February 2014
Monthly Provider Support Call Summary

Please share with your case managers and administrative staff or other employees.

Each month the WDH-Behavioral Health Division holds a monthly provider support call to let providers know what is going on and give additional clarification on items that have been released or provided during the last month. The next call will be the last Thursday of March (Mar 27) at 2pm.

Waiver Update

Currently, IBAs are scheduled to be released at toward the end of March. Adult DD waiver participants will have until the end of September to technically switch to the new Comprehensive waiver, but most will transition this summer. We are working right now to update all of our electronic systems for the new waivers. We are also developing new forms for some of the new services and building trainings for all the changes.

Legislative updates

- **CFCM bill** – We are moving forward with our model until we know otherwise. If the bill passes we will be working with our Attorney General's office on how to proceed since the statute will not be in compliance with a federal regulation. We will also work with CMS on how to proceed.
- **Employment First Bill –** We are working with the Governor's planning council and other agencies to implement changes to employment policies, but the bill may move that along quicker. The bill would also require providers to have employment first policies. The bill also may require us to work with a taskforce to put on an employment conference and more details will come out on that idea after we hear that the bill passes and we meet with the taskforce to plan it as needed.

Provider Training and enrollment information

We held a provider training last week on the new services and the provider enrollment process for the new waivers, and a recording of that training and materials and FAQs from the training are now available on our website. We are using a YouTube recording format so most of your computers and smartphones will have a browser that is compatible with YouTube and you will be able to have easier access to the training.

Frequently asked questions from the training are posted on the Division's website and we will add to them as we have more questions received and answered.

Provider Enrollment

Qualifications form and the Towns and Services form are posted on Division's website and were updated after the training. The Towns and Services form is due by March 10 to your provider support specialist.

Staffing flexibility

As of January 1, 2014, providers of the tiered levels of habilitation services from 1:2 to 1:4 were allowed to start implementing some flexibility in staffing. The 1:1 and 2:1 levels are not allowed to be flexible. Until the Staffing Flexibility Provider Bulletin is issued, we want providers to tell participants and guardians about where the flexibility might be implemented. The provider must ensure they have a procedure in place to plan for adequate staffing and review staffing needs as changes occur in the organization's workforce, clients served, and other environmental impacts. The Division distributed a bulletin Thursday (2-27-14) with the specific requirements for updating staffing policies and discussing the flexibility with the participant and guardian and completing the new Supervision flexibility form. If a residential or day habilitation service provider is implementing flexibility with staffing with some participants, they must comply with the requirements specified in the bulletin. If you did not get the bulletin, please check our DD section of the website to find the bulletin and CM form.

QUESTIONS FROM THE CALL

*** What are providers required to document on the schedules due to the staffing flexibility bulletin?**

*** What does the Division require for Levels 1 and 2 of the new residential habilitation tiers when the 8 hour minimum rule requires the participant to be in the provider's service for at least 8 hours in order to bill. The "on-site" part of levels 1 and 2 and the 8 hour rule seems to conflict.**

The service definition in regard to Level of Service 1 and 2 states that those assessed at these levels require minimal staff support, monitoring, or personal care and requires staff to be on site meeting periodically with the participant during awake hours for support and 24-hour on-call support. Those assessed at levels 1, and 2, do not require 24 hour direct support.

Senate Enrollment Act No. 82 requires the Division to "Replace where possible higher cost residential and day habilitation services with lower cost, more integrated services" and to create individual budget amounts for each person served that reflect the individual's assessed need. Those assessed needs place individuals in one of six Levels of Service, Levels 1 and 2 reflecting assessed needs that may not require full 24/7 support and supervision in residential habilitation. If a provider chooses to provide residential habilitation to participants who have been assessed at levels 1 and 2, then all the requirements of residential habilitation apply according to the service definition for residential habilitation, including a minimum 8 hours of direct onsite support and supervision. Most likely, these people could transition to a supported living service in a non-residential habilitation facility and receive around 7 hours a day of support.

*** Will we be waiving the 30 day rule at all for submitting plans of care when people are transitioning to the new waivers?**

A plan of care for the comprehensive waiver may be submitted any time after the Individual Budget Amount has been received by the participant and team members. Teams will be able to submit a transitional plan of care between April 1 and August 31. The Division will not be able to process all of the transitional plans in less than 30 days. Special consideration may be made on a case by case basis, but the Division will expect all plans to be submitted by August 31, 2014.

Those plans that will require a Clinical Review Team (CRT) consideration should be submitted well in advance, however, to allow for CRT review. If plans are submitted for CRT review without enough time for review, a plan of care may have to be approved without the extra consideration until the CRT can review and make a decision. A request to the CRT may be made any time after the team receives an IBA that is believed to be inadequate to meet the participant's needs.

*** How does the state expect to pay for behavior support services when we don't have but 4 people in the state who are Board Certified Behavior Analysts?**

Multiple providers can provide this service if they enroll as a provider and have staff that meet our qualifications. The BCBA is one way to be qualified. Here is the list:

A provider may have a Master's Degree and be a Board Certified Behavior Analyst
or
have similar nationally recognized certification in positive behavior supports with approval from the Division.
or
A provider may be an agency with individuals providing the service who have a current license to practice mental and behavioral therapy by either the Mental Health Professions Licensing Board or Board of Psychology per Wyoming Medicaid Rules, Chapter 45, and provide proof of specific training on positive behavior supports from an organization acceptable by the Behavioral Health Division.
or

A provider may be a Medicaid certified or state licensed Mental Health Agency fully licensed in Wyoming with individuals providing the service who have a current license to practice mental and behavioral therapy by either the Mental Health Professions Licensing Board or Board of Psychology per Wyoming Medicaid Rules, Chapter 45, and provide proof of specific training on positive behavior supports from an organization acceptable by the Behavioral Health Division.