

July 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. **The next call is Monday, August 25th at 2pm.**

CALL TOPICS & SUMMARY

Service Definitions

- Providers- the services being provided must meet the definition of the service and are provided pursuant to the participant's individual plan of care. For example, if a provider is providing supported living to two participants, the provider must bill at the rate for supported living *group* and not for supported living *individual* for each separate participant. Another example would be that if a provider is providing respite for a participant for over nine hours, the provider must bill the daily respite rate, not the 15 minute unit. However, at this time, PPL's system is not currently set up to allow billing for the daily respite service when over nine hours of service has been provided during two separate times during the same day. For example if an employee provides respite from 8:00AM to 12:00PM and also from 2:00PM to 7:15PM, the employee would bill the 15 minute unit for the entire time. Enhancements to PPL's system are being discussed at this time.
- Please reference the service definitions on the DD website for all services and be aware of the scope and limitations of each service.
- When errors in documentation standards are identified, the Provider Support Specialist involved is required to obtain copies of the documentation and make a referral to the Office of Healthcare Financing for possible recovery of funds due to the errors.

Service Clarifications

a. Employment Discovery and Customization

100 units of service can be completed without going to DVR, but it is a similar service to DVR so the service should also be used to help the participant schedule appointments with DVR and attend with them if requested by participant.

- b. **Res Hab** 8 hour requirement – The definition of RH in the new waiver changed. The On-site and 8 hour rule must be a combo of awake and asleep time. It also says, "Since residential habilitation is paying for support to an individual who needs support 24 hours a day, the provider must be in the residence of the participant providing service during both awake and sleeping time for a minimum of 8 hours in a 24 hour period (from 12:00am-11:59pm) for the provider to be reimbursed." Many people who have res hab on their plan but are in apartments and have a provider available to them in the building will not meet this requirement unless the eight (8) hours in the residence is met. So some people who do not need that level of support may be better off switching to supported living so the provider is not over supervising or supporting them when they don't need it.

c. Adult Day Services

Services in the home may be allowed by policy exception only with this day service (not community integration). These exceptions must follow the BHD approval process. Appropriate situations may involve a person whose age or medical condition necessitates the person staying at home most of the time, severe weather, and possibly as an innovative approach to people who do community (non-facility) based integration services and need supervision and help to get ready

for the activities in the community planned for the day or receiving supervision in between times they are not getting out to work or community activities.

- d. **Community Integration**- the standard habilitation objective form can still be used to plan the training part for this service. It is expected with the service.

We also were inspired from the Disability Crossroads Conference to look at exception uses **to the higher tier of the Community integration service** when people from the lower level of service need scores (levels 1, 2, 3 or 4) want to go out into the community 1:1 or with one other friend to engage in meaningful activities, joining clubs or groups, or building new relationships with people. We want to see how providers would want to use this service in a 1:1 or 1:2 way to really help participants have more natural interactions and opportunities in the community. The service provided would have to be completely community based 100% of the time if the person with a lower level score were to access the higher rate.

If you are a provider who is interested in trying a service like this with a participant, please let us know about it.

Example: Maybe Stanley, who is “retired” and has a level of service need score of 2.9, wants to get up 10 am and watch tv, do some chores and eat a late breakfast, then go to McDonald’s for coffee and to the rec center for a walk, then to his volunteer job at Hospice. The Adult day service can cover some of the time at home when he needs supervision, but then community integration at the higher tier level can take him 1:1 in the community for his 2- 3 hours of meaningful activities.

Chapter 3 Medicaid Rules: Provider Participation

- Requirements set forth in Chapter 3 Medicaid rules regarding provider participation, specifically the rules relating to provider records found in Section 7, state that all providers shall make financial or medical records available upon request to representatives of the Division, the United States Department of Health and Human Services, HCFA, the Comptroller General of the United States, the Wyoming Attorney General or the Medicaid Fraud Control Unit. The refusal of a provider to make financial or medical records available and accessible shall result in:
 - The immediate suspension of all Medicaid payments to the provider;
 - All Medicaid payments made to the provider during the record retention period for which records supporting such payments are not produced shall be repaid to the Division within ten days after written request for such repayment; and the suspension of all Medicaid payments for services furnished after such date.
 - Reimbursement shall not be reinstated until the Division determines that adequate records have been produced or are being maintained.
 - In addition, the Division may copy records pursuant to the record copying provisions located in Chapter 16 Medicaid rules.
 - Record requests are often sent to the provider via certified mail, and many of our providers have their mail delivered to a P.O. Box; therefore, we would like to remind those providers to make sure they check their mail often and pick up any certified letters that are sent to them.

Wait List Update

The BHD has received exceptional funding to begin funding applicants off the Child and Adult DD wait lists by length of time on the wait list. BHD staff have been working on verifying the status and eligibility of those on the wait lists who have been waiting the longest first.

Dr. Sandy Jensen has been reviewing psychological evaluations for eligibility criteria. In some of the older cases, we have on record evaluations that are in excess of 5 years and do not clearly define or include test scores that verify eligibility, particularly in the area of functional limitations. Some of these will need to be re-evaluated before we can proceed with a funding opportunity.

Where eligibility criteria are questionable, the BHD will need to verify eligibility before providing funding opportunities. This will require in many cases a psychological re-evaluation in order to provide the information we need to verify eligibility. This cost will be incurred by the BHD through state funds. Therefore, when making appointments for psychological evaluations, CMs will need to inform the psychologist's office to send the bill directly to Rory Schiffbauer, Participant Support Unit Manager, for processing and payment. A copy of the psychological evaluation should accompany the invoice.

So far, the BHD has provided 37 funding opportunities this month. We will continue to send out letters throughout the next few months as we work our way down the list. If a participant has been passed over, it just means we need to verify eligibility and will send a funding opportunity as soon as possible.

Transitioning to the Comprehensive Waiver

As mentioned earlier, we have received authorization from CMS to extend the ADD Waiver through September 30th. The next several months will be very busy times for both CMs and PSS staff. Field PSS eligibility staff will be assisting with plan reviews and approvals so that these transitions occur quickly and without delays. During the next three months, the BHD requests that modifications be held to a minimum and to address health and safety concerns and provider changes only. Please hold off on sending in specialized equipment, home modifications, and goods and services requests until after October 1, 2014, unless absolutely necessary. Thank you for your cooperation with this.

ABI Transition process

With the new federal regulations which allow the state to combine target populations on one waiver, the Division will be moving forward with the legislative mandate in the 2013 bill for Medicaid Reform, which included the ABI population in the Supports and Comprehensive waiver model. The waivers are in the process of being amended and going out for public comment this next month. Therefore new people not yet on the ABI waiver will be funded onto the supports waiver when it is allowed and people on the ABI waiver will move to the Comprehensive similar to our DD adult and child waiver process. More information on these amendments and transitions will come out soon.

Reenrollment with Medicaid

New Process Requirements

- As was presented in the May provider support call, all Medicaid providers must reenroll with Medicaid using the new electronic process by December 31, 2015. This includes all HCBW providers.

- Beginning with recertifications in September 2014 and continuing through August 2015, providers will be sent a letter from their provider support specialist after their recertification has been completed and any QIP's have been approved by Division staff. Providers who have already received a two year recertification this year will be sent the enrollment letter sometime during the next few months.
- Division staff will not be allowed to help a provider fill out the online enrollment due to the enrollment being a legal document. Xerox has created tutorials on their website to assist providers with the enrollment process. Xerox suggested you view the website, and the Frequently Asked Questions. Any questions that you may have on completing the enrollment application should be answered by following the tutorials which was suggested you print prior to enrolling.
- The website is: http://wymedicaid.acs-inc.com/aca_reenrollment.html

Crossroads conference and improvement items

The Disability Crossroads Conference offered information on ways to implement changes in the waiver system and help people move out on their own and work in competitive jobs. There were several examples of best practices and transforming an organization into becoming truly person-centered and outcomes based. The Division is working with the other conference organizers to post videos from the conference in the near future.

Clarification of CRT role, purpose, # of cases reviewed

The purpose of the Clinical Review Team (CRT) is to review requests regarding a participant's Level of Service Need score concerns. The CRT also reviews requests for Extraordinary Service or Support Needs. This team does not replace the Extraordinary Care Committee (ECC). The ECC provides the process to make an adjustment to the participant's IBA based on an emergency, out of home placement request or a material change in the participant's circumstances.

If a participant's Plan of Care Team believes a participant's level of service score for the Comprehensive Waiver does not reflect the participant's needs, the Team may request a review by the Division's CRT. The process begins by the Case Manager completing the CRT Adjustment Request form. Once the formal request is submitted through the Electronic Medicaid Waiver System (EMWS), the Participant Support Specialist assigned to the Participant's case works with the case manager to assemble the information and data needed to support the request. The request must be accompanied by any additional information that the participant's Team does not think is adequately captured in the present ICAP, such as significant medical or behavior needs or extraordinary support or service needs. It is the responsibility of the Case Manager and Plan of Care Team to provide the information needed to support the request.

When the completed request is ready, the Division managers then review the request for and schedule the CRT review date. During the CRT review meeting, the CRT members review all of the case information as well as the request and any additional information submitted with the request. The plan of care, ICAP and Psych assessments, and evidence/verification of need submitted are part of this review and discussion. The CRT members then use the Level of Service (LOS) Need rubric and the Residential Habilitation Tiers to determine if the requested increase matches the descriptions in the rubric or tier levels. Once a decision has been made by the CRT, the Division notifies the case manager and participant or guardian of the decision by a letter that is mailed to the participant or guardian and placed in EMWS.

The CRT has the authority to request additional assessments including a new ICAP, a Supports Intensity Scale or another appropriate and standardized assessment. The goal of the additional assessments is to assist the CRT in evaluating the need for a different Level of Service Need or extraordinary service or support.

To date, the CRT has reviewed thirty cases, but the Division does not report exact numbers due to confidentiality concerns. Of those cases reviewed, several cases have been sent back to the case manager for documentation to help in supporting the request for a level of service change, some cases have been approved for an increase in Level of Service, and other cases have had no change in the Level of Service Need score and there has been approval of Supported Employment.

Third Party Liability Form

- If you are hitting a roadblock for nursing and therapies through the Medicaid State plan, please write about the situation in an email and send to your PSS. We have been getting Medicaid and home health agencies on the phone to work through issues that may be coming up. If we need to approve a small amount of services until the form is signed, we will do that for participants who already have those services on their plans.
- Employment services and DVR signatures have been an issue in some counties as well. The Division has met with DVR managers to work through the problems with this form. There may be times they won't open a case, but they will sign the form and explain why. BHD and DVR will put together a process / reference guide to help all parties understand when DVR will get involved and to what extent... barring the disclaimer that "every case is individually reviewed and may vary." If there are difficulties with getting a DVR counselor signature, please let your PSS know. We may authorize 45 days of service from the waiver in order for a participant to not have service interrupted due to this requirement.

CM Quarterly Reports

Clarification on CM quarterly reports when it asks for restraints and restrictions. Does this apply to PBSP, what is written in the POC, or incidental, emergency and thus critical restraints?

If it is restrictions within the POC do we count each time the restriction occurs or just the 1 restrictions. For instance, if a person is not able to call their guardian until 6pm each day, but requires frequent reminders / restrictions during the day would that be counted once as a restriction or every time that the team has to restrict them?

The quarterly report asks to check a box if the participant has a Positive Behavior Support Plan (PBSP). If the participant does have a PBSP, you will identify the number and type of restraints imposed for each month. You will also identify the number and type restrictions for each month. The number of restrictions would be how many times an actual restriction was imposed on a participant.

Questions/Responses

How are staffing ratios being addressed? The new definitions do not address this, but we have been told that ratios are not going away. How does the team need to address it, and how does case managers need to enforce it?

The Division is working with a provider group on an alternative solution. In the meantime, services must be delivered per the approved plan of care and the flexibility form must be completed if participants are on the old waivers still. The new plan on the Comprehensive Waiver addresses supervision needs in it and the supplemental form is not needed. A bulletin on this topic will go out in two weeks regarding this issue.

Should we allow the Employment Discovery and Customization service to be covered by the waiver for people without going through DVR first?

If DVR meets with a person, they have to "want to work". But we know that a lot of people who have been in DH or PV for years, may not know if they want to work. They may need our Employment D & C service in order to find out if they are interested in working....Therefore, the Division will allow the first 100 units of Employment D & C to be added to a plan if a person is not sure they want to work in order to start completing the packet. We will also add the first 100 units to a plan if a person wants to work and has not met with DVR and the Employment services provider will help them attend the DVR meetings and complete the packet and plan for employment with DVR.

What employment training curriculums are providers using to meet the supported employment curriculum requirement?

The 5 resources we have approved so far:

1) Virginia Commonwealth University Job Development and Job Coaching training

<http://www.worksupport.com/training/courses.cfm>

2) College of Direct Support - Employment track

<http://directcourseonline.com/employmentservices/core-curriculum/>

3) Dale Dileo has the Training Resource Network that has an Employment First site with online modules: <https://trn-store.com/>

**APSE is recommending each of these courses and has posted information on discounts for taking them: <http://www.apse.org/training/resources.cfm>

4) Customized employment training by Griffin-Hammis Associates, LLC which has been provided in Wyoming through a project with the Governor's Council on Developmental Disabilities. Two providers have used them. The training is an ACRE (Association of Community Rehabilitation Educators) certified curriculum that consists of 40 hours of classroom training. In the case of the Wyoming training it was presented over 6.5 days in April and May of this year. In addition to attending all the training modules, participants completed a pre and post-test and needed to score a minimum of 80% on the post-test (which everyone who participated accomplished).

In addition to the training, both providers are continuing to receive onsite technical assistance to coach them with Discovery and Customized Employment practices. I would encourage to visit our

website, www.griffinhammis.com as well as the ACRE website, www.acreducators.org if you would like to learn more about the training and certification.

email: bniemiec@griffinhammis.com www.griffinhammis.com www.mntat.org

5) Another program recently approved covers career development theory, assessments, and practical resources and skills to aid people (not restricted to people with developmental disabilities) with career development. This course also comes with an option for credentialing which should meet and far exceed any requirements and expectations.

The Career Development Facilitator from the NCDA website is in-depth training in the areas of career development in the form of up to 120+ class/instructional hours, provided by a nationally trained and qualified instructor. A Career Development Facilitator may serve as a career group facilitator, job search trainer, career resource center coordinator, career coach, career development case manager, intake interviewer, occupational and labor market information resource person, human resource career development coordinator, employment/placement specialist, or workforce development staff person.

Support call notes are now posted to our website

<http://health.wyo.gov/ddd/ComprehensiveandSupportsWaiver.html>

Next Call

Next call is August 25th at 2pm. Calls will be held on the last Monday of each month when there is no holiday interruption.

Thank you for reading and for making time to call in each month!