# *Wyoming Department of Health*
## *Division of Healthcare Financing*

COMMUNITY

CHOICES

# Policy & Procedures

**Provider Instructions**

Wyoming Department of Health

Commit to your health.

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# Wyoming Department of Health

Mission Statement:

- State Plan Services

The Division of Healthcare Financing (DHCF) under the Wyoming Department of Health administers the Medicaid Programs. Medicaid provides a variety of services in two areas:

- State Plan Services
  - Wyoming offers a variety of State Plan services as approved by the Federal Government. Services are offered based on specific eligibility requirements
  - Each state may differ in income and resource limit guidelines, as well as specific services available and amounts included in their State Plan
- Waiver Services
  - Services under an approved waiver authority are an exception to the State Plan. Each state may apply for a waiver authority and must be approved by the Federal Government in order to provide these services. Services are offered based on specific eligibility requirements

*Information and literature is available through the Wyoming Department of Health Medicaid Long Term Care Financial Eligibility Unit at 1-855-203-2936*

## Waiver Overview

Federal Government waiver program definition:

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in 1915(c) of the Social Security Act. The program allows a State to furnish a range of home and community-based services that assist Medicaid recipients to live in the community, in the least restrictive environment and avoid institutionalization. The State has sufficient discretion to develop its waiver program to address the needs of the waiver's target population. Waiver services supplement the services that are available to participants through the Medicaid State Plan and other federal, state, and local public programs as well as the supports that families and communities provide. A State has the latitude to design a waiver program that is cost-effective and involves a variety of service delivery methods, including participant direction of services.

Wyoming has chosen to provide services under the Division of Healthcare Financing through the Community Choices Home and Community Based Services Waiver. The Waiver targets individuals who are nursing home level care but choose to remain in the community. This Waiver was developed for the purpose of offering another option for individuals who need nursing home care level of care. Listed below are the waiver services available through this waiver:

- **Services in an Assisted Living Facility (ALF)**
  - Case Management
  - ALF Level I
  - ALF Level II
  - ALF Level III

- **Services in the Home**
  - Case Management
  - Home Delivered Meals
  - Lifeline Installation Personal Emergency Response System (PERS)
  - Lifeline Monthly Service Personal Emergency Response System (PERS)
  - Non-Medical Transportation
  - Adult Day Care
  - Skilled Nursing

- **Additional services In Home Agency Option**
  - Personal Care Attendant
  - Respite Care

- ***Additional services in home – Participant Directed Option***
  - Direct Service Worker
  - Fiscal Management Services

*****Not all participants receive all services. Services are determined based on availability in the participant's geographic area. Participants only receive services that are identified on the LT101 assessment, and what the person-centered team determines are necessary. The person-centered team includes the Case Manager, the participant, and any other essential individuals.

## Who is Eligible for the Community Choice Waiver

- The applicant must be 19 years of age or older
- Must meet Nursing Home Level of Care, as determined by the LT-101 assessment, which will be completed by a Public Health Nurse in the applicant's county
- Must meet financial eligibility which is determined by the Medicaid Long Term Care Financial Eligibility Unit. *There are special income guidelines for these programs, so even if you have not qualified for help before, you may now.* If you are under age 65 you will also need to meet the disability requirements
- If choosing the In Home Participant Directed Option
    - Must demonstrate that they are capable of directing their own care. This means that they must be **able and willing** to accept and perform all rolls and responsibilities of an employer
        - Participants with **dementia or cognitive** impairments that prevent effective communication, understanding or evaluation of performance of tasks are not eligible to choose this option
    - Capability to direct their own care **is NOT** the same as determining competency. Only a court of law determines the decision-making capacity of an individual "Capacity", "competent" and "incompetent' are legal terms. Unless a court has determined otherwise, all persons are consider competent to make decision
        - If there is a court order an individual is not eligible for this option.
    - Decision making capability is a clinical judgment referring to an individual's ability to make an informed decision. It is possible for individuals to retain capability in some activities in their lives (treatment decisions etc.) but not in other activities (managing finances)
    - Capability is determined from the LT101. Individuals that do not meet this on the LT101 are not eligible for this option
    - For participants that do not successfully meet the "Participant Capability" criteria, there is an additional option to consider. If the recipient has a legally valid Advance Health care Directive (Power of Attorney for Health Care) in place **prior** to the completion of the LT101 determining capability, and the authorized representative meets specific criteria, the authorized representative may in the participant's place, participate in the participant directed care option
    - Must take on the responsibilities for and Employer.
        - Responsibilities include:
            - Understanding and follow program requirements
            - Writing a job description for their employee(s)
            - Developing a work schedule based on authorized service units
            - Developing a back-up plan for help

- Recruiting and selecting worker(s)
- Each participant is required to have one (1) primary direct service worker and one (1) back-up direct service worker in place in the event that the primary worker is unable to perform scheduled work)
- Notifying selected worker(s) of their responsibilities
- Assuring that employment forms are completed and submitted to the fiscal agent
- Training worker(s) to perform specific tasks
- Validating worker(s) time sheets
- Maintaining copies of all worker(s) timesheets and employment records
- Supervising worker(s) to assure tasks are accomplished correctly and completely
- Evaluating worker(s) performance and providing feedback
- Terminating worker(s) employment when necessary
- Notifying fiscal agent of any changes
- Participating in ongoing eligibility review and program oversight by the Case Manager
- Communicating with the Case Manager as necessary
- Accepting and performing all the required responsibilities of an employer is a serious undertaking. Participants must clearly understand what they are agreeing to and willingly accept that role. It is the role of the Case Manager to support, train and guide the participant in becoming a successful employer

# Case Management

Case Management for Community Choices Home & Community Based Waiver Services (HCBS) is a process where an individual's specific needs are identified, and the social and medical services required to meet those needs are located, coordinated, and monitored.

*FUNCTIONS:*

The Case Manager must be able to:

- Assess the physical, environmental, psychological, and socioeconomic status of a participant
- Assess participant eligibility under various third-party programs
- Develop and validate a person-centered care plan
- Provide interdisciplinary and inter- and intra-agency coordination
- Supervise resource allocation
- Implement the plan of care
- Ensure services are delivered
- Oversee provider compliance with state standards and certification requirements
- Monitor cost containment elements in the plan of care
- Act as the participant's advocate

# Qualifications of Case Management Agency

**An Approved Case Management Agency may include:**

- Case Management Agency
- Counseling Agency
- Home Health Agency
- Public Health Office
- Centers for Independent Living Agency
- Wyoming Home Services (WyHS) Agency

**License Requirements**

- Home Health Agencies must be Medicare Certified or State Licensed Home Health Agency fully licensed by the Wyoming Department of Health, Office of Healthcare Licensing and Survey

- All agencies must be approved by the program

**A Provider agency approved to provide case management services shall:**

- Obtain and maintain own National Provider Identifier (NPI) number for case management services through the Medicaid enrollment process
- Require that each case manager meets the criminal background and central registry check requirement
- Have policies and procedures for backup case management for each case manager's caseload and meet with their designated backup to review all participant cases on a quarterly basis, with the review documented in case notes.
- Require that each case manager initially and annually submit proof of competency by providing documents showing successful completion of the Division approved case management training curriculum
- Document in the plan of care that the Case Management agency and or all case managers have no conflict of interest with the participant or family
- Meet the following conflict of interest requirements:
    - The case management agency and any managing employee may not own, operate, be employed by, or have a financial interest or financial relationship with any other person or entity providing services on the participant's individual plan of care, if the interest would meet the definition of conflict of interest outlined in 42 CFR §441.301(c)(1)(vi)
    - The case management agency may be certified in other waiver services, but shall not provide case management services to any participant that they are providing any other waiver services to, including participant directed services
    - The case manager or case management agency may not serve any participant that receives waiver services from a waiver provider if any of the provider's owners, officers, or managing employees are related by blood or marriage to the case management agency and any managing employee of the case management agency

- Any employee of a guardianship agency may not provide case management to any participant who is receiving any services from the guardianship agency
- Also, a case management agency may not:
  - Employ case managers that are related to the participant, the participant's guardian, and/or a legal representative served by the agency. Or if a sole proprietor, may not be related to the participant, the participant's guardian, and/or a legal representative served by the agency
  - Be authorized to make financial or health-related decisions on behalf of the participant receiving services from that agency, including but not limited to a guardian, representative payee, power of attorney, conservator or other position as defined by the Division;
  - Employ case managers, or if a sole proprietor, live in the same residence as the participant in which they provide case management services, nor live in the same residence of any provider on a participant's plan in which they provide case management services; or
  - Be an approved provider or employee hired through participant directed services

- If a rural area of the State does not have a case manager without a conflict of interest for a participant, the participant or legally authorized representative may request to have a case manager with a conflict. If:
  - The Division confirms that there are no other case managers available in the region or a nearby region to provide case management, and then the conflicted case manager may be approved on an annual basis
  - A third party entity without a conflict shall be involved in the participant's team to mediate, advocate for the participant as needed, and address unresolved grievances for any conflicts that are approved
  - The Centers for Medicaid and Medicare shall be notified of case managers servicing with a conflict of interest

**Required documentation for becoming Case Management Agency**

Complete the Community Choices Waiver Provider Application (CCW -12)

- Complete the Wyoming Medicaid Provider Participation Agreement on line by visiting:
  - **https://wyequalitycare.acs-inc.com/wy/general/providerEnrollmentHome.do.**
- Obtain a National Provider Identifier (NPI)
  - For more information visit
    - **https://npiregistry.cms.hhs.gov/**
- Receive Approval from the Department of HealthCare Financing Home Care Services Provider Oversight Manager

Documentation will be reviewed and evaluated as meeting requirements by the Division

# Qualifications of Case Manager

**Case Manager must be employed by an approved Case Management Agency**

**All Case Managers must have one (1) of the following:**

- A Master's degree from an accredited college or university in one (1) of the following related human services fields:
  - Counseling
  - Education
  - Gerontology
  - Human Services
  - Nursing
  - Psychology
  - Rehabilitation
  - Social Work or
  - A related degree, as approved by the Division or

- A Bachelor's degree in one (1) of the related human services fields from an accredited college or university, and one (1) year work experience as a case manager in a related human services field, as approved by the Division or

- An Associate's degree in one (1) of the related human service fields from an accredited college, and four (4) years of work experience as a case manager in a related human services filed, as approved by the Division;

- A case manager employed by an agency or certified prior to July 1, 2016 may provide case management services, without meeting the above criteria as long as the case manager has a high school diploma or GED and six (6) years of work experience as a case manager on any 1915 C waiver, as an exception for not meeting the required education requirements of this section

- A case manager employed by a Wyoming Home Services (WyHS) agency that is currently state-funded may provide case management services, without meeting the above criteria as long as the case manager has a high school diploma or GED and six (6) years of work experience as an Access, maintain full certification with WyHS and is in good standing with the WyHS program as an exception for not meeting the required education and requirements

- A Case Manager employed by an agency or certified by the Division prior to July 1, 2016 who is seeking to qualify under this section shall obtain the additional education and/or work experience by June 30, 2019

  - The Division shall terminate a case manager from providing case management services under Community Choices waiver program who fails to obtain the required education or work experience

**<u>Other Standards</u>**

- All Case Managers must meet the criminal background and central registry check requirement for the waiver program
- Have policies and procedures for backup case management for each case for each case manager's caseload and meet with their designated backup to review all participant cases on a quarterly basis, with the review documented in case notes
- Case Managers shall not function as a legal guardian, power of attorney, financial or legal representative on behalf of any waiver participant to whom they provide waiver service; or any waiver participant of the agency or entity that they are currently employed with
- Case Managers shall not be employed to provide services to elderly, disabled, and/or blind participants who ever left employment because of, or have been convicted of abuse or neglect
- Case Managers are required to successfully complete the Division approved case management training curriculum prior to providing any case management services

**Required documentation for becoming Case Manager**

The Approved Case Management Agency must submit the following documentation to the Division of Healthcare Financing Home Care Services Unit:

- Waiver Case Manage/Delegate Request Form (CCW-13)
- Current resume
- Copy of Diploma for Education
- Copy of current proof of licensure from the Wyoming Board of Nursing (this can be a copy of the printout from the Wyoming Board of Nursing)
- Copy of license for
    - Licensed Clinical Social Worker (LCSW)
    - Psychology
    - Counseling
    - Or any other required licenses

Documentation will be reviewed and evaluated as meeting requirements by the Division.

## Case Manager Responsibilities

The Case Manager is responsible for the following:

- **Must** be in compliance with Health Insurance Portability and Accountability Act (HIPPA) of 1996, Pub.L.No.104-191, including all implementing regulations and all amendments
- Identifying and documenting the formal and informal resources currently being utilized to meet the needs of the participant
- Not authorizing services for participants who have the ability to complete tasks themselves or have someone in the home who can perform the services
- Ensuring each participant has been educated about:
    - All available case management agencies
    - All available direct service providers
    - The Medicaid Eligibility Long Term Care Unit for financial eligibility
    - Adult Protection Services through the Department of Family Services
- Ensuring that the participant is offered:
    - Choice of community or institution
    - Choice of providers in the community
    - Choice to change providers at their discretion
- Developing and implementing a person-centered plan of services for each participant, that will include at a minimum:
    - A statement of need
    - A list of individually identified, measurable objectives to be met by the services required to be provided for both waiver services and non-waiver services
    - The specific services to be provided to the individual participant, including frequency (units, duration and eligible providers) and estimation of cost for all services
- Developing a person-centered plan of care that reflects the individual's strengths, preferences, and minimizes risk factors
- Locating, facilitating, and documenting the resources in the community available to meet the identified unmet needs documented in the care plan, as well as advocate for services to meet the needs of the participant
- Organize and Facilitate Care Conference Meetings
- Case Manager will submit additional required documents to the Waiver Program for approval upon request
- Request Waiver Program Manager approval for plan of care costs above the set maximum
- Maintain individual participant records for each participant and uploaded to EMWS. These shall include, but are not limited to:

    - ***For Agency Option***
        - Participant Choice of Service (CCW-1)
        - Participant Rights and Responsibilities (CCW -3)
        - Provider Duties Sheet (CCW-6)
        - Monthly Evaluation (CCW-7)
        - Notice of Termination (CCW-10)
        - Change of Case Management Agency (CCW-11)

        - Participant Choice of Provider (CCW-14)
        - Doctor's Orders are required for Skilled Nursing. Orders can be on a prescription pad or Form CMS-485 "Home Health Certification and Plan of Care". Orders on an RX pad are valid for 1 year from the date it is written (unless otherwise stated). The orders on the 485 are good for the 60 day certification period listed on the 485. New orders must be obtained when the order expires. The Doctor's Order must be uploaded in EMWS before skilled nursing can be added to the plan and the services can only cover the time of the order
        - Clinical notes
        - 30 Day Termination Letter
        - Complaint/Tracking Response
        - Critical Incidents Reports
        - Case Conference
        - Nurse Supervision
        - Personal Care Monthly Verification
        - Advance Directive and/or Durable Power of Attorney for Health Care information ( if participant has)
        - Durable Power of Attorney (if participant has)
        - Guardianship Papers (if participant has)
        - Release of Information documentation (if participant has)

    - ***In Addition for the Participant Directed Option***

        - Participant Agreement (PDC-2)
        - Consumer Profile (PDC-3)
        - Verification of Employer Training provided
        - Direct Service Worker Log

- Monitor the provision of services at a minimum of once a month, with additional visits as required, to ensure quality of care as well the safety and health of the participant
- Monitor participants for appropriateness of services:
    - Services are determined based on availability in the participant's geographic area
    - Participants only receive services that the person-centered team determines are necessary based off the Nursing Home Level of Care Assessment
        - The person-centered team includes the Case Manager, the participant, and any other essential individuals
    - Participants should only receive the services that they need to keep them in their home
- Verify and document that plan services are being provided as indicated on a monthly basis
- Monitor service costs to ensure cost-effectiveness is maintained
- Update any demographic changes for a participant, including change of address, phone number, etc.
- Completion of modifications to the plan of care in a timely manner

- Re-assessing the participant at the appropriate timeframes; re-determine the individual's level of functioning; identify areas of functioning needing assistance, and identify medical and/or social services appropriate to meet the individual's needs
- When a participant elects to transfer from one Case Management provider to another, a Change in Case Management Agency form (CCW-11) must be completed and submitted to the Division of Healthcare Financing Waiver Program. This must be complete within 5 working days. The current Case Manager will serve as Case Manager of record and continues to remain responsible for the participant until the change is reflected in the Electronic Medicaid Waiver System and both Case Managers have been notified of the change by the Waiver program
- Documentation by a provider on a participant must be retained for six (6) years after termination of services to the participant. If legal proceedings are being undertaken, documentation must be retained for six (6) years after the legal activity is completed. Complete the Task in the Electronic Medicaid Waiver System in a timely fashion:
    - Update Demographics – ten (10) working days or less
    - Acknowledgement – five (5) working days or less
    - Case Manager Closure Review – five (5) working days or less
    - Select Case Manager – five (5) working days or less
    - Submit Plan of Care - forty-five (45) working days or less
    - Case Management Documents - thirty (30) working days or less
    - Change in Case Management– fifteen (15) working days or less

**Case Managers will receive a corrective action plan for failure to comply with policies and procedures.**

- This may result in service payments being reimbursed by the Case Management agency

# Eligibility Process for Participants

Prospective Waiver Participant must initiate the eligibility process by contacting the Division of Healthcare Financing Long Term Care Unit at 1-855-203-2936 to request an application. Applications may also be completed via telephone by calling the above number.

There are four (4) steps this process.

- Medicaid Long Term Care Financial Eligibility Unit
- Home Care Services Unit
- Public Health Nurse
- Case Manager

## Medicaid Long Term Care Financial Eligibility Unit

- The participant completes a Medicaid application and submits to the Medicaid Long Term Care Financial Eligibility Unit along with supporting financial documentation
- The Medicaid Long Term Care Financial Eligibility Unit will notify the Home Care Services Unit to send additional information on the program
- The Medicaid Long Term Care Financial Eligibility Unit reviews the application and determines financial eligibility
- Eligibility worker enters determination into EMWS
- If participant does not meet financial eligibility, a task in EMWS is sent to the Case Manager and the Waiver Program
- If participant meets financial eligibility a task in EWMS is sent to the Case Manager and the Waiver Program

## Home Care Services Unit

When the Home Care Services Unit receives information on a prospective waiver participant the following occurs:

- Home Care Services Personnel will mail a packet that includes:
    - List of Case Management Agencies in the individual's area
    - Fact Sheet on the program
    - Form to complete on choice of Case Management agency
    - Return self-addressed envelope

- Home Care Services Unit personnel will enter all information in the Electronic Medicaid Waiver System (EMWS), to begin the task process (EMWS manual) once the choice of case management agency form is completed and received

## Public Health Nurse (PHN)

- When referral is received the Public Health Nurse has:
  - Seven (7) calendar days to complete LT101 assessment
  - Three (3) working days to enter the LT101 information into the Electronic System

## Case Manager

- The Case Manager prepares an informal plan of care using participant input and LT101 Assessment
- The Case Manager
  - Offers the participant a choice of service settings through the Participant Choice of Service form (CCW-1)
  - Completes the Participant Rights and Responsibilities form (CCW-3)
  - The Case Manager shall discuss Advance Directive and/or Power of Attorney for Health Care options with the participant
  - Uploads all above listed forms to the EMWS
  - Documents in the note section of the EWMS the date the Advanced Directive and/or Durable Power of Attorney for Health Care options discussion was conducted with participant
    - Completion of the above initiates a task to waiver program for review of a funding opportunity

# Funding Opportunity Processes

When a funding opportunity becomes available (after the Case Manager has submitted documentation) the Electronic Medicaid Waiver System (EMWS) generates the following tasks:

- Two (2) tasks to the Case Manager
  - Confirm Demographics
  - Submit Plan of Care
- One (1) task to Medicaid Financial Eligibility
  - Verifies Financial Eligibility

**The Case Manager will:**

Confirm Demographics

- Is required to contact the participant prior to completing task in EMWS to confirm demographics and ensure the participant is ready to move forward and begin waiver services
- If the participant is not ready to move forward and begin waiver services the case manager will select the option to place the individual on the Pending Status list

Submit Plan of Care

- Is required to enter the Person-Centered Plan of Care in EMWS for approval by the Home Care Services unit.

## Placing the Applicant on the Pending Status List

The pending status list is for Applicants who are not ready to received waiver services because the waiver involves coordination with an open bed at the Assisted Living Facility chosen by the applicant, they are in the process of hiring their Direct Services workers or any other reason the applicant may have. Participant names are positioned on the waiting list based on the date and time the case manager completed the request to move to the applicant to the pending status list through the Electronic Waiver System (EMWS).

The case manager chosen by the applicant is notified every 90 days through the Electronic Medicaid Waiver System (EMWS) from the date the applicant was place on the pending status list of a funding opportunity, or the case manager can request that the applicant move forward from the list when they are ready to start services.

# Plan of Care Development

## Responsibilities of the Case Manager

- Review Current LT101 (within 90 days of plan start)
- Meet with the participant and prepare a person-centered plan of care based off the LT101 identified needs using participant input as to what services are available or can be provided outside of the waiver. The Case Manager should discuss:
    - Overall objectives and treatment plan
    - Participant Choice of Service (CCW-1) and have the participant sign the form
    - Participant Rights and Responsibilities form (CCW-3) and obtain participant signature on the form
    - Advance Health Care Directives and/or Durable Power Attorney for Health Care options
    - Provide participant with Choice of Providers
        - The Case Manager MUST offer the participant a choice of all providers located in the participant's service area by using current Participant Choice of Provider form (CCW-14) located in EMWS**.** Case Manager **MUST** remaining objective when offering a choice of providers
    - Coordinate and work with providers to provide services
    - Complete the provider duty sheet (CCW-6) to communicate the information that each provider needs to have in order to deliver the service
        - The form must contain:
            - The service requested
            - The amount of units to be delivered each month of the plan
            - The charge per unit
            - The participant information
            - The Case Manager signature
        - The agency providing the service must return a signed copy to the Case Manager to verify that they are intending to provide the service for the amount listed. This is considered the contract between the Case Manager and providers to authorize services. This is not an authorization for payment. Providers should not begin providing services to a participant until a prior authorization is received

### Types of Services

Not all communities are able to offer all services. Services for each participant are based on identified needs from the LT101 assessment. Services should take into account natural supports as well as the participant's strengths and preferences.

## Service under the Assisted Living Option

**There are Three Levels of Assisted Living**:

- **ALF Level I**
- **ALF Level II**
- **ALF Level III**

**Services must be provided by approved qualified Assisted Living Facilities**

- An Assisted Living Facility must be fully licensed by the Wyoming Department of Health, Office of Healthcare Licensing and Surveys
- The Assisted Living Facility must meet all program rule requirements for waiver residents, as with non-waiver residents. This includes:
    - Assessment and review of needs and services
    - Nursing assessment
    - Preparation and updates to the resident care plan
    - As for non-waiver residents, waiver resident needs cannot exceed the license requirements for the facility (i.e. ability to evacuate, etc.).
    - The LT101 medical necessity scores allow the Assisted Living Facility waiver resident to receive services in either the nursing home or the Assisted Living Facility if their needs do not exceed the license scope of the Assisted Living Facility
    - Maintain the safety and welfare of both non-waiver and waiver residents as required by their license
    - Admission of new waiver Assisted Living Service residents is prohibited if the facility license changes to provisional status or is revoked

**Service Definition**

- Adult residential services are provided in a home-like environment in a fully-licensed community care setting in conjunction with residing in the Assisted Living Facility, other services could include:
    - Personal care
    - Homemaker
    - Medication oversight (to the extent permitted under State las)
    - Service includes twenty-four hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence
    - Provides supervision
    - Safety and security based on resident needs
    - Services are reimbursed based on a daily rate and only paid for days the resident is at the facility
    - Excluded Assisted Living Services are:
        - Home health care
        - Physical therapy
        - Occupational therapy
        - Speech therapy

    - Intermittent skilled nursing services
    - Periodic nursing evaluations
    - Transportation
    - Room & Board Cost

- Service amount, frequency and duration are not limited by the waiver. Only the waiver service reimbursement is limited. The established tiers take into account functional needs and potential intensity of services (tiers based on score of LT101) which the facility agrees to provide for the tier reimbursement
- The facility must meet the needs of anyone under their care, regardless of their reimbursement
- If the facility is unable to meet the needs of the resident, a discharge plan is required under their license rules
- The health and welfare of all assisted living facility residents is overseen by the licensure mandate of the facility

**Participants will only receive services that are authorized in their plan of care!**

## Services under the in Home Option are:

### Skilled Nursing

**Qualifications for Skilled Nursing are:**

- **Home Health Agency**
  - An employee of a Home Health Agency licensed in Wyoming, who is:
    - A professional nurse (RN) currently licensed in Wyoming
    - All Skilled Nurses must meet the criminal background and central registry check requirements for the waiver program
    - Skilled Nurses shall not function as a legal guardian, power of attorney, financial or legal representative on behalf of any waiver participant to whom they provide waiver service; or any waiver participant of the agency or entity that they are currently employed with

- **Home - Individual**
  - A skilled nurse employed in a home – Individual must:
    - Hold a current professional (RN) license in Wyoming
    - Maintain professional liability insurance
    - All Skilled Nurses must meet the criminal background and central registry check requirement for the waiver program.
    - Providers shall not function as a legal guardian, power of attorney, financial or legal representative on behalf of any waiver participant to whom they provide waiver service

**Provider Responsibilities**

- It is the providers responsibility to work with the case manager to provide the needed services on the participant plan of care

**Service Definition**

- Nursing tasks that are ordered by a physician
- Nursing tasks that are ordered by a physician
- Nursing tasks that are within Wyoming Nurse Practice Act
- Are provided by a nurse licensed to practice in the State of Wyoming
- Are not covered as standalone services under the Medicare or Medicaid home health benefit
- Services may include:
  - Set up of medication box
  - Administration of an injection
  - Foot Care for participants with identified risk for compromised skin, circulatory or neurological systems.
  - Service is provided as intermittent care for chronic conditions and not as a substitute for acute private duty nursing need

## Personal Emergency Response System (PERS)

### Qualifications of Personal Emergency Response System (PERS)

**Personal Emergency Response System Vendor must be:**

- A licensed business entity that provides, monitors, responds and supports equipment they furnish that meet the Federal Communications Commission certification under 47CFR 15 and 47 CFR 68 standards and Underwriter Laboratory testing standards for home health care signaling equipment, or digital alarm communicator system units

**Provider Responsibilities**

- It is the provider responsibility to work with the case manager to provide the need services on the participants plan of care

**Service Definition**

- **Installation**
  - This service provides installation of electronic equipment necessary for the operation of the Personal Emergency Response System (PERS)
  - It is a one (1) time fee for each start of service. It is usually only once per participant, but may be repeated if the participant
    - Moves
    - Has a break in services because of a:
      - hospital stay
      - nursing home stay
    - Service provider goes out of business

  - **Services Includes:**
    - Providing a base unit and necessary activation equipment
    - Delivery and installation of equipment
    - Providing training to the participant

    **Note: This is a one-time fee for each start of service. It is usually only once per participant, but may be repeated if the participant moves, has a break in service because of a hospital or nursing home stay, they change service providers, or a service provider goes out of business**

- **Monthly**
  - Provide an electronic communication link to assistance outside the participant's home to enable participants:
    - Who live alone
    - Are alone for significant parts of the day
    - Have no regular caregiver for extended periods of time
    - Would otherwise require extensive routine supervision
    - Secure help in an emergency, to lower risk of injury or to prevent institutionalization

- Providing live twenty (24) hour seven (7) days a week monitoring by professional staff for appropriate response
- Ongoing monthly equipment fees that include:
  - Monitoring
  - Troubleshooting
  - Response to alerts and alarms
- Documentation/communication with responders and Case Manager

**Note: Monthly defined service, regardless of the number of alerts or alarms transmitted. Service does not include purchase of installed equipment**

The provider must document that the equipment was installed, operational, and tested for each month that the fee is reimbursed. The monthly fee covers all defined services, regardless of the number of alerts or alarms transmitted. Services do not include the purchase of installed equipment.

## Home Delivered Meals

### Qualifications of Home Delivered Meals

- All licensed commercial Food Services Operators:
    - Must maintain a current food service license or permit from the state in which the commercial food service preparation facility is located, and comply with all Federal, State and local food regulations
    - Comply with food service facility inspections by the licensing entity and are subject to review by the Waiver Program
    - Must demonstrate the ability to produce, handle, store, prepare and deliver food under current Federal, State and local food handling safety guidelines
    - Providers shall not function as a legal guardian, power of attorney, financial or legal representative on behalf of any waiver participant to whom they provide waiver service; or any waiver participant of the agency or entity that they are currently employed with
    - Nutritional analysis of delivered meals must be available to the waiver program for review upon request to confirm meals meet the nutritional standard for reimbursement

- **Provider Responsibilities**
    - It is the providers responsibility to work with the case manager to provide the need services on the participants plan of care

- **Service Definition**

    - A meal delivered to the home of the participant or to an Adult Day Care when the participant is in attendance which meets:
        - The nutritional standard as established by the Home Care Services Program Manager
        - The delivery of meals must document the content of the meal and the receipt of the meal by the participant
    - Up to two (2)nutritionally complete meals per day

## Adult Day Care

### Qualification of an Adult Day Care Facility

- An Adult Day Care Facility must be fully licensed by the Office of Healthcare Licensing and Surveys under the Wyoming Department of Health

- Providers shall not function as a legal guardian, power of attorney, financial or legal representative on behalf of any waiver participant to whom they provide waiver service; or waiver participant of the agency or entity that employs them

- **Provider Responsibilities**
    - It is the providers responsibility to work with the case manager to provide the need services on the participants plan of care

- **Service Definition**

    - Services furnished for four (4) or more hours per day, on a regular schedule, for one (1) or more days per week (as specified in the Plan of Care) but for less than twenty four (24) hours each day
    - Services must be provided in a community based setting by an Adult Day Care facility fully licensed by the Wyoming Office of Healthcare Licensing and Survey
    - Services encompass both health and social needs to ensure the optimal functioning of the individual
    - Meals provided as part of these services shall not constitute a full nutritional regimen (three (3) meals per day)
    - The cost of meals is not included in the reimbursement for this waiver service. Meals may be reimbursed under the Home Delivered Meals waiver service (if the service is included in the participant's Plan of Care) and meet all waiver standards under that service
    - Services may not be provided in the participant's home
    - May not occur continuously over a twenty four (24) hour period
    - May not include staying overnight
    - Transportation to or from or during the participant's stay at the facility is not included in the service reimbursement
    - May be reimbursed under the Non-medical Transportation waiver service (if the service is included in the participant’s Plan of Care)

## Non-Medical Transportation

### Qualifications of Non-Medical Transportation

**Agency**

- Licensed Commercial Transportation Operator
    - Services provided by a public or private entity that meets all Federal, State or local legal requirements to operate a business and is capable of safely transporting participants to access community resources;
        - Meets all  federal, state and local laws and regulations for driver licensing, liability insurance, business operation and vehicle transportation safety standards;
        - Carries a fire extinguisher in vehicle during transportation
        - Carries a first aid kit in vehicle during transport
        - Is capable of summoning assistance if needed during transport
        - Provides upon request, a current safety inspection verification report which assures prudent safety maintenance and repair for vehicles used to transport waiver participants

**Individual Driver**

- Holds a current valid driver license from any state
    - Services provided by an individual who:
        - Is at least eighteen (18) years old
        - Is capable of safely transporting participants to access community resources
        - Meets all federal, state and local laws and regulations for driver licensing
        - Has current vehicle liability insurance and vehicle transportation safety standards
        - Carries a fire extinguisher in vehicle during transport
        - Carries a first aid kit in vehicle during transport
        - Is capable of summoning assistance if needed during transport
        - Has a current safety inspection verification report which assures prudent safety maintenance and repair for vehicles used to transport waiver participants

**Provider Responsibilities**

- It is the providers responsibility to work with the case manager to provide the need services on the participants plan of care

**Service Definition**

- Service offered to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the Plan of Care
- This service is offered in addition to medical transportation required under 42 CFR § 440.170(a) and transportation services under the State plan, defined at 42 CFR § 431.43 (if applicable) and does not replace them
- Whenever possible, family, neighbors, friends or community agencies which can provide this service without charge are utilized

- Non-medical transportation costs are not included in the reimbursement for Adult Day Care, Personal Care Attendant or Respite waiver services.
- **Limited to a total of $80.00 per month**

## Additional in Home Services – Agency Option

### Personal Care Attendant (PCA)

#### Qualifications

- A qualified Personal Care Attendant (PCA) is an employee of a Home Health Agency licensed in Wyoming, who is:
    - Certified Nursing Assistant with current certification in good standing with the Wyoming State Board of Nursing
    - Under the supervision of a registered nurse as provided in accordance with the Wyoming Nurse Practice act
- The PCA must have also completed the additional Community Home Health Aid training requirement under the Wyoming state board of Nursing
- All PCA's must meet the criminal background and central registry check requirement for the waiver program
- Supervision of the Certified Nursing Assistant must occur at least every sixty days, but may occur more frequene6tly in accordance with the home health agency policy
- Providers shall not function as a legal guardian, power of attorney, financial or legal representative on behalf of any waiver participant to whom they provide waiver service; or any waiver participant of the agency or entity that they are currently employed with

#### Provider Responsibilities

- It is the providers responsibility to work with the case manager to provide the need services on the participants plan of care

#### Service Definitions

- Personal Care Services include a range of assistance to enable waiver participants to accomplish task**s** that they would normally do for themselves if they did not have a disability. The services are provided in the home
- This assistance may take the form of hands-on assistance, cueing to prompt the participant to perform a task or supervision of the task to assure the safety of the participant
- The services vary depending on the identified needs form the LT101 assessment. The Case Manager and participant will develop what services the Personal Care Attendant will provide as identified by the LT101 assessment, as well as review care needs and requirements. These are documented on the Aid Personal Care Attendant Log. The completed Personal Care Attendant Log must be uploaded into the Electronic Medicaid Waiver System (EMWS), with a copy to the provider and participant
- Personal Care Tasks are performed in the participant's home:
    - Activities may include but are not limited to:
        - Appropriate and safe techniques in personal hygiene and grooming that include:
            - Dressing
            - Daily Grooming
            - Bathing and/or stand by assistance

- Teeth and oral hygiene
- Toileting and elimination
- Bowel or bladder care beyond routine toileting
- Safe transferring and ambulating
- Normal range and motion and positioning
- Nail and skin care

- Non Personal Care Services may include:
  - Changing bed linens
  - Assistance with preparation of meals including:
    - Grocery shopping
    - Medication Pick-up
    - Preparing, serving food, assistance with eating
      - Ensuring adequate nutrition and fluid intake
    - Meal clean-up (washing participant dishes, sorting leftovers etc.)
    - This does not include the cost of the meal themselves
  - Household Tasks that are incidental to the personal care or that are **essential to the health and welfare of the individual rather than to the individual's family.** This does not include chore services or heavy cleaning in the home or in areas of the residence which are not frequented by the participant
    - Household task may be completed only if personal care task are part of the Plan of Care
    - Household tasks include:
      - Light house cleaning
      - Laundry

- **Excluded services**
  - Personal Care services do not include se**rvice**s that maintain an entire household or family, or are not necessary to the health and welfare of the participant
  - Excluded services include but are not limited to the following:
    - Phone call reminders
    - Cleaning floors and furniture in areas that the participant does not access.
    - Laundering clothing or bedding the participant does not use
    - Shopping for groceries or household items the participant does not need for their health and nutritional needs
    - Providing babysitting and child supervision.
    - Friendly visiting or companionship
    - Maintaining pets
    - Providing home and outside maintenance, such as
      - Snow removal
      - Window washing
      - Lawn mowing
      - Woodcutting
      - Heavy lifting

**Transportation Costs**

- Transportation costs associated with the provision of personal care outside the participant's home **must be billed** separately and may not be included in the scope of personal care
- Qualified transportation costs **may** be billed separately under medical transportation under the State plan or non- medical transportation under the waiver

## Respite Care Attendant

### Qualifications

- A qualified Respite Care Attendant is an employee of a Home Health Agency licensed in Wyoming, who is:
    - Certified Nursing Assistant with current certification in good standing with the Wyoming State Board of Nursing
    - Under the supervision of a registered nurse as provided in accordance with the Wyoming Nurse Practice act
- The Respite Care Attendant must have also completed the additional Community Home Health Aid training requirement under the Wyoming state board of Nursing
- All Respite Care Attendant's must meet the criminal background and central registry check requirement for the waiver program
- Supervision of the Certified Nursing Assistant must occur at least every sixty days, but may occur more frequene6tly in accordance with the home health agency policy
- Providers shall not function as a legal guardian, power of attorney, financial or legal representative on behalf of any waiver participant to whom they provide waiver service; or any waiver participant of the agency or entity that they are currently employed with

### Provider Responsibilities

- It is the providers responsibility to work with the case manager to provide the need services on the participants plan of care

### Service Definitions

- Respite Care Services include a range of assistance to enable waiver participants to accomplish task**s** that they would normally do for themselves if they did not have a disability. The services are provided in the home
- This assistance may take the form of hands-on assistance, cueing to prompt the participant to perform a task or supervision of the task to assure the safety of the participant
- The services vary depending on the identified needs form the LT101 assessment. The Case Manager and participant will develop what services the Respite Care Attendant will provide as identified by the LT101 assessment, as well as review care needs and requirements. These are documented on the Respite Care Attendant Log. Respite Care Attendant Log must be uploaded into the Electronic Medicaid Waiver System (EMWS), with a copy to the provider and participant
- Respite Care is limited to:
    - Personal Care Tasks are performed in the participant's home:
        - Activities may include but are not limited to:
            - Appropriate and safe techniques in personal hygiene and grooming that include:
            - Dressing
            - Daily Grooming
            - Bathing and/or stand by assistance
            - Teeth and oral hygiene

        - Toileting and elimination
        - Bowel or bladder care beyond routine toileting
        - Safe transferring and ambulating
        - Normal range and motion and positioning
        - Nail and skin care

- Non Personal Care Services may include:
    - Changing bed linens
    - Assistance with preparation of meals including:
        - Grocery shopping
        - Medication Pick-up
        - Preparing, serving food, assistance with eating
            - Ensuring adequate nutrition and fluid intake
        - Meal clean-up (washing participant dishes, sorting leftovers etc.)
        - This does not include the cost of the meal themselves
    - Household Tasks that are incidental to the personal care or that are **essential to the health and welfare of the individual rather than to the individual's family.** This does not include chore services or heavy cleaning in the home or in areas of the residence which are not frequented by the participant
        - Household task may be completed only if personal care task are part of the Plan of Care
        - Household tasks include:
            - Light house cleaning
            - Laundry

- **Excluded services**
    - Respite Care services do not include se**rvice**s that maintain an entire household or family, or are not necessary to the health and welfare of the participant
    - Excluded services include but are not limited to the following:
        - Phone call reminders
        - Cleaning floors and furniture in areas that the participant does not access.
        - Laundering clothing or bedding the participant does not use
        - Shopping for groceries or household items the participant does not need for their health and nutritional needs
        - Providing babysitting and child supervision.
        - Friendly visiting or companionship
        - Maintaining pets
        - Providing home and outside maintenance, such as
            - Snow removal
            - Window washing
            - Lawn mowing
            - Woodcutting
            - Heavy lifting

**Transportation Costs**

- Transportation costs associated with the provision of personal care outside the participant's home **must be billed** separately and may not be included in the scope of personal care
- Qualified transportation costs **may** be billed separately under medical transportation under the State plan or non- medical transportation under the waiver

**Respite Care is limited to 30 days in a plan period (12 months).**

## Additional in Home Services - Participant Directed Option

### Direct Service Worker (DSW)

**Qualifications**

- Individual who is at least eighteen (18) years old, has met the skills, experience, and reference, and prior employment standard set by the employer
- Must meet the criminal background and central registry check requirement of the waiver program
- Must complete CPR & First Aid certification
    - Can be online – must also have "hands on" instruction by a nationally recognized course
        - Contact for information on where an when courses are being offered
            - American Heart Association at 1-877-242-4277
            - American Red Cross at 307-637-5242
- DSWs may be a family member if they are not:
    - Spouse
    - Legal Guardians
    - Power of Attorney (POA)
    - Power of Attorney for Health Care
    - Health Care Directive Designee
- Participants on any of the waiver programs receiving waiver services may not be the DSW
- Each participant is required to have one (1) primary direct service worker and one (1) back-up direct service worker in place in the event that the primary worker is unable to perform scheduled work
    - The employer (participant) must:
        - Maintain an employee file including:
            - The employment application
            - The I-9 background check information
            - Payroll withholding forms
            - Employee enrollment forms sent to the fiscal services management
        - Responsible for assuring each employee meets their employee standards and,
        - The standards of the waiver program
    - The Fiscal Services Management provider verifies:
        - All needed information is received and does not enroll the employee or generate payroll until all information is received
        - All documentation is provided by the employer to the Fiscal Services Management provider to support the request

**Service Definitions**

- Direct Service Worker duties include a range of assistance to enable waiver participants to accomplish task that they would normally do for themselves if they did not have a disability.

- The assistance may take the form of hands-on assistance, cueing or prompt the participant to perform a task or supervision of the task to assure the safety of the participant.

- The duties vary depending on the identified needs from the LT101 assessment. The Case Manager and participant will develop what duties the Direct Service Worker will provide as identified by the LT101 assessment, as well as review care needs and requirements. These are documented on the *Participant Profile* (PDO-3). The completed PDO-3 form must be uploaded into the Electronic Medicaid Waiver System (EMWS), and the original is returned to the participant.

  ***Two-thirds (2/3) or more* of the total direct service worker hours outlined on the "Plan of Care" must be utilized providing the Personal Care Task listed below.**

- Direct Service Worker services provide **direct** assistance with and may include the following: **Personal Care Tasks are performed in the participants home**
  - **Activities may include but are not limited to:**
    - Appropriate and safe techniques in personal hygiene and grooming that include
      - Dressing
      - Daily Grooming
      - Bathing and/or stand by assistance
      - Teeth and oral hygiene
      - Toileting and elimination
      - Bowel or bladder care beyond routine toileting
      - Safe transferring and ambulating
      - Normal range and motion and positioning
      - Nail and skin care

  - **Services may include:**
    - Changing bed linens
    - Assistance with preparation of meals including:
      - Grocery shopping or Medication pick-up
      - Preparing, serving food, assistance with eating
        - Ensuring adequate nutrition and fluid intake
      - Meal clean-up (i.e. washing participant dishes, storing leftovers)
        - This does not include the cost of the meal themselves
    - Household Tasks that are incidental to the personal care or that are **essential to the health and welfare of the individual rather than to the individual's family.** This does not include chore services or heavy cleaning in the home or in areas of the residency that are not frequented by the participant
      - Household task may be completed only if personal care task are part of the Plan of Care
      - Household tasks include:
        - Transport participant to non-medical activities
        - Light house cleaning
        - Laundry

**Hours provided doing Household Tasks (see above) *may not exceed one-third (1/3)* of the total Direct Service Worker (DSW) hours on the "plan of care".**

- **Excluded services**
  - Direct Service worker services do not include services that maintain an entire household or family, or are not necessary to the health and welfare of the participant
  - Excluded services include but are not limited to the following:
    - Phone call reminders
    - Cleaning floors and furniture in areas that the participant does not access.
    - Laundering clothing or bedding the participant does not use
    - Shopping for groceries or household items the participant does not need for their health and nutritional needs
    - Providing babysitting and child supervision.
    - Friendly visiting or companionship
    - Maintaining pets Providing home and outside maintenance, such as
      - Snow removal
      - Window washing
      - Lawn mowing
      - Woodcutting
      - Heavy lifting
      - Transportation cost associated with the provision of personal care outside the participant's home must be billed separately and may not be included in the scope of Direct Service Worker
      - Qualified transportation costs must be billed separately under medical transportation under the State plan or non- medical transportation under the waiver

**Hours provided doing Household Tasks (see above) *may not exceed one-third (1/3)* of the total Direct Service Worker (DSW) hours on the "plan of care".**

- **Wages/Hours**
  - Participant directed participants we the wage payment for the DSWs. The rage range is:
    - $10.00 – 12.00 per your
  - Participant directed participant can then use any savings for more DSW hours or provide a retention of some amount
  - The Direct Service Worker cannot exceed a total of 40 hours per week, per employer they provide services

## Fiscal Management

### Qualifications

### Fiscal Employer Agent

- Must apply for and be approved by the Internal Revenue Service (under IRS revenue Procedure 70-6 and Proposed Notice 2003-70) to act as an employer agent on behalf of individuals
- Providers shall not function as a legal guardian, power of attorney, financial or legal representative on behalf of any waiver participant to whom they provide waiver service; or any waiver participant of the agency or entity that employs them
- Providers must adhere all Federal, State and local laws and regulations concerning business operation and reporting
- Providers must follow an independent audit schedule and process

### Provider Responsibilities

- It is the providers responsibility to work with the case manager to provide the need services on the participants plan of care

### Service Definition

- Fiscal Management Services are only available to participants who meet the criteria for and choose the participant-direction option for personal care attendant waiver services. Fiscal management services include:
    - Providing assistance to established employer status and to produce payroll
    - Provide financial reporting an related functions on the participant's behalf as the employer of record shall include:
        - Provision, distribution, collection and processing of direct care timesheets and task documents approved by the participant
        - Establishment and maintenance of a record for each participant and each of their employees
        - Preparation and distribution of payroll using a predetermined schedule including:
            - Monthly summary reports provided to the Waiver program and to each participant which reflect the payroll and service utilization as defined by the program
            - Assurance that all W-2,1099 or wage and tax statements are provided in accordance with the federal, state and local laws and requirements
            - Documentation of the dates of services, type, scope and duration of services for which payroll is generated
        - Enrollment of new employers and new employees for established employers in accordance with applicable waiver standards
        - Operation of staffed call center that is available to resolve:
            - Participant inquires
            - Resolve payroll concerns
        - Provide support and feedback to enrolling employers or employees
        - Services shall only be reimbursed for the month enrollment of a new employer is completed

- Services shall only be reimbursed for each month in which payroll was generated on the employer's behalf for the employee(s)
- Provider shall prepare and distribute all management reports to the waiver Program Manager as requested

## Provider Duties

Case Managers are required to complete the provider duty sheet (CCW-6) to communicate the information that each provider needs to have in order to deliver the service.

Case Managers are required to send out provider duty forms to any provider of waiver services excluding ACES$. The form must contain the service requested, the amount of units to be delivered each month of the plan, the charge per unit, the participant information, and the Case Manager signature.

The agency providing the service must return a signed copy to the Case Manager to verify that they are intending to provide the service for the amount listed.

This is considered **the contract between the Case Manager and providers** to authorize services. The provider duty **is not** an authorization for payment. **Providers should not provide services until a prior authorization is received.**

## Plan of Care Requirements

Plans of care are confidential and should not be shared with other providers by the Case Manager. These forms contain protected health information.

Case Manager must submit all plans of care electronically in the Electronic Medicaid Waiver System (EMWS).
**The service plan must:**

- Reflect a setting chosen by the individual and integrated into community
- Reflect the individual's strengths and preferences
- Reflect clinical and support needs as identified through an assessment of functional need (LT101)
- Include individually identified goals and desired outcomes, and reflect the services and supports (paid and unpaid) that will assist the individual to achieve these goals
- Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed
- Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her.
    - Written in manner and language understandable to the individual, consistent with 42 CFR §435.905(b)
- Identify the individual and/or entity responsible for monitoring the plan.
- Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.
- Be distributed to the individual and other people involved in the plan
- Include those services that the individual elects to participant-direct
- Prevent the provision of unnecessary or inappropriate services and supports
- Document that any modification to the plan of care, must be supported by a specific assessed need and justified in the **person-centered service plan**. The following requirements must be documented in the person-centered service plan:
    - Identify a specific and individualized assessed need
    - Document the positive interventions and supports used prior to any modifications to the person-centered service plan
    - Document less intrusive methods of meeting the need that have been tried but did not work.
    - Include a clear description of the condition that is directly proportionate to the specific assessed need.
    - Include a regular collection and review of data to measure the ongoing effectiveness of the modification.
    - Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
    - Include informed consent of the individual.
    - Include an assurance that interventions and supports will cause no harm to the individual.

## Submitting Initial Plan of Care

When Submitting an Initial Plan of Care, notification is sent to the Case Manager through a task in the Electronic Medicaid Waiver System (EMWS). Please refer to the Electronic Medicaid Waiver System Manual for more detailed information regarding this process on page 59.

- Cannot be dated prior to the LT101 or funding opportunity date
- If the Plan of Care is rolled back to you check the notes section prior to resubmitting

## Submitting a Modification

After a new or renewal Plan of care has been approved by the Home Care Services unit and prior authorizations have been received from the Medicaid Fiscal Agent-Xerox, modifications to the Plan of Care may be performed. Please refer to the Electronic Medicaid Waiver System Manual page 129 for more detailed information regarding this process.

- Place a note in the comments as to what the modification is. Be specific of what services is being changed or added
- If the Modification is rolled back to you check the notes section prior to resubmitting

## Submitting a Renewal

Assessment of the level of care of all participants of waiver services will be completed every twelve (12) months. Reassessments will be performed on-site by the Public Health Nurse, using form LT101 in a manner identical to the initial assessment process. When a participant becomes due to renew their Plan of Care, notification is sent to the Case Manager in the Electronic Medicaid Waiver System. Please refer to the Electronic Medicaid Waiver System Manual for more detailed information regarding this process.

Case Manager/ must submit Plans of Care no later than the 15th of the month that the participant's services will be ending. Monthly visits for those participants who require a renewal should be conducted in the beginning of the month to ensure all renewal paperwork is in place no later than the 15th of that month.

**If Plans are not submitted by the last day of the month that the plan expires, the Case Manager will be deducted units based on the lateness (minus one (1) unit for every day after the 1st of the month the plan is not submitted).**

Deductions will not be assessed if the LT101, Medicaid Financial eligibility was delayed or circumstances beyond the Case Manager control.

# Plans Over $1800.00

**Plans over $1800.00 for the in home services must be approved by the Home Care Services Program Manager**

A Case Manager must be able to justify the need for a plan over $1800.00. To request approval by the program manager, the Case Manager must enter the following information into a note in the Electronic Medicaid Waiver System (EMWS). The note must include:

- Previous plan high (not necessary for new plans)
- New plan high, if this is a renewal or modification, document if there is a plan change or not
- Reason for plan high (services are based upon need, not necessarily want)
- History of participant (examples: quadriplegic, has broken arm, decline in health, LT101 has increased, etc.)
- Any further information that will assist the Program Manager in making the determination

## Monthly Visit Requirements

Case Managers are required to complete a face-to-face visit with each participant, every month in their home or at the Assisted Living Facility. Case Managers are **required** to contact the Home Care Services Program Manager for **prior approval** if they are unable, for any reason, to complete the face-to-face visit requirement.

During the monthly visit, the Case Manager must complete a Monthly Evaluation form (CCW-7) and have the participant sign the form.

Case Managers shall document the following information on the monthly evaluation form during each visit:

- Service appropriateness
- Service satisfaction
- Reminder of Adult Protection Services through the Department of Family Services
- Other Medicaid referrals needed
- Other Medicaid referrals made
- Other non-Medicaid services needed
- Other non-Medicaid service referral made
- Safety planning
- Incident or critical event
- Changes in plan needed
- Follow up comments

The purpose of the visit is to evaluate the services on the plan, identify any needed changes and to support the participant.

**NOTE:** If the Case Manager is unable to complete a face-to-face visit with a participant in their home or at the Assisted Living Facility in any month, they **cannot** bill for any case management provided in the month the visit was not completed.

**Case Managers will receive a corrective action plan for failure to comply with the monthly visit requirements.**

## Discharging a Participant

Participants are discharged when:

- They fail to re-qualify on the LT101 assessment.
- Loss of financial eligibility
- Non-compliance
- No current plan in place
- Admission to nursing home, **be specific to date and name of nursing home**
- Other institutional admission, **be specific to date and name of institution**
- Participant choice
- Moves to another waiver
- Moved out of state
- Participant death, **list cause and place of death in comments**
- Not using waiver services for 30 days

If a participant fails to qualify on the LT101, they may request reconsideration or an administrative hearing in writing, within thirty (30) days of receiving a Denial. Only the **participant or their family may request reconsideration for a participant who does not qualify**.

Any participant that has been discharged and is interested in returning to the waiver must begin the application/eligibility process again unless the participant was discharged for a nursing home admission.

Discharges are completed in the Electronic Medicaid Waiver System (EMWS). Please refer to the Electronic Medicaid Waiver System Manual page 138 for more detailed information regarding this process.

All Community Choices Home & Community Based Waiver Services participants who have been admitted to a nursing home shall be discharged from the waiver when they have been in the nursing home for 30 days. Failure to discharge the participant from the waiver after 30 days causes problems with claims payments and proper implementation of the participant contribution to the nursing home. If you know a participant's nursing home stay will exceed 30 days, discharge them right away. If it looks as if the stay may be less than 30 days, you may wait until the end of the 30 days to discharge them.

If a nursing home stay is less than 30 days and the participant was not discharged, a new plan is not required. A new plan of care is required if a participant was discharged from the waiver while in the nursing home. A waiver participant, who has been discharged while in the nursing home, will keep his/her slot and may be reinstated on the waiver with the same paperwork as a funding opportunity when they return home.

A discharge for eligibility reasons, either LT101 or financial, must be completed as early in the month as possible.

The participant's actual waiver services and the Medicaid benefit will continue until the end of the month if due to financial, or LT101.

Case Managers are required to help the participant identifying other services in their community.

When discharging a participant from services, the Case Manager are required to send notice to all providers with the effective date of services canceled by sending the Provider Duty Sheet (CCW-6). This will prevent the provider from providing and billing for unentitled services.

- Failure to send the provider duty sheet timely which results in the provider continuing to provide the services, the Case Manager agency will be responsible to reimburse the provider for the services.

## Termination of a Participants Services

To provide assurance that both the participant and the provider have a safe environment, a participant can be terminated from services under the following conditions:

- Unsafe Situation
  - When there is an unsafe situation (e.g., verbal or physical aggression, or home conditions that risk illness or injury) for the worker, the worker will report this to his/her supervisor immediately.
  - The supervisor will report this to the Case Manager immediately. This will be documented in writing
  - The Case Manager will confront the participant detailing the unsafe situation in writing, within 5 days, providing a copy to the worker's supervisor. The participant will be advised that the unsafe situation must be rectified and that failure to do so will result in termination of services. A copy of the documentation will be sent to the provider of the service and Division of Health Financing (DHCF) If the situation continues, or other similar situations occur, the worker will again report this to his/her supervisor immediately
  - The supervisor will report to the Case Manager that the situation continues
  - The Case Manager will write the participant informing them that their service is terminated. The letter will include the dates of the two (2) incidents, the reason services are being terminated, and the participant's right to reconsideration. A copy of the letter will be sent to the provider of the services and Division of Healthcare Financing (DHCF)
  - If the situation warrants, the Case Manager and/or supervisor will refer the case to Adult Protection Services or the local law enforcement agency
  - Noncompliance is defined as failure to comply with the plan of care or medical regime that threatens the health and well-being of the participant
  - When the provider feels the participant has been noncompliant with his/her plan of care or the home situation is unsafe for the participant, the worker will notify his/her supervisor immediately
  - The supervisor and case manager will visit the participant in his/her home to assess the situation and discuss the situation with the participant. The participant will be advised that the unsafe situation must be rectified and failure to do so will result in termination of services. If the situation is an emergency, the proper agency will be notified and documentation will be sent. If the situation is not determined to be an emergency, the meeting and situation will be documented in writing and followed up within ten (10) business days. A copy will be sent to the provider of service and the participant
  - If the situation does not improve within three (3) to five (5) days of the meeting, the worker will again notify his/her supervisor immediately
  - The supervisor will report to the Case Manager that the situation continues.
  - The Case Manager will inform the participant in writing of the unsafe situation and explain that services will be terminated. Referrals will be made to the proper agencies. The Case Manager will document the meeting and action taken.

- The Case Manager will write the participant informing them that the service is terminated. The letter will include the reason services are being terminated. A copy of the Notice of Termination must be uploaded in the Electronic Medicaid Waiver System. Please refer to the Electronic Medicaid Waiver System Manual for more detailed information regarding this process.
- Loss of contact (unable to contact within 30 days) is an immediate termination.

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## Loss of Eligibility

If a participant loses Medicaid Eligibility, the Case Manager is notified through the Electronic Medicaid Waiver System (EMWS). A Case Manager/ will complete closure in EMWS. Please refer to the Electronic Medicaid Waiver System Manual for more detailed information regarding this process.

The Case Manager must also notify all service providers with the effective date that the participant will no longer be receiving services by sending a Provider Duty Sheet (CCW-6).

If the Case Manager fails to notify the services provider and the service provider continues to provide services it is the Case Manager Agencies responsibility to reimburse the Service Provider.

The Case Manager is required to assist the participant in identifying and procuring other community services.

## Service Verification Requirements

The Electronic Medicaid Waiver System (EMWS) maintains proof of service delivery. Case Managers are responsible for certifying that services are delivered by confirming in EMWS, with the participant during the monthly visit and during the Quarterly Care Conference.

## Documentation

Consistent and complete documentation in the participant's record is an essential component of providing quality care and services. The Case Manager must ensure that participant records are stored in a secure manner.

Case Managers are required to document any pertinent information relevant to the current or proposed plan of care. This may include but is not limited to:

- Response to services in his/her waiver plan
- Identified needs or utilization of non-waiver services
- Measurement of outcomes
- Participant satisfaction
- Change in health status
- Nursing visits and observations
- Critical incidents

Each monthly visit must be documented to support the provider's claims for delivery of case management services. Documentation must be kept confidential.

## Changing Providers

A Participant transferring to another agency or provider is not a discharge.

If your agency or a provider can no longer serve a participant or the participant chooses to change to another agency or provider, it is necessary to allow the participant the time to find another agency or provider and to provide them with contact information for all the other providers in their area.

If they fail to establish services with another agency and go without waiver services for thirty (30) days, they must be discharged from the waiver.

## Services Rates

# WYOMING

### COMMUNITY CHOICES WAIVER RATE SCHEDULE

| | |
|---|---|
| T2024 | Case Management Services Agency Option: $8.81 per day, per participant. |
| T1019 | Personal Care Attendant Services: $28.24 per hour, $7.06 per 15 minute unit. |
| S5150 | Respite Care Services, in home: $25.12 per hour, $6.28 per 15 minute unit. |
| S5170 | Home Delivered Meals: Limited to $5.25 per meal, Not to exceed two meals per day. |
| S5160 | Lifeline Installation: $70 per installation, Not to exceed one installation per lifetime. |
| S5161 | Lifeline Monthly Service Charge: Limited to $45 per month. |
| T2003 | Non-Medical Transportation: Limited to $5.40 per one way trip, limited to $80.00 per calendar month. ($80.00 = 14 one way trips) |
| S5100 | Adult Day Care: Limited to $8.40 per hour, $2.10 per 15 minute unit. |
| S9123 | Skilled Nursing: $66.61 per hour. |

**Participant-Directed Services:**

| | |
|---|---|
| T2024 TF | Case Management Services: $6.00 per day, per participant |
| T2041 | Direct Service Worker (DSW) Assistant: $10.00 - $12.00 per hour (participant choice) |
| T2040 | Fiscal Management: Unit Cost $80.00 |

Total aggregate services may not to exceed $1800.00 per calendar month per participant without verbal permission

### ASSISTED LIVING FACILITY WAIVER RATE SCHEDULE

| | |
|---|---|
| T2024 | Case Management: $4.00 per day, per participant |
| T2031 | ALF Level I: $42.00 per day |
| T2031 TF | ALF Level II: $50.93 per day |
| T2031 TG | ALF Level III $61.25 per day |

## Billing

Case Managers must ensure that the plans of care that begin in the middle of the month reflect only the days of services the participant receives, except for Personal Emergency Response System (PERS).

The unit size for Personal Care, Respite Care and Adult Day Care is fifteen (15) minutes. Services provided in, less fifteen (15) minute increments **cannot** be rounded up.

Travel time to and from the participants home is not reimbursable. .

Services cannot be billed during a period when the participant is:

- In a nursing home
- In a hospital
- Out of state
- Unavailable to receive services
- After the participants date of death

The following cannot be billed on the day of admission from hospital or nursing home:

- Case Management

The following can be billed on the day of discharge from hospital or nursing home:

- Case Management

The following can be billed on both the day of admission and day of discharge from hospital and nursing home:

- Personal Care
- Direct Service Worker (DSW)
- Respite Care
- Home Delivered Meals
- Personal Emergency Response System (PERS)
- Non-Medical Transportation
- Adult Day Care
- Skilled Nursing
- Assisted Living Level of Care

If a Case Manager does not complete a face-to-face visit with a participant in their home or in the Assisted Living Facility during any given month, the agency cannot bill for any case management services in that month.

- The Case Manager must have the participants (POA, or Authorized Representative) signature on the monthly evaluation form to verify the visit was completed.

Participant assessment activities, that occur prior to the establishment of eligibility for waiver services and an approved plan of care, will not be billed as a medical claim.

Providers must submit all claims electronically to Medicaid Fiscal Agency-Xerox.

## Participant Forms

Participants must receive either the original or a copy of the:

- Person-Centered Plan of Care
- Participant Choice of Services (CCW-1)
- Participant Rights and Responsibilities (CCW-3)
- Monthly Evaluation (CCW-7)
- Participant Agreement (PDO-2)
- Participant Profile (PDO- 3)

**A Participant should not be given a copy of the LT101.**

## Adult Abuse and Neglect

Case Managers are required to address adult protection issues with each of their participants and document the initial communication and the follow up conversations on the monthly visit forms

**All providers who** have a reasonable suspicion or knowledge that an adult is being abused, abandoned, exploited, neglected, intimidated or is self-neglecting is required to make a report to the Department of Family Services or law enforcement. **This must be documented,** copy of the documentation should be provided to the Home Care Services Unit. This must be reported as a Critical Incident.

## Fraud Reporting

All providers including Case Managers are required to report any suspected fraud. **This must be documented.**

- Report to:
  - Fraud Hotline: 1-855-845-2563
  - Fraud Website: http://stopmedicaidfraud.wyo.gov

## Waiver Forms

Forms are available on the Home Care Services Web site at http://www.health.wyo.gov/healthcarefin/medicaid/homecareservices.html

**Participant Choice of Service (CCW-1) –** A participant choice of service verifies the participant's request to receive care in the community instead of an institution. It also indicates that a participant has participated in and agrees with their plan of care

**Participant Rights and Responsibilities (CCW-3) –** Details the participant's rights and responsibilities when participating in the waiver program. This document includes items such as appeal rights, right to choice, to be informed about the care to be furnished, the responsibility to inform Case Manager of changes, responsibility to be a cooperative and active participant in the development of their plan of care, etc.

**Provider Duties (CCW-6) –** The contract between the Case Manager and the provider that details the services being provided, duration, quantity, and allowable charges. This is an agreement to provide services, not an authorization for payment

**Monthly Evaluation (CCW-7) –** Completed by the Case Manager each month during the face-to-face visit conducted with the participant. It documents items such as satisfaction of services, other identified needs, changes in participant's condition, and any change in plan needed

**Termination Notification (CCW-10) –** This notification details a participant's termination from the waiver program. It is only completed if it affects a participant's eligibility

**Change in Case Management Agency (CCW11) –** Documents when a participant has chosen to change agencies

**Community Choices Waiver Provider Application (CCW-12) - Application** to become a provider. To be completed by the requesting Agency

**Community Choices Waiver Case Manager/Delegate Request Form (CCW-13) –** Request for new Case Manager/Delegate. To be completed by the requesting Agency

**Participant Choice of Provider (CCW-14) –** Allows the participant to choose providers of waiver services available in his/her community. The participant will sign indicating the choices he/she has made

**Participant Agreement (PDO-2) –** Outlines the expectations and responsibilities the participant agrees to perform and accept

**Participant Profile (PDO-3) –** Indicates tasks the participant needs help completing, the amount of help needed for each task, the approximate amount of time needed to complete the task and who will provide the help

**Request for Review of Authorized Representative Status (PDO-5) –** Request to review of an Authorized Representative for participants who do not successfully meet the "*Determination of Capacity*". The Authorized Representative must be the person named in the Advance Health Care Directive and/Power of Attorney for Health Care

**Authorized Representative Review (PDO-6) –** Approval or Denial of the "*Request for Review of Authorized Representative"* by the Home Services Program