic home maintenance, managing finances, managing medications, phone use or other communication devices, shopping, and transportation (driving or handling public transit).

**LOC**

Level of Care

**MDS-HC**

Minimum Data Set for Home Care. The standard comprehensive assessment instrument used in the EPAS program.

**PA**

Personal Assistant

**SAS**

A Self-Administered Service is a service delivery option that allows the Medicaid participants to employ and directly supervise the EPAS employee who meets provider qualifications established by the Medicaid Agency. Under this service delivery method, the Medicaid participant is responsible for hiring, training, supervising, setting work schedule, and carrying out disciplinary actions. Medicaid participants who choose to receive EPAS through the SAS delivery option must utilize a Financial Management Services provider to ensure that the necessary employer related duties and tasks, including managing the EPAS employee's payroll, are properly completed.

## SC

Service Coordinator

## 2 Provider Participation Requirements

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

Any willing provider that meets the qualifications defined below may enroll at any time to provide EPAS services. To enroll as an EPAS provider contact the EPAS Specialist. The EPAS Specialist will facilitate completion and submission of the required Medicaid provider application. The provider is only authorized to provide the EPAS services specified and approved in their Medicaid provider agreement.

### 2-1 Service Coordinator Enrollment

Service Coordinator Agencies are responsible for the ongoing management of the EPAS participant's case. Management of the case includes: verification of employment, verifying and assisting the participant to maintain Medicaid eligibility, assisting the participant with training the EPAS personal assistant(s), creating and implementing Care Plans, and scheduling and coordinating with the EPAS Assessor to complete periodic reassessments. Service Coordinator provider qualifications include:

- Possess a Bachelor's Degree, preferably in Human Services or related field or can substitute a year of equivalent work providing services to the target population for each year of the required education.
- Possess a valid State or Federal photo identification
- Have an applicable business license
- Pass a Utah criminal history and background check
- Have general liability/professional liability insurance
- Attend the mandatory EPAS Service Coordinator Training provided by State Medicaid Agency staff and demonstrate required competencies for service coordination, protocols and procedures.
- Complete the Utah Medicaid Provider Application
- Complete Attachment A (located in the online PRISM enrollment system)
- Complete and agree to provider responsibilities in Attachment B (located in the online PRISM enrollment system)

## 2-2 Financial Management Services Agency Enrollment

If an EPAS participant chooses a non-agency individual to provide their personal care services, a Financial Management Services Agency must be used to assist the EPAS participant in payroll and employer related taxes. Fiscal Agencies are responsible for processing paychecks and issuing them in a timely manner. Financial Management Services provider qualifications include:

- Possess a business license
- Pass a Utah criminal history and background check
- Possess a valid State or Federal photo identification
- Complete the Utah Medicaid Provider Application
- Complete Attachment A (located in the online PRISM enrollment system)

## 2-3 Assessor Enrollment

EPAS Assessors are responsible to conduct EPAS assessments to determine participants' program eligibility and to evaluate needs for Care Plan development. The Minimum Data Set- Home Care (MDS-HC) assessment tool is the required assessment tool. EPAS Assessor provider qualifications include:

- Must be a Licensed Clinical Social Worker (LCSW) or a Registered Nurse (RN)
- Pass a Utah criminal history and background check
- Possess a valid State or Federal photo identification
- Attend the mandatory EPAS Assessor training provided by state Medicaid agency staff and demonstrate required competencies for completing assessments, protocol and procedures.
- Complete the Utah Medicaid Provider Application
- Complete Attachment A (located in the online PRISM enrollment system)

## 2-4 Personal Care Agency Enrollment

EPAS may be delivered by a Personal Care Agency licensed to provide personal care services or through the Self-Administered Services (SAS) delivery option. The SAS delivery option allows Medicaid participants to employ and directly supervise the EPAS employee who meets provider qualifications established by the Medicaid Agency. EPAS personal care services include physical assistance and cognitive cuing to direct self-performance of necessary activities. Medicaid participants who choose to receive EPAS through the SAS delivery option must utilize a Financial Management Services provider to ensure that the necessary employer related duties and tasks, including managing the EPAS employee's payroll, are properly completed.

Personal care services may be delivered by an agency licensed to provide personal care services outside of a 24-hour supervised living setting, in accordance with Utah Code Annotated, Title 26, Chapter 21.

**Personal Care Agency Provider Qualifications:**

Personal Care Agencies must be licensed in the State of Utah in accordance with UAC R432-725 Personal Care Agency Rule.

**SAS Provider Qualifications:**

- Must be at least 16 years of age
- Possess a valid State driver's license
- Possess automobile liability insurance if providing transportation services
- May not be the spouse of the EPAS participant
- May not be the parent of an EPAS participant under the age of 18
- Receive training on how to deliver EPAS services according to the authorized Care Plan by the EPAS participant and/or Representative upon every Care Plan renewal.

### 3 Participant Eligibility

#### 3-1 Eligibility for EPAS Services

To be eligible for the EPAS program the Medicaid participant must:

- Meet the SSI definition of disability
- Be gainfully employed in an integrated community setting making at least minimum wage.
  - An integrated community setting is defined as a workplace or environment where there are persons with and without disabilities employed within the same company.
  - Gainful employment is defined as an employment situation where the employee receives consistent work and payment of at least minimum wage from an employer.
- Be employed and working for an employer at a minimum of 40 hours per month, or
  - Enrollment onto the EPAS program is determined on a case-by-case basis. If the applicant is unable to work 40 hours per month due to company restrictions, location, or other circumstances, despite the applicant's capacities to work 40 hours per month, the applicant may submit rationale to petition to be enrolled onto the EPAS program.
- Be self-employed and able to demonstrate substantial income and specific work activity each month
- Need a personal assistant in order to remain employed

The participant is not eligible if:

- The participant is employed by the institutional setting in which they reside.
- The participant is enrolled in a 1915(c) Home and Community Based Waiver Program where personal care services are provided as a component of covered waiver services.

## General Eligibility

A Medicaid participant is required to present the Medicaid Identification Card before each service, and every provider must verify each participant's eligibility each time before services are rendered. For more information regarding verifying eligibility, refer to provider manual, *Section I: General Information, Verifying Medicaid Eligibility* or to the Eligibility Lookup Tool located at <https://medicaid.utah.gov/eligibility>, or from these additional sources:

- AccessNow: (800) 662-9651
- Medicaid Customer Service: (801) 538-6155

### 3-2 EPAS Participant's Freedom of Choice of Service Providers

At the time of initial Care Plan development and any time a change is made to the participant's Care Plan, the Service Coordinator or EPAS Specialist will present the participant with a Freedom of Choice Consent Form.

The Freedom of Choice Consent Form allows the participant to declare their choice of available services and providers within their county of residence. The Service Coordinator and EPAS Assessor must maintain a signed copy of this form in the participant's case records.

## 4 Program Coverage

### 4-1 Covered Services

#### Personal Assistant Services

Personal assistants may only provide assistance with ADLs or IADLs in support of assisting the EPAS participant to maintain employment. Services are not available for other household participants living with the Medicaid participant. Duplicate services at different times of the day from different providers are permitted, however, duplicate services at the same time of day are not allowed. Any instance where an individual requires two PA's at the same time of day to perform multiple tasks requires justification and prior authorization from the SMA.

A. ADLs include the following services:

1. Mobility in Bed
2. Transferring
3. Locomotion in and outside of home
4. Dressing
5. Eating

6. Toileting (excludes assistance with enemas, suppositories, catheters and ostomy care or insertion of feminine hygiene products).
7. Personal Hygiene
8. Bathing

B. IADLs include the following services:

1. Meal Preparation
2. Ordinary Housework
3. Laundry
4. Managing Finances (includes assistance with simple budgeting, paying bills, and maintaining Medicaid eligibility spend downs or Medicaid Work Incentive requirements).
5. Medications Reminders and Cueing (In compliance with the Utah Nurse Practice Act, Personal Assistants may not administer medications, including the application of prescription ointments or creams).
6. Shopping to include purchase of items such as groceries, personal hygiene products, prescription medications, uniforms or work clothing. Shopping for clothing will be authorized on an occasional and limited basis with the intent of assuring that the participant is dressed appropriately for work as per the authorized Care Plan.
7. Transportation: Payment is rendered according to the time spent traveling from one destination to another. (EPAS does not provide Medical transportation nor allow compensation for mileage, gas or time when the participant is not in the vehicle with their personal assistant) Authorized uses of travel include:
  - a. Accompanying the individual to and from public transportation for work.
    - i. Time is authorized for when the Personal Assistant is with the participant.
  - b. Transporting the participant to and from work
  - c. Time is authorized for when the Personal Assistant is with the participant in the vehicle. Transporting the individual to go shopping for items described in Item 6 above
  - d. Self-employed participants who require specific products in order to maintain their business may be allotted time for purchasing these products as per the authorized Care Plan.
  - e. Transporting the individual to and from the pharmacy to pick up or drop off prescription medication orders.
  - f. Transporting the individual to and from the bank/financial institution to fulfill services described above in Item 4.



### **EPAS Assessment Services**

A Licensed Clinical Social Worker (LCSW) or a Registered Nurse (RN) who has received initial and annual training by the State Medicaid Agency must conduct an EPAS Assessment utilizing the Department's required assessment tool, the MDS-HC assessment instrument.

The MDS-HC Assessment is a standardized, minimal assessment and screening tool designed for clinical use. The MDS-HC Assessment Form consists of items and definitions that should be used as a guide to structure a clinical and social assessment in planning for community-based care and services.

The assessment process requires communication with the person and primary caregiver/family member (if available), observation of the person in the home environment, and review of secondary documents when available. Where possible, the person is the primary source of information. EPAS requires that whenever possible, the MDS-HC assessment should be performed during a face-to-face visit within the individual's home. In special circumstances, the EPAS Specialist may pre-approve the completion of the assessment in another setting or over the phone.

Items on the MDS-HC Assessment Form flow in a logical sequence and can be completed in the order in which they appear. However, the assessor is not bound by this sequence. Items may be reviewed in any order that works for the assessor and the participant.

To determine EPAS eligibility, a score will be derived from the completed assessment based on the nine critical areas of the assessment.

The EPAS Assessor will utilize the MDS-HC Criteria Scoring Form to determine if the applicant meets the minimum eligibility criteria for the program. The individual must score > 0 on five or more of the nine criteria listed on the Scoring Form. Instruction and training on the use of the Scoring Form will be included in the EPAS Assessor's mandatory training.

### **Service Coordination Services**

As part of the Care Planning process, the Service Coordinator is responsible to review the results of the MDS-HC Assessment and the MDS-HC Criteria Scoring Form. The Service Coordinator is responsible for developing a written individualized Care Plan.

The plan must include:

- (a) The name, date of birth, and Medicaid ID of the individual
- (b) Employment data
- (c) Care plan type selection of initial, annual, or change in information
- (d) Billing or HCPCS codes for Service Coordination, Financial Management Services Agency, and Personal Attendant Services.
- (e) Name of chosen service providers

- (f) The recommended amount and frequency of services. Explained in both weekly and monthly hours.
- (g) The Care Plans beginning and end date of services
- (h) Other employment or community supports being utilized by the individual
- (g) The basis for the need of ADL or IADL assistance, including MDS-HC impairment score data
- (h) Signatures from the participant or representative, Service Coordinator, and State Medicaid Agency.

### Annual Assessment and Care Plan Process

All Assessments for active EPAS participants are valid for a period of 12 months. Care Plans must be developed within 30 calendar days of each new assessment; therefore, Care Plans must be completed annually as well. The process of conducting the annual assessment process consists of the following activities:

1. The Service Coordinator and EPAS Assessor are responsible to coordinate and regulate appointments in a timely manner for all annual EPAS reviews. The EPAS Assessor or Service Coordinator will initiate the need for a new assessment.
2. The EPAS Assessor and Service Coordinator must verify the Medicaid eligibility of the participant before providing any services.
3. The Assessor must complete the annual reassessment in the same calendar month as the previous assessment.
  - i. It is possible to complete several assessments within a one year time frame due to possible changes in health status or circumstances of the EPAS participant. Each time a new assessment is completed a new Care Plan must also be developed.
4. The Service Coordinator has 30 calendar days from the date of the completed assessment to develop an annual renewal Care Plan. The Care Plan must be turned into the EPAS Specialist 10 days prior to the begin date of the new Care Plan.
  - i. For Example: If a participant's new Care Plan begin date was January 1, the Service Coordinator must have the new Care Plan turned into the EPAS Specialist 10 days prior, on Dec 21, in order to give the EPAS Specialist time to review and approve the Care Plan prior to its begin date.
  - ii. Please note that although an initial Care Plan may begin any day of the month, an annual Care Plan must begin at the first of the month. Example: A participant's initial Care Plan was authorized to begin January 13, 2015, however, upon developing the participant's annual Care Plan, the Care Plan must start on the first of the month or January 1, 2016.
5. Once the Care Plan, MDS-HC, and all other initial paperwork are turned into the EPAS Specialist, the EPAS Specialist will review the Care Plan and assessment for validity and justification of hours allotted to the participant. The approved Care Plan is the authorization for the EPAS Assessor, Service Coordinator,

and Personal Care Services. Financial Management Service Agencies will receive a separate authorization/budget for each EPAS participant.

**4-2 Non-Covered Services**

- Medical Transportation, including transportation to doctor appointments or other medically related services
- Work Training including job coaching, job training, or reasonable accommodations that an employer is required to provide under the Americans with Disabilities Act).
- Participants who are self-employed may not use their personal assistant(s) as an employee in their business.
- Cleaning EPAS participant’s vehicle, running miscellaneous errands, or providing any other services not listed under Covered Services.
- Taking care of EPAS participant’s personal pets or animals
- Watching, or tending to EPAS participant’s children or relatives

**5 Billing**

Refer to the provider manual, *Section I: General Information*, for detailed billing instructions.

**5-1 Billing and Rate Codes**

<u>HCPCS</u>	<u>Description</u>	<u>Provider Type</u>	<u>Unit</u>	<u>Rate (Unit/hour)</u>
T1028	Home Assessment, Determination of PT’s Needs	68	Per Encounter	Rate can be found on Coverage and Reimbursement Look-Up Tool*
S5125	Self-Directed Service Attendant Care	54	15 min = 1 unit	Self-Directed Service Attendant Care is 61% of the Maximal Allowable Rate (MAR) for Traditional Attendant Care*
S5125	Traditional Attendant Care Services	54	15 min = 1 unit	Rate can be found on Coverage and Reimbursement Look-Up Tool*

T2040	Financial Management Services, Self-Directed	68	1 unit allowed per month, per member	Rate can be found on Coverage and Reimbursement Look-Up Tool*
T2024	Service Coordination, Service Assessment/Plan of Care Development	68	15 min = 1 unit	Rate can be found on Coverage and Reimbursement Look-Up Tool*

\* Utah HCPCS rates are found on Medicaid’s Coverage and Reimbursement Look-Up Tool:  
<https://medicaid.utah.gov/coverage-and-reimbursement>

**5-2 Application Requirements and Prior Authorization of EPAS Services**

The application process and performance of the initial assessment consist of the following activities:

- A. An applicant submits their application into the EPAS Specialist. The EPAS Specialist reviews the application to determine if the applicant meets basic program eligibility. If the EPAS Specialist determines that the applicant meets basic program eligibility, the Specialist will send the applicant an EPAS program packet that includes the Freedom of Choice Consent Form. Once the applicant completes and submits the paperwork to the EPAS Specialist, a referral from the EPAS Specialist to the chosen EPAS Assessor and Service Coordinator is made.
- B. The EPAS Assessor and Service Coordinator must first verify the Medicaid eligibility of the participant before providing any services, and work together to assure appointments are set up with the participant in a timely matter.
- C. The EPAS Assessor has 30 calendar days from the date of referral from the EPAS Specialist to complete the initial assessment and give it to the participant’s Service Coordinator and EPAS Specialist. The Service Coordinator has 30 calendar days from the date the initial assessment was completed to develop the participant’s Care Plan and submit it to the EPAS Specialist.
- D. Once the Care Plan, MDS-HC, and all other initial paperwork are turned into the EPAS Specialist, the EPAS Specialist will review the Care Plan and assessment for validity and justification of hours allotted to the participant. The approved Care Plan is the authorization for the EPAS Assessor, Service Coordinator, and Personal Care Services. Financial Management Service Agencies will receive a separate authorization/budget for each EPAS participant.

All EPAS authorizations will contain the following information:

- 1. The HCPCS billing code
- 2. The amount and frequency of the service ordered
- 3. The start and end date of the services

4. EPAS Specialist signature and date

## 6 Suspension of EPAS Services

### 6-1 Holds and Suspensions

When the participant is not meeting the program requirements on a temporary basis, the EPAS Specialist may place an EPAS participant's case on hold. Reasons for placing a participant's case on hold may include:

- The participant is hospitalized or admitted to a nursing facility and is unable to remain working.
  - If the participant remains in the hospital or nursing facility longer than 60 days without continuing employment, the participant will be disenrolled from the program.
- The participant is unable to be contacted.
  - If the participant is unable to be contacted by the Service Coordinator for more than 30 days their case will be reviewed for possible disenrollment.
- The participant is on vacation.
  - If the participant is on vacation for more than 30 days their case will be reviewed for possible disenrollment.
- The participant goes on maternity leave.
  - If the participant is receiving personal time or annual pay while away on maternity leave, services may continue uninterrupted. However, if the participant is not receiving income from their place of employment during maternity leave, services will be suspended until they return to work.
- The participant did not pay their Medicaid Work Incentive (MWI) premium or spend down for the month.
  - If the participant does not pay their premium or spend down, their services will be on hold until the outstanding amount is paid. If the participant's case is closed by the Division of Workforce Services (DWS) for outstanding premium or spenddown amounts the participant will be disenrolled.
- The participant does not meet the minimum of 40 work hours per month criteria, or fails to submit monthly employment information.
  - If a participant's illness or sickness makes them absent from work longer than two work weeks, the participant's case will be placed on hold until they have returned to work and are able to continue performing the 40 hour minimum per month. An absence longer than 60 days will be reviewed for possible disenrollment.

- If the participant is consistently not meeting the 40 hour minimum work hour criteria, their case will be reviewed for possible disenrollment. Each situation will be evaluated on a case by case basis by the EPAS Specialist.
- If the participant has personal, sick, or annual time in which they may still receive income when they are not working, their services may continue uninterrupted.
- Self-employed participants who fail to submit their monthly income financial statements, ledgers, work activity logs, or federal tax returns for 60 days or more will be reviewed for possible disenrollment. All work hours must be accounted for in relation to the participant's business. If an activity does not have the potential to produce a new consumer or revenue, it is not considered to be work related.
- Participants who are employed by others and fail to submit at least one earning statement per month to their chosen Service Coordinator, for 60 days or more, will be reviewed for possible disenrollment.

## 6-2 Disenrollment, Termination and Reenrollment of EPAS Services

### Disenrollment

Participation in the EPAS program is voluntary. Participants may disenroll from the program at any time. The EPAS Specialist will conduct periodic reviews of cases that have been placed on hold to determine if program termination is warranted. The EPAS Specialist will review cases that are non-routine in nature and involve circumstances that are specific to the participant involved. In addition, the EPAS Specialist will consider cases for termination when any of the following circumstances exist.

- The participant no longer meets Medicaid program eligibility requirements and was determined to be ineligible for Medicaid by DWS (i.e. moved out of state, participant did not submit Medicaid review documentation, outstanding premium or spenddowns, etc.)
- The participant's employment has been terminated for any reason (quit, fired, laid off).
  - The participant has 30 days from their last day of work to regain employment before they will be disenrolled from the program. If the participant is working with Vocational Rehabilitation or similar job coaching company, the participant will have 60 days to regain employment before the case is terminated.
- Self-employed participants who are unable to sustain business operations or receive income after a period of 12 months.
- Participant is noncompliant with the authorized Care Plan and/or program policies and regulations.
- Participant has not utilized EPAS services for 60 days or more (i.e. did not hire a personal assistant).
- Fraud and/or misuse of Medicaid funds

The Service Coordinator or EPAS Specialist may initiate disenrollment. The EPAS Specialist will review all recommended disenrollments that are submitted by the Service Coordinator. Should the disenrollment request be approved, Medicaid will provide the participant with a notice of decision. The notice will include the reason for termination, last date of service, information on how to contact the EPAS Specialist, and information on how the participant may exercise their right to an appeal if they disagree with the decision. Upon final termination, including the final determination of any appeals, the EPAS Specialist will send written notice to the participant's provider agencies with a date of termination.

### **Reenrollment**

If the participant is disenrolled from the EPAS program for more than 90 days, the participant must complete a new application and complete the enrollment process as if they were a new applicant.

If the participant is disenrolled from the EPAS program for less than 90 days, the applicant's case will be reviewed to assure that participant has not had a significant change in health conditions. If there is a significant change in condition, a new MDS-HC must be completed by the EPAS Assessor. If there have been no significant changes in health conditions, the last MDS-HC assessment completed will be considered valid and the Service Coordinator will be required to submit the following documents to the EPAS Specialist:

- a Care Plan with new begin and end dates
- a new Participant Information Form
- a new Freedom of Choice Selection Form
- a new SAS Employer/Employee Agreements

The EPAS Specialist will then create authorizations of service for the participant.

## **6-3 Retroactively Opening Cases or Making Payments**

The EPAS Specialist will only open or authorize claims to be paid out 90 days retroactively consistent with the eligibility date as determined by the Division of Workforce Services (DWS). The participant's case may be open retroactively in the following circumstance:

- The participant was determined ineligible for Medicaid, for any reason, but remained working and continued to meet EPAS eligibility criteria (i.e. working 40 hours per month), and was retroactively opened by DWS to a status of Medicaid eligible. EPAS services may be retroactive consistent with the eligibility date as determined by the Division of Workforce Services (DWS).

## **7 Provider Reimbursement**

### **7-1 Service Coordinating Agency, Financial Management Services Agency, EPAS Assessor, and Personal Care Agency Reimbursement**

- A. A unique provider number is issued for each provider. When submitting claims for reimbursement, the provider must use their unique provider identification number, and the proper provider type number (68-

Personal Services Agent or 54-Licensed Home Health Service, Category 21 Personal Care Services) associated with EPAS. Claims containing a provider number that is not associated with the proper program will be denied.

- B. Provider agencies will be reimbursed according to the specified reimbursement rate(s) found on the Coverage and Reimbursement Look-Up Tool (<https://medicaid.utah.gov/coverage-and-reimbursement>).
- C. Provider agencies may only claim Medicaid reimbursements for services that are ordered by the EPAS Specialist and for which the provider has a current service authorization form. Service authorizations are valid for a maximum of 12 months, and must be reissued annually. The EPAS Specialist will supply the provider with a service authorization that contains the following information:
  - 1. The HCPCS billing code
  - 2. The amount and frequency of the service ordered
  - 3. The start and end date of the services
  - 4. EPAS Specialist signature and date

Claims must be consistent with the amount, frequency and dates authorized by the EPAS Specialist in order to be paid. Any services provided that exceed the amount or frequency authorized or for which there is not current service authorization form are not eligible for payment and will be denied. Any claims inaccurately paid will be recovered.

D. Financial Management Services Reimbursement

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

## 7-2 Self-Directed Personal Care Reimbursement

- A. To allow for accurate payroll processing, personal assistants are required to fill out all necessary paperwork designated by the EPAS participant's chosen Financial Management Services agency. The personal assistant(s) will not be paid for any dates of service prior to the FMS agency paperwork being completed.
- B. Timesheets must be submitted in a timely manner by the EPAS participant to the Financial Management Service Agency according to the payroll calendar. EPAS participants are required to receive, sign and copy



all employee timesheets and submit them to the FMS agency. The participant is responsible to verify the accuracy of all hours billed by the employee(s).

- C. Personal assistants may only claim reimbursement for services that are authorized by the EPAS Specialist on the Care Plan. Care Plans are valid for a maximum of one year, and must be reissued annually. The EPAS participant must provide all personal assistants with a copy of the authorized Care Plan that clearly identifies the EPAS service requested including:
1. The amount and frequency of the service ordered
  2. The start and end date of the service
  3. The category sub-task(s) and notes explaining the service to be rendered to the EPAS participant.

Timesheets/claims must be consistent with the amount, frequency and dates authorized by the EPAS Specialist in order to be paid by the Financial Management Services Agency. Any services that exceed the amount or frequency authorized on the Care Plan or for which there is not an authorized Care Plan are not eligible for payment and will be denied. Any claims inaccurately paid will be recovered.

- D. Personal assistants are accountable for all terms, agreements, and responsibilities as defined in the Employer/Employee Agreement Form, signed upon initial hire and the EPAS participant's annual review.
- E. Inappropriate personal assistant use will be reviewed by the SMA and may result in disciplinary action. Suspected misuse of personal assistant services can be reported to the Utah Office of Inspector General for review and possible investigation.

## 8 Employment Verification

### 8-1 Employed by Others

EPAS participants who are employed by others must work a minimum of 40 hours per month, and be gainfully employed in an integrated community setting making at least minimum wage. An integrated community setting is defined as a workplace or environment where there are persons with and without disabilities employed within the same company. Gainful employment is defined as an employment situation where the employee receives consistent work and payment of at least minimum wage from an employer. Employment must be reported monthly to the Service Coordinator and annually to the Department of Workforce Services.

1. Employment is verified through the Department of Workforce Services (DWS) annual Medicaid review, including earning statements as required by DWS. It is the responsibility of the EPAS participant to report employment to DWS and assure they remain Medicaid eligible in order to receive EPAS services. It is also the responsibility of the participant to submit earning statements monthly if they are affected by a Medicaid Work Incentive Premium (MWI) in which their income fluctuates.

2. Employment is also verified monthly by the Service Coordinator. Service Coordinators are responsible to contact the EPAS participant each month and gather a report of the amount of hours the EPAS participant has worked or will work that month. Service Coordinators are also responsible to verify employment hours by gathering the EPAS participant's earning statements for the previous month. In the case of participants who are self-employed, the Service Coordinator is responsible to collect documentation indicating the amount of hours worked, the type of work activity that was performed, as well as a financial statement indicating incoming and outgoing business expenses.
3. It is the EPAS participant's responsibility to assure they are meeting the minimum hour criteria of 40 hours per month (except for those who are self-employed) according to program requirements. Every EPAS participant must accurately report the number of hours worked each month to their Service Coordinator, as well as submitting monthly earning statements for the previous month to the Service Coordinator.
  - i. If the EPAS participant does not meet the 40 hour per month minimum criteria they must report this to their Service Coordinator. Each case is subject to a hold, suspension, or disenrollment on a case by case basis if participant is not meeting the minimum EPAS requirements.

## 8-2 Self-Employment

EPAS participants may be self-employed. Self-employed participants must show that they are making a good faith effort to produce income and make a profit. Service Coordinators will be required to verify a participant's self-employment status. In order to verify self-employment status for the EPAS program, participants must provide the following documents at least annually:

1. Proof of business registration through the State of Utah or any applicable local municipalities. This may include a valid business license issued by either the State of Utah or a local municipality.
2. Submitted Federal Income Tax forms showing profit or loss from the business (e.g. IRS Form 1040 Schedule C) if applicable.

In addition to the documents listed above, at least two of the following documents must be provided monthly to the Support Coordinator:

- a) Log of hours worked with a description of activities
- b) Copy of Invoices or receipts sent or received during the month
- c) Copy of a lease on the business location (other than primary residence)
- d) Copy of Bank Statement showing payments to or from the business during the month

## 9 Adult Protective Services Reporting Requirements

Utah law (62A-3-305) mandates any person who has reason to believe that a vulnerable adult is being abused, neglected, or exploited must immediately notify Adult Protective Services or the nearest law enforcement office. Abuse may include physical abuse, emotional/verbal, caretaker neglect, self-neglect, or exploitation.

For definitions or more information about Adult Protective Services see:

<http://daas.utah.gov/adult-protective-services/>

## 10 Fair Hearings

### 10-1 EPAS Participant Fair Hearing Rights

The State Medicaid Agency provides an eligible individual applying for or receiving EPAS services an opportunity for a hearing upon written request, if the eligible individual is:

- Denied access to EPAS provider(s). If more than one provider is available to render the service(s),  
OR
- Experiencing a denial, reduction, suspension, or termination of EPAS services.

The process of a fair hearing will consist of the following activities:

1. An individual and the individual's legal representative as applicable, will receive a written Notice of Agency Action from the EPAS Specialist for any of the reasons listed above. The Notice of Agency Action delineates the individual's right to appeal the decision.
2. The aggrieved individual may request a formal hearing within 30 calendar days from the date written notice is issued or mailed, whichever is later. The Division of Medicaid and Health Financing may reinstate services for recipients or suspend any adverse action for providers if the aggrieved person requests a formal hearing not more than 10 calendar days after the date of action.
3. The individual is encouraged to utilize an informal dispute resolution process, directed by the EPAS Specialist, to expedite equitable solutions but may forgo or interrupt the available informal resolution process at any time by completing a request for hearing and directing the request be sent to the Department of Health, Division of Medicaid and Health Financing for a formal hearing and determination.

An informal dispute resolution process does not alter the requirements of the formal fair hearing process. The individual must still file a request for hearing and a request for continuation of services within the mandatory time frame established by the Division of Medicaid and Health Financing. An informal dispute resolution must occur prior to the deadline for filing the request for continuation of service and/or the request for formal hearing, or be conducted concurrent with the formal hearing process.

## 11 Security Breaches

### 11-1 Data Security and Privacy

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

### 11-2 Breach Reporting/Data Loss

Providers must report to the EPAS Specialist in the Division of Medicaid and Health Financing (DMHF), either by email or telephone, any breach or loss of PHI/PII. This report should be completed not more than 24 hours after the provider knows, or should have reasonably known about the breach. The provider must also submit a report in writing/by email to DFHP within five business days of the breach. The provider will also cooperate with any investigation of the breach or data loss.

## 12 References

Utah Administrative Code

R414-38, Personal Care Service

R432-725, Personal Care Agency Rule

42 CFR 440.167 Personal Care Services