Provider Training

Presented By:
The New Choices Waiver Program Office
Division of Medicaid and Health Financing
Introductions

Who are we?
Who are you?
Why are we here today?

1. Training is required as part of the provider enrollment process for New Choices Waiver
2. New providers become better prepared to offer New Choices Waiver services in accordance with regulations
3. New providers have an opportunity to ask questions about the program
What are you hoping to learn in today’s training session?

“Once I learn how to use Google, isn’t that all the education I really need?”
By show of hands, does anybody know what a home and community-based (HCBS) waiver program is?

Are any of you already enrolled to be providers for other waiver programs in the state?
What is a Medicaid waiver?

• In 1981, Congress passed legislation allowing states greater flexibility in providing services to people living in community settings.

• This legislation, Section 1915(c) of the Social Security Act, authorized the “waiver” of certain Medicaid statutory requirements.

• The waiving of these requirements allowed for the development of joint federal and state funded programs called Home and Community Based Services Waivers.
How does a waiver work?

• The Utah Department of Health has contracts with the federal government that allow the state to have Medicaid 1915(c) HCBS waivers.

• These contracts are called the State Implementation Plans (SIPs) and there is a separate plan for each waiver program.

• Each SIP describes in great detail how the state will operate the waiver and how it will comply with all federal regulations governing HCBS programs.
• States may develop waivers providing HCBS to a limited, targeted group of individuals (example: people living long term in nursing facilities).

• Individuals participate in a waiver only if they require the level of care provided in an institutional setting such as a nursing facility.

• The waiver must be cost neutral - HCBS must cost the same or less than institutional living.

• Services provided cannot duplicate services provided by Medicaid under the State Plan.

• States must provide assurances that necessary safeguards are taken to protect the health and welfare of the recipients of a waiver program.
Waivers are designed to:

- Provide services statewide.
- Allow participants to return to or remain in their homes or other community-based settings.
- Help individuals live as independently as possible with supportive services.
- Provide person centered service delivery that promotes and supports self-determination.
WAIVER LIMITATIONS:

• A limited number of individuals are served.

• New Choices Waiver does not have a waiting list, but most other waivers do.

• Individuals can access only those waiver services they are assessed as needing.

• Waivers are payers of last resort.

• Waivers may supplement, but cannot duplicate services provided by the Medicaid State Plan or any other payer.
1. Are home and community-based waiver benefits available to all Medicaid recipients?

2. What is the main purpose of waiver programs?

3. Can a waiver client have a waiver service that they are not assessed to need?

4. Is New Choices Waiver limited to a certain geographical area of the state?
• **State Plan** refers to the standard benefit package that is offered to all Medicaid recipients.
  - Things like physician services, pharmacy, hospital, emergency room, etc.

• A **Medicaid card** acts like a **key** to access State Plan services.
State Plan and HCBS Waiver programs are two different Medicaid programs that work together to form one complete benefit package.
Utah has eight waivers:
- Acquired Brain Injury Waiver
- Aging Waiver (Age 65 or older)
- Community Supports Waiver
- Medicaid Autism Waiver
- Medically Complex Children Waiver
- New Choices Waiver
- Physical Disabilities Waiver
- Technology Dependent Waiver
Now let’s examine New Choices Waiver more closely.

This fact sheet is included with your handouts.

At-a-glance reference guide.

New Choices Waiver

Purpose
This waiver program is designed to serve people who have been residing long term in a nursing facility, assisted living facility, small health care (Type N) facility or other Utah licensed medical facility that is not an institution for mental disease (IMD). The program provides supportive services to enable individuals to live in their own homes or in other community-based settings.

Eligibility
- Applicant must be at least 18 years old;
- Applicant must satisfy Utah Medicaid financial eligibility requirements;
- Applicant must require a nursing facility level of care to meet their needs;
- Applicant’s primary condition must not be attributable to mental illness;
- Applicant must not require an “Intensive Skilled” level of care; and
- Applicant must not be eligible for admission to an intermediate care facility for people with intellectual disabilities (ICF/IID).

In addition to the above criteria, an eligible individual must be:
- Receiving Utah Medicaid reimbursed nursing facility care on an extended stay basis of 90 days or more; or
- Receiving Medicare reimbursed care in a licensed Utah medical institution (that is not an IMD), on an extended stay of at least 30 days, and will discharge to a Medicaid certified nursing facility for an extended stay of at least 60 days; or
- Receiving Medicaid reimbursed services through another one of Utah’s home and community-based waiver programs and have been identified as in need of immediate or impending nursing facility care; or
- Residing in a licensed assisted living facility or a small health care (Type N) facility on an extended stay basis of 365 days or more.

Limitations to the waiver
- Serves a limited number of individuals.
- Individuals can receive only those services they are assessed to need.
- The program reserves at least 80% of available capacity for people residing in nursing facilities or other medical facilities (non-IMD).

Contact Information
Phone: 801-538-6155 (option 6) or 1-800-662-9651 (option 6)
Fax: 801-323-1186
E-mail: newchoiceswaiver@utah.gov

Medicaid 1915(c) Home & Community Based Services Waiver Informational Fact Sheet
Utah Department of Health (UDOH) - Bureau of Authorization & Community Based Services (BACBS)
Eligibility

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- Applicant’s primary condition must not be attributable to mental illness;
- Applicant must not require an ‘Intensive Skilled’ level of care; and
- Applicant must not be eligible for admission to an intermediate care facility for people with intellectual disabilities (ICF/ID).
How is the New Choices Waiver unique?

- The New Choices Waiver (NCW) is the only Utah waiver that was designed as a deinstitutionalization program.

- As such, it is only available to people who have been residing long term in a hospital, nursing facility or licensed assisted living facility (ALF).

- Even though people must live in a qualifying type of facility at the time they apply, when they enroll in New Choices Waiver they can choose to live in any home and community based setting that can safely meet their needs.
New Choices Waiver clients can choose to live in any home and community-based setting as long as their needs can be safely met and as long as they can afford the room and board in that setting:

- Their own home or apartment
- The home of a friend or family member
- Senior communities
- Independent living facilities
- Assisted living facilities
## New Choices Waiver Services

- Adult Day Care;
- Adult Residential Services;
- Assistive Technology Devices;
- Attendant Care;
- Caregiver Training;
- Case Management;
- Chore Services;
- Consumer Preparation Services;
- Emergency Response Systems;
- Environmental Accessibility Adaptations;
- Financial Management Services;
- Habilitation Services;
- Home Delivered Meals;
- Homemaker Services;
- Community Transition Services;
- Medication Assistance Services;
- Non-medical Transportation;
- Personal Budget Assistance;
- Respite Care;
- Specialized Medical Equipment, Supplies and Supplements; and
- Supportive Maintenance.

*(Services highlighted in red are the most commonly used services in the New Choices Waiver program.)*
Every individual enrolled on the New Choices Waiver must meet the program’s medical criteria at the time of enrollment AND continuously throughout enrollment.

The medical criteria is called “nursing facility level of care.”

Registered nurses within waiver case management agencies are responsible to assess whether this criteria is met for each individual.

(We will not be covering the specific criteria for nursing facility level of care in this training.)
1. True/False: When somebody enrolls in the New Choices Waiver program, they give up all of their other Medicaid benefits.

2. Do New Choices Waiver clients have the right to choose which home and community-based setting they want to reside in after they are enrolled in the program?

3. Is New Choices Waiver a deinstitutionalization program or a nursing home diversion program?

4. True/False: There is no medical criteria for enrollment in New Choices Waiver.
The New Choices Waiver Program Office operates and performs intake for the waiver.

Applications are not available on the web at this time. To request an application, call the NCW Program Office:

801-538-6155, Option 6 or
800-662-9651, Option 6
There are 2 entry pathways for people wishing to access the New Choices Waiver program:

1. **Reserved Slots** – the majority of available waiver capacity is reserved for people residing in nursing facilities, hospitals and other Utah licensed medical institutions.

2. **Non-reserved Slots** – any remaining available waiver slots that are not reserved. These slots may be accessed by any qualifying individual, but limitations do apply.
Entry Pathways

• Applications for the reserved slots will be accepted throughout the year, until the reserved slots fill up.

• Applications for the non-reserved slots are only accepted during three open application periods each year:
  - July 1 – July 14
  - November 1 – November 14
  - March 1 – March 14
  - A limited number of people applying for the non-reserved slots will be enrolled during each open application period.
  - If more applications are received in an open application period than can be enrolled, applicants are ranked and selected based on length of stay in a qualifying setting.
Applicants who meet all NCW eligibility requirements to enroll in the waiver enroll on different timeframes, depending on where they were living at the time of application.

- Applicants from hospitals and nursing facilities enroll on the 1\textsuperscript{st} of the month, following the month in which they have met all enrollment requirements.

- Applicants from assisted living and Type N facilities can enroll on any day of the month, provided they have met all enrollment requirements.
Case Management Services

Every New Choices Waiver client is required to have case management services, provided by a NCW case management provider.

The case management agency (CMA) the client or their representative has selected is responsible for overall management of the client’s case and has many responsibilities.
Case Management Services

Some of these responsibilities are:

- Negotiating rental agreements with Adult Residential Services providers
- Person centered-care planning
- Issuing Services Authorization forms to NCW service providers
- Affording the client freedom of choice in choosing providers
- Receiving and responding to notifications of negative incidents involving NCW clients
Freedom of Choice Consent Form – Salt Lake County

Applicant’s Name: ___________________________________ DOB: _______________

This form is designed to help you (the applicant) to select a case management agency. This form should never be completed without your involvement, nor should it ever reflect a choice that you did not make of your own free will. If you experience any undue influence, please call the New Choices Waiver program office to report the incident and to notify the program office of your actual choice of case management providers. (800-662-9651, option 6)

Every New Choices Waiver applicant will need to select a case management agency. You are free to choose from the list of all case management agencies that are available in your area. If your application is selected to move to the next step in the process, a referral will be made to the case management agency that you have chosen. They will send a registered nurse and a social worker to meet with you in person. Which case management agency would you like?

☐ Advocates for Independence
☐ Canyon Home Care and Hospice
☐ Disabled Rights Action Committee
☐ Dynamic Grace Home Health
☐ Flex Care
☐ Salt Lake County Aging
☐ Roads to Independence
☐ Timpanogos Supports
☐ Envision Quality Supports
☐ Utah Case Management

Once the New Choices Waiver program office makes a referral, the case management agency will perform a review of your application materials. Case management agencies have the right to decline a new referral. If they do this, you will receive a notice in writing. Under certain circumstances you will have the option to select a different case management agency. The New Choices Waiver program office will advise you if this option is available to you.

If the case management agency decides to move forward, they have up to 14 days to perform a face-to-face assessment. The date of the assessment is important to remember because it is only valid for up to 60 days. If any of the waiver enrollment criteria (including Medicaid financial eligibility determination) remains unmet by the end of 60 days, a new assessment must be performed and waiver services cannot begin prior to the new assessment date. This cycle repeats as each 60 day window passes.

By signing below, I certify that I have read and understand the information in this form. I also certify that I made this case management agency selection of my own free will.

____________________________________________
Signature
____________________________
Date

Who is signing?  ☐ Self/Applicant  ☐ Family Representative  ☐ Legal Representative

Representative’s Name (Print): ____________________________________________
Rental Agreements

The New Choices Waiver program pays for services only. Each New Choices Waiver client is responsible to pay their own rent or room and board when living in a HCBS setting.

For clients living in Adult Residential Services settings, room and board consists of the cost of the room itself, any utilities and the cost of raw food.

Each New Choices Waiver client living in an Adult Residential Services setting must have a rental agreement that specifies the amount the client is to pay for room and board costs.
CMAs know the clients’ financial situations and can assist in negotiating the rental agreement between the provider and the client.

Division of Workforce Services allows shelter and utility deductions for most NCW clients.

Clients who have no income are not able to move into Adult Residential Services settings. They may have an option to move back home or into the home of a relative.
New Choices Waiver
Residential Room and Board Agreement

Name: ___________________ Medicaid #: ___________ DOB: ___________

Type of residence: Assisted Living Facility _____ Independent Living Facility _____
Alzheimer’s/Secure Unit ____ Own Home/Apartment ____

Facility Name: __________________________

Facility Address: __________________________

Facility Phone Number: _________________________

I, (resident name), agree to pay ($_______) per month for room and board at this facility. I understand that there may be a more detailed contract with the facility/landlord and I will be subject to the terms of that agreement.

The rate is broken down into the following components:

- Room Rate
- Electricity
- Water
- Food Costs
- Gas
- Telephone
- DWS allows a deduction for shelter costs ("Room" amount on this agreement) and a utility allowance, if part of the rate is being paid toward heating/cooling costs.

This rate is effective (insert date) pending my approval for the New Choices Program.

Resident Name: ____________________
Signature of Resident or Responsible Party: ____________________
Name of Responsible Party: ____________________
Relationship to Resident: ____________________

Emergency Contact Information:
Name: ____________________ Relationship to Resident: ____________________
Phone: ____________________

Case Management Agency (CMA) Information:
CMA Name: ____________________ CMA Phone: ____________________
CMA Address: ____________________

This is the Room and Board Agreement template that NCW CMAs will use. It must be completed even if you have a separate facility lease agreement.

Be prepared to break down the total monthly rate into room rate, utilities and food costs to maximize potential deductions for NCW clients.
When the enrollment process is underway, it is the CMA’s responsibility to work with the client to develop a person-centered care plan.

The care planning process is driven by the client and the expectation for the waiver program is that the process will support the client’s personal preferences, strengths and goals, while addressing the needs the CMA identified in their assessment of the client.
Identified needs should be addressed through the following means:

Natural supports or private resources the client has in place:
- This is always the first choice for services that can be appropriately provided through this method, such as transportation or assistance with finances.

Medicaid State Plan benefits, Medicare or other payer source:
- This is the second choice, and typically the provider for services such as home health, specialized medical equipment and supplies and pharmacy.

New Choices Waiver Services:
- NCW is the payer of last resort, if no other paid or unpaid source is available to provide the service, e.g. Adult Residential Services.
Accountable care organizations (ACOs) are health plans contracted by Medicaid to provide state plan medical services to Medicaid members in many counties. NCW clients in these counties must choose a health plan and must receive medical services from a provider enrolled in that ACO’s network.

NCW clients living in areas without ACOs may use any Utah Medicaid provider for medical services.
Freedom of Choice is central to the NCW program, and clients are afforded freedom of choice in every aspect of their care and the services they have been assessed to need.

NCW clients have the freedom to choose from all willing available waiver providers for each service their case manager has assessed them to need.

It is the role of the chosen case management agency to provide Freedom of Choice of Providers Forms to their clients.
Once you are enrolled as a NCW provider, the name of your business will be added to the Freedom of Choice forms for each service you are enrolled to offer.

Adult Residential Services providers are not permitted to require clients to work with particular CMAs, home health or other provider agencies.

If you suspect a client’s CMA or provider choice is being manipulated, report it to the New Choices Waiver Program Office immediately.
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Freedom of Choice of Providers Forms are organized by county and by service.

Each form contains a complete list of all NCW services and the providers enrolled to provide each service in that county. (Actual Freedom of Choice of Providers forms are several pages long).
When all of the service providers and supports have been identified and selected, the CMA will add them to the client’s person-centered care plan. The care plan is the official document that authorizes all waiver services. It includes:

- A beginning and ending date for the entire care plan
- A beginning and ending date for each service
- The names of each agency providing services
- The number of units requested for each service
- The frequency for each service
CMAs will then authorize New Choices Waiver services the client has been assessed to need, with a service authorization form for each individual NCW provider listed on the care plan.
Let’s take a break!
It is important to remember that New Choices Waiver services cannot be provided or billed unless they have been authorized through the care planning process.

**DO NOT PROVIDE SERVICES TO A NEW CHOICES WAIVER CLIENT UNTIL YOU HAVE A SIGNED SERVICE AUTHORIZATION FORM IN HAND!**

If a New Choices Waiver client contacts you to begin services, ALWAYS ask who their case management agency is and call them to find out if services have been approved and to request a Service Authorization Form.
ALWAYS refer to the approved NCW Service Authorization form to determine the date you can begin billing for services you provide.

- Claims paid for waiver services outside of the date span listed on the Service Authorization will be recovered.

- Claims paid for waiver services with a higher number of units or frequency than was authorized on the service authorization form will be recovered.
Do not assume a service has been authorized or will be authorized.

Service Authorization Forms are only valid for a maximum of 1 year even if the “end date” is left blank.

Once the service authorization has been signed, make sure the services on the adult residential service plan match those on the service authorization form.

Communication with the case management agency is critical!
“When you say I have trouble communicating with my associates, what exactly do you mean?”
NEW CHOICES WAIVER

Service Authorization Form

Participant Name: ________________________  DOB: __________  Medicaid ID: ________________________

Participant Phone Number: ________________________  Residential Facility/Apartment Complex: ________________________

Address: ________________________  City: ________________________  Zip: __________  Room/Apt: ________________________

Case Management Agency: ________________________  Case Management Fax Number: ________________________

Case Manager: ________________________  Case Manager Phone Number: ________________________

R.N. Case Manager: ________________________  R.N. Case Manager Phone Number: ________________________

Authorized Provider: ________________________  Provider Phone Number: ________________________

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Service Tasks

<table>
<thead>
<tr>
<th>Task</th>
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<tbody>
<tr>
<td>Bathing</td>
<td>Hair Care, Shampoo</td>
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<tr>
<td>Toilet Assistance</td>
<td>Ambulation Assistance</td>
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<tr>
<td>Transportation</td>
<td>Observe Meds/Remind</td>
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<tr>
<td>Kitchen/Stove/Fridge</td>
<td>Shopping/Errands</td>
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<tr>
<td>Mop Floors</td>
<td>Laundry</td>
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<td></td>
<td>Skin Care</td>
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<tr>
<td></td>
<td>Meal Preparation</td>
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<tr>
<td></td>
<td>Assist w/ dressing</td>
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<tr>
<td></td>
<td>Change/Make Bed</td>
</tr>
<tr>
<td></td>
<td>Dust/Sweep/Vacuum</td>
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<tr>
<td></td>
<td>Healthy Eating</td>
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<tr>
<td></td>
<td>Oral Hygiene</td>
</tr>
<tr>
<td></td>
<td>Respite</td>
</tr>
</tbody>
</table>

Case Manager: ________________________  Date: ________________________

Provider Representative: ________________________  Date: ________________________


NEW CHOICES WAIVER
Adult Residential Services Provider Authorization Form

<table>
<thead>
<tr>
<th>Participant Name:</th>
<th>DOB:</th>
<th>Medicaid ID:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant Phone Number:</td>
<td>Residential Facility:</td>
<td></td>
</tr>
<tr>
<td>Case Management Agency:</td>
<td>Case Management Fax Number:</td>
<td></td>
</tr>
<tr>
<td>Case Manager:</td>
<td>Case Manager Phone Number:</td>
<td></td>
</tr>
<tr>
<td>R.N. Case Manager:</td>
<td>R.N. Case Manager Phone Number:</td>
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<tr>
<td>Adult Residential Service Authorized:</td>
<td>Level I</td>
<td>Level II</td>
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<table>
<thead>
<tr>
<th>Elements of Adult Residential Service</th>
<th>Frequency Required to Meet Participant’s Needs</th>
<th>Start Date</th>
<th>End Date</th>
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<tbody>
<tr>
<td>Dressing Assistance</td>
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<td>Housekeeping Assistance</td>
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<td>Incontinence Care</td>
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<td>Laundry Assistance</td>
<td></td>
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<tr>
<td>Meal Preparation (Three Meals Per Day, Minimum)</td>
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<tr>
<td>Medication Monitoring and Assistance</td>
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<td></td>
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<tr>
<td>Non Medical Transportation</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>On Site Response System / Supervision</td>
<td>Twenty Four Hour Monitoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Showering / Bathing Assistance</td>
<td></td>
<td></td>
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<tr>
<td>Social and Recreational Programming</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Other:</td>
<td></td>
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</tbody>
</table>

The above activities are integral elements of providing Adult Residential Services. It is agreed that these services will be included in the Facility’s Service Plan and provided in accordance with the participant’s identified need. It is understood that this is a communication form and does not take the place of the Facility Service Plan.

Participant/Representative: ______________________________ Date: _____________

Case Manager: ______________________________ Date: _____________

Residential Facility Representative: ______________________________ Date: _____________
Approved Service Authorization Forms are not a guarantee of payment. Providers must verify their client’s Medicaid eligibility every month.

There are two ways to verify client eligibility each month:

1. Call Access Now: 800-662-9651, option 1, option 1

2. Use the eligibility look-up tool on the Medicaid website:
   
   [https://medicaid.utah.gov/eligibility](https://medicaid.utah.gov/eligibility)
1. What is the name of the form that authorizes you to provide services to a New Choices Waiver client?

2. Is every New Choices Waiver client required to have case management services?

3. True/False: If you have a signed Service Authorization Form in hand, you are guaranteed payment for services rendered to that client.

4. Which entity is responsible to operate the application and intake process for New Choices Waiver?
Providers must keep records of each service encounter. At a minimum each log note should include:

- The client’s first and last name
- The date of service for each service encounter
- The start and end times for each service encounter
- The service(s) provided (by service title)
- Notes describing the service encounter in detail
- The name(s) of the individual(s) who performed the service
- Signature(s) of the individual(s) who performed the service
- Signature of the client who received the service (Non-Medical Transportation only)
If a provider renders more than one service for a client, all of the services provided must be documented separately and must be in line with the service description for each of the services.

Example:

- A provider offers Non-medical Transportation (NMT) and Attendant Care services to a client on a random Wednesday afternoon.
  - The service details for the NMT must be documented in detail and must be in line with the service description for NMT.
  - The service details for Attendant Care must also be documented separately from NMT and the services provided must be in line with the Attendant Care service description.
Client: Bart Simpson
Date of Service: December 1, 2016
Service Provided: Attendant Care
Start Time: 12:30 pm
End Time: 1:15 pm
Number of Units: 3
Worker’s Name: Clark Kent
Notes of Service Detail: Physical assistance getting into and out of the vehicle, hands on assistance with ambulation during shopping at Smith’s grocery store. Physical assistance putting items into shopping cart and assistance with payment at check out counter.
Worker's Signature: ________________________________
Client: Bart Simpson
Date of Service: December 1, 2016
Service Provided: Non-Medical Transportation
Start Time: 12:20 pm
End Time: 1:30 pm
Number of Units: 2 one-way trips
Worker’s Name: Clark Kent
Client’s Signature: Bart Simpson
Notes of Service Detail: Drove client from home to Smith grocery store. Returned client from Smith’s to home.
Worker’s Signature: ____________________________
Adult Residential Services providers must keep daily records of the specific services they provide to each client. This should include:

- The client’s first and last name
- The date
- The activity or type of assistance that was provided, e.g. assisted client with shower or dressing
- The number of times assistance was provided for each activity during the day
- Assistance provided should match the approved service authorization form
- Documentation can be kept in a chart form or another method
<table>
<thead>
<tr>
<th>Date</th>
<th>Dressing</th>
<th>Grooming</th>
<th>Bathing</th>
<th>Toileting or Incontinence Care</th>
<th>Transferring</th>
<th>Ambulation</th>
<th>Recreation</th>
<th>Feeding</th>
<th>House-Keeping</th>
<th>Medication Administration</th>
<th>Medication Reminder</th>
<th>Meal Preparation</th>
<th>Emergency Response</th>
<th>Notes</th>
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<td>XXX Bart fell today. See incident report</td>
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</table>
• New Choices Waiver documentation requirements are separate and distinct from Licensing’s documentation requirements.

• Assisted living facility providers must meet the requirements for both New Choices Waiver AND Licensing.
Non-reimbursable Circumstances

Examples of circumstances that are not reimbursable by Medicaid:

- Billing Medicaid for a missed appointment, when the client misses or cancels a scheduled appointment
- Services provided to a NCW client who was not authorized to receive the service
- Unused units that have been authorized for one client cannot be transferred to another client
Examples of circumstances that are not reimbursable by Medicaid continued:

- Claims for services that were not rendered to the client are not reimbursable, even if there are unused units remaining on the service authorization form.

- With the exception of case management services, providers may not provide waiver services to or submit claims for services provided to clients who are admitted to an inpatient setting.
For adult residential services providers:

Always notify the participant’s case manager if:

• The participant has left your facility, e.g. hospitalization or nursing home admission, overnight family visits or vacations

• You have concerns regarding client safety and/or believe that their needs can no longer be met at the facility

• The participant has been involved in a negative incident
For other service providers:

Maintain open communication with ARS and CMA providers. Notify them of any concerns or issues you have with regard to the client or providing services to the client.

Always notify the participant’s case manager if:

• You have concerns regarding client safety
• The participant has been involved in a negative incident.
**Why Reporting is Necessary**

**State Law**

In accordance with Utah State law, professionals and the public are required to report instances of abuse, neglect and exploitation. All incidents of suspected abuse, neglect and exploitation shall be reported by the waiver coordinators and waiver providers to Adult Protective Services (APS) for investigation.

Adult Protective Services Intake Office  
1-800-371-7897

Submit an APS referral online at  
https://daas.utahealth.gov/adult-protective-services/

**Required for Medicaid Funding**

New Choices Waiver requires the service provider to notify the client’s case manager within 24 hours of discovery of the negative event.

**Reportable Negative Events**

All negative events experienced by NCW clients must be reported by NCW service providers to the case management agency within 24 hours of discovery. Incident reports should be sent using the fax or email specified by each agency, as listed on the other side of this brochure. Negative events include, but are not limited to:

- Death, regardless of the circumstances
- Changes in medical or functional status
- Falls with or without injury
- ER treatment for any reason
- Hospital admission for any reason
- Mental health decline
- Start of hospice or home health services
- A move to a skilled nursing facility
- Any negative event that occurs at the client’s place of residence or that occurs while the client is in the community
- Events described further in this brochure as possible Critical Incidents

Case management agencies must review all negative events experienced by NCW clients and report any possible Critical Incidents to the NCW Program Office within 24 hours of receiving notification.

**Possible Critical Incidents**

1. Death, unexpected or accidental
2. Suicide attempt (does not include threats only)
3. Incidents expected to receive media, legislative or public scrutiny
4. Compromised living environment requiring evacuation
5. Person missing at least 24 hours or, regardless of the amount of time, under suspicious or unexplained circumstances
6. Injury (includes burns, choking, brain trauma, fractures etc.)
7. Abuse (physical or sexual)
8. Neglect (caregiver neglect or self-neglect)
9. Exploitation (by someone in a relationship of trust)
10. Waste, fraud or abuse of Medicaid funds
11. Human rights violation such as unauthorized use of restraints, seclusion, or infringement of personal privacy rights
12. Medication/treatment error resulting in marked adverse side effects (includes inappropriate medication use where the medication is control of the provider, participant, or other individual)
13. Law enforcement involvement resulting in charges being filed
14. Other type of incident causing concern for health and safety
Incident Reporting Protocol

NCW Case Management Agency Incident Report Submission Method

Advocates for Independence
Phone (801) 679-6461
Incident Report Fax (801) 948-8001

Bear River Area Agency on Aging
Phone (435) 752-7242
Incident Report Email shaunmae@brag.utah.gov

Care Advocates
Phone (801) 722-4229
Incident Report Fax (801) 702-8002

Davis County Health Department - Senior Services
Phone (801) 525-5050
Incident Report Fax (801) 525-5071

Disabled Rights Action Committee (DRAC)
Phone (801) 347-0370
Incident Report Email dracsc@earthlink.net

Dynamic Grace
Phone (801) 703-0658
Incident Report Fax (801) 384-7110

EnVision Quality Supports
Phone (801) 209-1357
Incident Report Fax (866) 941-4708
Incident Report Email info@envisionquality.com

Five County Association of Governments
Phone (435) 673-3548
Incident Report Fax (435) 688-9088

FlexCare (North)
Phone (801) 294-6747
Incident Report Fax (801) 424-6250

Golden Age Center—Uintah County Area Agency on Aging
Phone (435) 789-2169
Incident Report Fax (435) 789-2171

MACS Plus
Phone (801) 625-3786
IR Fax (801) 778-6818
Incident Report Email lauraraw@weberhs.org

Mountainland Association of Governments
Phone (801) 229-3804
Incident Report Fax (801) 229-3671

Rocks to Independence
Phone (801) 734-5678
Incident Report Fax (801) 612-3732
Incident Report Email andy@roadstoind.org

Salt Lake County Aging and Adult Services
Phone (385) 468-3270
Incident Report Fax (385) 468-3264
Incident Report Email tnagahiro@slcog.org

Southeastern Utah Association of Local Governments
Phone (435) 613-0636
Incident Report Fax (435) 637-5448

Utah Case Management
Phone (888) 786-4445
Incident Report Fax (888) 400-9232

New Choices Waiver

Incident Reporting Protocol

NCW Program Office
Cannon Health Building
288 North 1460 West
Salt Lake City, UT 84116
Phone: 801-538-6155
Fax: 801-323-1586
E-mail: newchoiceswaiver@utah.gov
Incident Reporting Requirements

• Waiver programs are required to meet the health and safety needs of participants on a continuous and ongoing basis.

• Even with excellent service coordination and monitoring, NCW clients will sometimes experience injuries, neglect, medication errors and other negative events or incidents, including death.

• When any negative incident occurs, NCW providers are required to act quickly and report the incident to the client’s case management agency within 24 hours.
Incident Reporting Requirements

When any negative event or a critical incident occurs, report as much information as possible within 24 hours.

The New Choices Waiver Brochure outlines each case management agency's contact information for ease of reporting for the NCW Service Providers.

This contact information can be found on the NCW Incident Reporting Protocol brochure and at http://health.utah.gov/ltc/NC/NCCMACContacts.htm
ARSS providers may fax or email their facility’s incident report form to the case management agencies. If a negative event does not meet the facility’s criteria for creating an incident report, it is permissible to email or fax a written statement of the events or the NCW Incident Report Form.

Please be responsive when the case manager contacts you for additional information as the NCW Program Office often requires clarifying information to determine the next steps.
In addition to reporting incidents defined in NCW policy as a Critical Incident any other negative incident or event should be reported by the Adult Residential Services Provider to the client’s case manager within 24 hours including, but not limited to:

- All participant deaths, regardless of the cause
- Changes in medical or functional status
- Any type of injury
- Falls with or without injury
- Emergency Room treatment for any reason
- Hospital admission for any reason
- Mental health decline
- Start of hospice or home health services
- A move to a skilled nursing facility
- Any negative event that occurs at the client’s place of residence or that occurs while the client is in the community
- Events described further, as possible Critical Incidents
Possible Critical Incidents

- Unexpected or accidental death
- Suicide attempt (does not include threats)
- Incident expected to receive media, legislative or public scrutiny
- Compromised work or living environment requiring evacuation
- Person missing for at least 24 hours or, regardless of the amount of time missing, under suspicious or unexplained circumstances
- Injury (includes burns, choking, brain trauma, fractures, etc.)
- Abuse (physical or sexual)
- Neglect (caregiver neglect or self-neglect)
- Exploitation (by someone in a relationship of trust)
Possible Critical Incidents

- Waste, fraud, or abuse of Medicaid funds
- Human rights violation
- Medicaid/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)
- Law enforcement involvement resulting in charges being filed
- Other type of incident causing concern for health and welfare
The NCW program office reviews submitted incident reports to determine whether they rise to the level of a Critical Incident that requires investigation.

What should you expect if/when an incident is accepted for investigation?

- Ensure the investigation document is filled out in its entirety.
- NCW requests information pertaining to implemented safeguards, changes to the care plan, the client’s current medication list (which may include, copies of the Medication Administration Record)
- Requests for documentation of staff training, employee coaching, facility process improvements, if applicable
- Requests for written policies outlining provider procedures, if applicable
Investigating a critical incident includes implementing new safeguards to ensure similar incidents do not recur in the future.

Documentation must show that the NCW providers did two specific activities in response to incidents:

1. Safeguards were put in place when needed

2. The case manager log notes reflect follow up to verify and assess the effectiveness of new safeguards
Case management agency responsibilities include:

• Receiving incident reports and forwarding them to the NCW Program Office.

• Verifying that reports of abuse, neglect or exploitation have been reported to Adult Protective Services and/or local law enforcement.

• Maintaining a record of all incident reports in the participant’s case file.

• Investigating Critical Incidents and submitting the investigation documentation to the NCW Program Office.

• Responding when indicated.
Make sure the following 5 questions are addressed when submitting incident reports:

1) Did the person sustain a physical injury as a result of the incident?
2) Was the person treated in the ER and released the same day?
3) Was the person admitted to the hospital?
4) If “yes” to #3, was the hospital admission directly related to the injury or was it for another medical reason or both?
5) Is/was the person receiving hospice care?
NCW Incident Report Form

The NCW Unit will accept any incident report form but providers can choose to use this one.

“Other type of incident causing concern for safety.”

No matter the method of reporting, make sure these five questions are addressed.
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. This includes all providers, case managers, residential, non residential, and self administered service employees.

- Adult Protective Services: 1-800-371-7897 or 24/7 on their website: https://daas.utah.gov/adult-protective-services/
- Local law enforcement. (UCA 62-A-3-301)
Health and Safety Agreements

What is a Health and Safety Agreement?

A health and safety agreement is a written document outlining an agreement between a case management agency and a client that is intended to safeguard the client’s health and safety by encouraging positive behaviors.
Who could benefit from a health and safety agreement?

- Any client who displays poor safety awareness, makes unsafe decisions, and/or displays behaviors that endanger the client’s health, safety, or wellbeing.
- Clients who have expressed suicidal ideations or have attempted self harm.
- Clients who have acted aggressively toward staff members/caregivers or other residents.
- Clients who are not compliant with facility policies.
- Clients who demonstrate non-compliance with their medical treatment plan or medication regimen.
- Clients who misuse medications, alcohol, or illegal drugs.
- Clients who are neglecting their own cares.
Required components in a health and safety agreement:

• Identify the issues affecting health and safety.
• Identify health and safety expectations.
• Identify interventions to help client meet expectations.
• Identify consequences of meeting or failing to meet expectations.
• Obtain written acknowledgement of health and safety expectations and potential consequences.
Prohibited Components

Health and safety agreements cannot include anything that conflicts with the CMS Settings Final Rule, unless an approved human rights restriction is in place based on an individual’s assessed need. A few examples include:

- Preventing a client from having visitors.
- Preventing a client from entering or leaving the facility as they wish.
- Restricting a client’s access to food.
- Not allowing a client to decorate their room as they wish.

Any approval of a human rights restriction would be coordinated through the NCW and the CMA before it could be included in a health and safety agreement.
A health and safety agreement is not valid unless the client understands the expectations they must meet and the consequences of not meeting the expectations.

- Does the client understand that their health and safety are at risk?
- Does the client understand why they are at risk?
- Does the client understand what expectations they must meet in order to remain safe and healthy?
- Does the client understand the consequence of not meeting these expectations?
A health and safety agreement is not valid unless the client agrees to the terms in writing

- The client must sign the agreement to indicate understanding of expectations and consequences.
- The client must sign the agreement to indicate their acceptance of the terms in the agreement.
1. List three of the items that must be present in log notes for each service encounter.

2. What should you do if you suspect an incident of abuse, neglect or exploitation?

3. True/False: If a New Choices Waiver client cancels an appointment at the last minute, it is permissible to bill Medicaid for the canceled appointment.

4. True/False: Providers do not need to notify anybody when a negative incident occurs involving a New Choices Waiver client.
NCW has historically allowed case management agencies to enroll to provide Personal Budget Assistance (PBA) due to having only a small number of other providers enrolled to provide this service.

The federal government has recently told states that case management agencies cannot be providers of any other service on a client’s waiver care plan.

Utah Medicaid is working on a transition plan toward full compliance with this new requirement.

We are encouraging any willing, qualified provider who wishes to enroll to be a PBA provider to do so. Including adult residential services providers.
ALF providers will be held to Administrative Rule 432-270-20, “Management of Resident Funds.”

All Personal Budget Assistance providers (including ALFs) will be held to waiver requirements listed in the waiver state implementation plan for Personal Budget Assistance:

1. Review finances/budget at least monthly with the resident or representative.
2. Maintain documentation of monthly reviews.
3. Submit budget review documentation to the case management agency monthly.
Personal Budget Assistance

HCPCS Code = H0038

Unit of Service: 15 minutes

Maximum Allowable Rate: $4.72
To enroll as a Personal Budget Assistance provider:

Visit:  http://health.utah.gov/ltc/NC/NCProviders.htm

Call:  Blake Minardi  
       NCW Provider Specialist  
       801-538-6497
Billing Methods

• Paper Claim
  – CMS 1500
  – Preprinted form
  – There are different vendors that have software to complete these forms
  – NOTE: All Medicaid paper claims must be sent via the U.S. Postal Service.

• Electronic Claim
  – Electronic format of the CMS 1500
  – All claims pass through UHIN
Contact **UHIN** to set up account and get your trading number.

- **Phone**: (801) 466-7705
- **Fax**: (801) 466-7169
Billing and Payment Information

- Providers can only bill for services they have already provided.
- Providers can only bill for services that they have been authorized to provide on a current, signed Service Authorization form for the particular client for whom they are billing.
- Providers must use the correct HCPCS Code.
- Providers must enter the correct waiver code into the procedure code modifier box – U8.
- If enrolled to provide services for another waiver program, make sure to use the designated provider number and modifier associated with each waiver program.
<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>SERVICE/PROCEDURE</th>
<th>UNIT OF SERVICE</th>
<th>PROGRAM IDENTIFIER (REQUIRED)</th>
<th>UTILIZATION MODIFIERS</th>
<th>FY 2013 MAXIMUM ALLOWABLE RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>SS102</td>
<td>Adult Day Care</td>
<td>Day</td>
<td>UB</td>
<td>None</td>
<td>$37.66</td>
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<tr>
<td>T2031</td>
<td>Adult Residential Services (Licensed Assisted Living Facilities Level I, Level II &amp; Type N Facilities)</td>
<td>Day</td>
<td>UB</td>
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<td>T2016</td>
<td>Adult Residential Services - (Licensed Assisted Living Facilities, Memory Care Unit)</td>
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<tr>
<td>T2033</td>
<td>Adult Residential Services - (Licensed Community Residential Care)</td>
<td>Day</td>
<td>UB</td>
<td>None</td>
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<td>H0043</td>
<td>Adult Residential Services - (Certified Independent Living Facilities)</td>
<td>Day</td>
<td>UB</td>
<td>None</td>
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<tr>
<td>T2038</td>
<td>Assistive Technology Devices</td>
<td>Per Item</td>
<td>UB</td>
<td>None</td>
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<tr>
<td>S5125</td>
<td>Attendant Care Services</td>
<td>15 Min</td>
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<td>TN (optional)</td>
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<tr>
<td>S5115</td>
<td>Caregiver Training</td>
<td>15 Min</td>
<td>UB</td>
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<tr>
<td>T5106</td>
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<td>T5224</td>
<td>Pre-enrollment and Inpatient Case Management</td>
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<td>S5120</td>
<td>Chore Services</td>
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<tr>
<td>T2038</td>
<td>Community Transition Services</td>
<td>Per Service</td>
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<tr>
<td>S5108</td>
<td>Consumer Preparation Services</td>
<td>Hourly</td>
<td>UB</td>
<td>TN (optional)</td>
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<tr>
<td>S5165</td>
<td>Environmental Accessibility Adaptations - Home Modification</td>
<td>Per Service</td>
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<td>T2039</td>
<td>Environmental Accessibility Adaptations - Vehicle Modification</td>
<td>Per Service</td>
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<tr>
<td>T2040</td>
<td>Financial Management Services</td>
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<td>UB</td>
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<td>T2017</td>
<td>Habilitation</td>
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<tr>
<td>S5170</td>
<td>Home Delivered Meals</td>
<td>Per Meal</td>
<td>UB</td>
<td>TN (optional)</td>
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<td>S5130</td>
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<td>TN (optional)</td>
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<td>S5185</td>
<td>Medication Administration Assistance - Medication Reminder System (Not face to face)</td>
<td>Monthly</td>
<td>UB</td>
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<td>H0034</td>
<td>Medication Administration Assistance - Medication Set-up</td>
<td>15 Min</td>
<td>UB</td>
<td>None</td>
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<td>H0038</td>
<td>Personal Budget Assistance</td>
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<td>UB</td>
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<tr>
<td>S5162</td>
<td>Personal Emergency Response System - Purchase, Rental, Repair</td>
<td>Per Item</td>
<td>UB</td>
<td>None</td>
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<tr>
<td>S5161</td>
<td>Personal Emergency Response System - Response Center Service</td>
<td>Monthly</td>
<td>UB</td>
<td>None</td>
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<tr>
<td>S5160</td>
<td>Personal Emergency Response System - Installation, Testing &amp; Removal</td>
<td>Per Service</td>
<td>UB</td>
<td>None</td>
<td>$50.00</td>
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<td>S5150</td>
<td>Respite - Routine - Hourly (5 or less hours)</td>
<td>Hourly</td>
<td>UB</td>
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<td>S5167</td>
<td>Respite Client's Home (5 or more hours)</td>
<td>Day</td>
<td>UB</td>
<td>TN (optional)</td>
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<td>H0045</td>
<td>Respite Care - Out of Home - Room and Board included</td>
<td>Day</td>
<td>UB</td>
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<td>T2029</td>
<td>Specialized Medical Equipment, Supplies and Supplements</td>
<td>Per Item</td>
<td>UB</td>
<td>None</td>
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<td>T1021</td>
<td>Supportive Maintenance Services</td>
<td>Hourly</td>
<td>UB</td>
<td>None</td>
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<td>S0215</td>
<td>Transportation - Non-Medical - Per Mile</td>
<td>Per mile</td>
<td>UB</td>
<td>TN (optional)</td>
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<td>T2003</td>
<td>Transportation - Non-Medical - Per One Way Trip</td>
<td>Per Trip</td>
<td>UB</td>
<td>TN (optional)</td>
<td>$14.94</td>
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<td>T2004</td>
<td>Transportation - Non-Medical - Public Transit Pass</td>
<td>Monthly</td>
<td>UB</td>
<td>None</td>
<td>$48.00</td>
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</tbody>
</table>

This sheet includes:
- **HCPCS Code**
- **Service/Procedure (Service name)**
- **Unit of Service** (This is how a unit of service is measured. It varies by type of service)
- **Program Identifier (modifier)**
• Adult Residential Services (ARS) providers may only bill for dates of service when a client was actively receiving services in the facility on that day.

• ARS providers may not bill Medicaid for days when a client is out of the facility for the entire (24-hour) day.

• Examples of non-billable days: Hospital or nursing home stays, overnight visits or vacations during which the client is not in the facility for 24 hours or more.

• If a client moves from one facility to another the facility the client is moving FROM bills for moving day.
Billing Timelines

- Providers determine how often they bill.
- All claims and adjustments for services must be received by Medicaid within twelve months from the date of service.
- Claims are processed weekly.
- Paper claims must be received by Tuesday to be processed that week.
- Electronic claims must be received by Thursday at 5:00 PM to be processed that week.
Payments

- Providers will receive payment directly from Medicaid
- Weekly EFT
- Occurs on the second business day of the week
- Normally Tuesday except for weeks with Monday holidays
Timely Filing of Medicaid 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.
Medicaid Customer Service staff are available to take your calls:

- In the Salt Lake City area, call 801-538-6155.
- From other states, call 1-801-538-6155.
- FAX Line: (1-801) 538-6805
- Or write to: Department of Health
  Division of Medicaid and Health Financing
  P.O. Box 143106
  Salt Lake City UT 84114-3106

NOTE: All Medicaid paper claims must be sent via the U.S. Postal Service.
The New Choices Waiver Provider Manual is posted on our website.

http://health.utah.gov/ltc/NC/NCHome.htm

Each NCW provider is responsible for reading this manual and understanding the policies and procedures it contains.
The Medicaid Information Bulletin (MIB) is published quarterly or more frequently as needed. It includes important policy and procedural updates and information regarding all Medicaid programs, including:

- Updates to the NCW Provider manual
- Changes to Medicaid billing procedures
- Progress reports on Medicaid’s new billing system, PRISM, and more

Each provider is responsible to check the MIB frequently for changes that will affect you, as a provider.
New Choices Waiver Contact Information

New Choices Waiver is available on the Medicaid Helpline:

Mon, Tues, Wed, and Fri: 8:00 a.m. - 5:00 p.m.
Thursdays: 11:00 a.m. – 5:00 p.m.

- 801-538-6155, option 6
- Or toll-free 1-800-662-9651, option 6
- FAX Line: (1-801) 323-1586
- Email: newchoiceswaiver@utah.gov
- Website: www.health.utah.gov/ltc
- Or write to: Department of Health
Divison of Medicaid and Health Financing
New Choices Waiver Program
P.O. Box 143112
Salt Lake City UT 84114-3112
1. How often is the Medicaid Information Bulletin published?

2. How many months from the date of service can a provider submit a claim to Medicaid before it will be denied for timely filing?

3. What is the name of the billing agent that Utah Medicaid uses for claims processing and reimbursement?

4. True/False: This training has been highly beneficial in orienting me to the New Choices Waiver program.