

Wyoming Department of Health

Division of Healthcare Financing

Community



Choices

Policy & Procedures

Provider Instructions



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DIVISION OF HEALTHCARE FINANCING OVERVIEW

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

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

Home Care Services Unit

The Home Care Services Unit (HCSU) oversees and administers the Home and Community Based Services (HCBS), Community Choices Waiver (CCW) for the DHCF.

Service Providers and Case Managers can be subject to a corrective action plan for failure to comply with these policies and procedures.

COMMUNITY CHOICES WAIVER (CCW) PROGRAM **OVERVIEW**

❖ Federal Government Waiver Program

Definition:

The Medicaid Home and Community-Based Services (HCBS) Community Choices Waiver (CCW) program is authorized in 1915(c) of the Social Security Act. The program allows a state to provide supports and services to individuals in their home or community setting, rather than in an institutional setting. Each state has sufficient discretion to develop a waiver program that addresses the needs of the state's target population, is cost-effective, and involves a variety of service delivery methods including participant-directed services.

The CCW Program acts as a supplement to assistance that is available to participants through the Medicaid State Plan and other federal, state, and local public programs. This program encourages natural supports provided by families and communities.

Wyoming has chosen to provide services under the Division of Healthcare Financing, Home Care Services Unit (HCSU) for the CCW Program. This waiver was developed to offer individuals who require nursing home level-of-care an option to remain in the community.

Determination of which services to provide for each participant depends on the availability of a provider of that service in the participant's geographic area, and the outcome of the LT101 functional assessment.

A person-centered team will determine which services are appropriate for the Person-Centered Plan of Care. This team consists of a Case Manager, the participant, and any other essential individuals identified by the participant or the Case Manager.

WHO IS ELIGIBLE FOR THE COMMUNITY CHOICES WAIVER (CCW) WAIVER?

Applicants must be 19 years of age or older and must meet:

- Nursing home level-of-care, as determined by the LT101 functional assessment.
 - ◆ The LT101 functional assessment provides a comprehensive method of determining eligibility based on functional needs for Medicaid long term care services. This determines whether an applicant or participant meets the nursing facility level of care requirements.
 - ◆ LT101 functional assessments are completed by specially trained public health nurses in each county.
- Financial eligibility as 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 assistance in the past, you may now.
- Disability requirements, if you are under age 65

If choosing the **Participant-Directed Option**, applicants must demonstrate that they are capable of directing their own care. Determining capability to direct one's own care is not the same as a determination of competency. Only a court-of-law can determine the decision-making capacity of an individual.

ELIGIBILITY PROCESS FOR PARTICIPANTS

Prospective Community Choices Waiver (CCW) participants can initiate the eligibility process by requesting an application from the Division of Healthcare Financing, Long Term Care Unit at 1-855-203-2936. Applications may also be completed via telephone at this number.

❖ THE APPLICATION PROCESS:

- Completion of the Medicaid application, it is submitted by the applicant to the Medicaid Long Term Care Financial Eligibility Unit, along with any necessary supporting documentation.
- The Medicaid Long Term Care Financial Eligibility Unit will review the application, determine financial eligibility, and enter the determination into the Electronic Medicaid Waiver System (EMWS) and a task will be sent to the case manager and HCSU waiver program notifying them of the determination
- Upon receipt of the applicant's information, the HCSU will mail an informational packet to the applicant that includes:
 - ◆ A list of case management agencies in the individual's area
 - ◆ A fact sheet about the program
 - ◆ Case Management Agency Choice Form
 - ◆ Self-addressed return envelope
- The completed Case Management Agency Choice Form is returned, HCSU staff will enter all necessary information into the EMWS to begin the LT101 functional assessment referral process
- When a request for an **LT101 functional assessment** is received, it is then referred to the public health office in the applicant's county. The Public Health nurse has 7 days to perform and enter the assessment for eligibility determination. Upon notification of the approved LT101 functional assessment, the case manager prepares an informal plan-of-care using participant input and the assessment. It is the Case Manager's responsibility to:
 - ◆ Offer the applicant a choice of service settings through the Participant Choice of Service Form (CCW-1)
 - ◆ Complete the Participant Rights and Responsibilities Form (CCW-3)
 - ◆ Discuss advance directive and/or power of attorney for healthcare options with the applicant
 - ◆ Document the date this discussion took place in the EMWS (notes section)
 - ◆ Upload these forms to the EMWS
- This initiates a task to the CCW program to review a "funding opportunity"
- When a funding opportunity becomes available (after the Case Manager has submitted documentation) the EMWS generates the following tasks: Confirm Update Demographics

The case manager must contact the applicant and confirm their demographics and submit a Person-Centered plan-of-care into the EMWS for approval by the waiver program.

- ▶ If the applicant is not ready to receive waiver services (e.g.: waiting for an open bed at their chosen assisted living facility, in a transition from an institution, etc.), the case manager will select the option in the EMWS to place the individual on the “pending status” list.
 - ◆ If a participant-directing is in the process of hiring a direct service worker, the participant can go on agency option during the transition.
- ▶ If a participant is in a nursing facility without a discharge plan, they should not be moved back to the “pending status” list. They should be closed out of the waiver until a discharge plan has been put in place.
- ◆ The Medicaid Financial Eligibility Unit must verify the applicant’s financial eligibility.

❖ EMWS PENDING STATUS LIST:

The pending status list is for applicants who are not ready to receive waiver services. Applicant names are added to the list based on the date and time the case manager completes the request to move the applicant to the pending status list.

The case manager will receive notification in EMWS of the applicant’s pending status every 90 days from the date the applicant was moved to the pending status list. The case manager can request that the applicant move forward from the list when they are ready to start services or request they go back to the pending status list

The case manager can request that an individual be removed from the pending status list at any time that the participant is ready to move forward.

SERVICES AVAILABLE THROUGH THIS WAIVER

Services in an Assisted Living Facility (ALF)

- Case Management
- ALF Level I
- ALF Level II
- ALF Level III

In-Home Services

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

Agency Provided In-Home Services

- Personal Care Attendant
- Respite Care

Participant-Directed In-Home Services

- Direct Service Worker
- Fiscal Management Services

CASE MANAGEMENT

❖ CASE MANAGEMENT AGENCY

Definition:

Case management agencies for the Community Choices Waiver (CCW) Program that employ case managers who identify participants' specific needs, and coordinate, monitor, and locate the social and medical services required to meet those needs.

Qualifications:

Case Management Agencies 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 licensed by the Wyoming Department of Health, Office of Healthcare Licensing and Survey.

All agencies must:

- Be approved by the CCW Program.
- Obtain and maintain a National Provider Identifier (NPI) number for case management services through the Medicaid enrollment process

Conflict-of-Interest Requirements:

Approved agencies must meet the following conflict-of-interest requirements:

- Neither the case management agency, nor any managing employee may own, operate, be employed by, have a financial interest in, or financial relationship with any other person or entity providing services on the participant's 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 a participant who is already receiving other waiver services through the agency, including participant directed services.
- If a case management agency's owners, officers, or managing employees are related by blood or marriage to a managing employee, owner, or officer of a participant's waiver services provider, the case management agency may not serve that participant.

- Employees of guardianship agencies may not provide case management to participants who are receiving services from that guardianship agency

Required documentation for becoming a case management agency:

- Obtain a National Provider Identifier (NPI)
<https://npiregistry.cms.hhs.gov/>
- Complete and submit the Wyoming Medicaid Provider Participation Agreement
<https://wyequalitycare.acs-inc.com/wy/general/providerEnrollmentHome.do>.
- Complete the Community Choices Waiver Provider Application (CCW-12)
- Receive approval or denial from the Department of Healthcare Financing, Home Care Services, Program Manager or designee

Documentation will be reviewed and evaluated by the Division to determine if requirements have been met.

Responsibilities:

An agency approved to provide case management services shall:

- Require that each case manager meets the criminal background and central registry check requirement.
- Have policies and procedures in place for backup case management of each primary case manager's caseload.
 - Meet with designated backup personnel to review participant cases on a quarterly basis and maintain documentation of the review in the case notes.
- Require that each case manager initially and annually submit proof of competency by providing documents to verify successful completion of Division-approved case management training.
- Document in the notes section of EMWS that the Agency and case managers have no conflict of interest with the participant or participant's family.

Case management agencies shall not:

- Employ case managers who are related to the participant, the participant's guardian or legal representatives served by the agency. This includes sole proprietors.
- Be authorized by any person or agency to make financial or health-related decisions on behalf of the participant receiving services from that agency.
- Employ case managers who live in the same residence as the participant to whom they provide case management services. This includes sole proprietors.
- Employ case managers who live in the same residence as any provider on a participant's plan-of-care to which they provide case management services.

- Be an approved provider or employee hired through participant directed services.

Case Management Agency Changes:

If a participant elects to transfer from one case management agency to another, a Change in Case Management Agency form (CCW-11) must be completed by the new case management agency.. This must be submitted to the CCW Program and a copy must be provided to the previous case manager within five (5) working days of the change. The CCW Program will notify both case managers by email when the case has been transferred in EMWS.

❖ CASE MANAGER

Definition:

A CCW Case Manager provides services that assist individuals who are eligible for waiver services to gain access to needed waiver and other State Plan services as well as other needed medical, social, and other services regardless of the funding source.

Qualifications:

A Case Manager must:

- Be employed by an approved Case Management Agency
- Meet the criminal background and central registry check requirement for the waiver program
- Maintain compliance with Health Insurance Portability and Accountability Act (HIPAA) of 1996, Pub.L.No.104-191, to include all implemented regulations and all amendments
- Have a designated backup(s) per their Case Management Agency's policies and procedures for each case management case within their caseload.
 - Meet with backup(s) quarterly to review all participant cases
 - Maintain documentation of all backup reviews in the participant's case notes.
- Successfully complete the Division approved case management training prior to providing any case management services
- *Have one (1) of the following:*
 - ◆ An Associate's degree from an accredited college in one of the human services fields listed below and four (4) years of work experience as a case manager as approved by the Division.
 - ◆ A Bachelor's degree from an accredited college or university in one of the human services fields listed below and one (1) year work experience as a case manager as approved by the Division.
 - ◆ 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

Exceptions:

- A case manager employed by an agency or certified by the Division prior to July 1, 2016* may provide case management services, without meeting the above criteria, provided the case manager:
 - ◆ Has a high school diploma or GED

- ◆ Has six (6) years of work experience as a case manager on any 1915-C waiver
- 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 provided the case manager:
 - ◆ Has a high school diploma or GED
 - ◆ Has six (6) years of work experience as a case manager on any 1915-C waiver
 - ◆ Maintains full certification with WyHS and
 - ◆ Is in good standing with the WyHS

**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 must obtain the additional education and/or work experience by June 30, 2019. Case managers who fail to obtain the required education or work experience shall be terminated from providing case management services under CCW Program by the Division.*

Required documentation for becoming Case Manager:

The approved Case Management Agency must submit the following documentation to the Division of Healthcare Financing HCSU for each Case Manager:

- Waiver Case Manage/Delegate Request form (CCW-13)
- Current resume
- Copy of Diploma
- 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
 - Any other required licenses

Documentation will be reviewed and evaluated by the Division to determine if requirements have been met. The Case Manager & agency will receive an approval or denial from the Department of Healthcare Financing, Home Case Services Program Manager or designee.

Responsibilities:

A Case Manager must be able to:

- Ensure appropriate services are authorized and no unnecessary services are provided for participants who have the ability to complete tasks by themselves or have someone in the home who can perform those tasks
- Ensure each participant has been educated about:
 - Available case management agencies
 - Available direct service providers
 - The Medicaid Eligibility Long Term Care Unit for financial eligibility
 - Adult Protection Services through the Department of Family Services
- Ensure that the participant is offered:
 - Choice of community or institutional care
 - Choice of providers in the community
 - Choice to change providers at their discretion
- Develop a person-centered plan-of-care that reflects the individual's strengths, preferences, and minimizes risk factors
- Develop and implement a person-centered plan of-care for each participant, that will include at a minimum:
 - A statement of need
 - Individually identified, measurable objectives that can be met with services provided (both waiver and non-waiver services)
 - Specific services to be provided to meet the identified objectives, including frequency (units and duration), eligible providers, and estimation of cost for each service.
 - Approval of participant directed back-up plans and monthly review
- Identify and document formal and informal resources being utilized to meet the needs of the participant, as well as resources available in the community to continue to meet the participant's needs as identified in the person-centered plan-of-care
- Advocate for services to meet the needs of the participant
- Organize and facilitate quarterly care conference meetings
 - The purpose of a care conference is to enable the participant. . . CMS PCP language
 - A care conference shall include a review of the service plan and goals to monitor progress, identify any unmet needs, or necessary changes to the service plan and/or goals.
 - Care conference attendees shall include, at minimum, the participant and the case manager. Other attendees may include . . .
- Request Waiver Program Manager approval for plan-of-care costs above the set maximum (1,800.00/month)
- Maintain individual participant records and ensure complete documentation is appropriately uploaded to the EMWS. This shall include, but is not limited to:

- 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)
- Participant Agreement (PDO-2) (Participant-Directed option only)
- Participant Profile (PDO-3) (Participant-Directed option only)
- Participant Capability (PDO-4) (Participant-Directed option only)
- Participant Back-up Plan (Participant-Directed option only)
- Physician's Orders (*Required for Skilled Nursing*) *must be completed by a physician*
 - ◆ Can be on a prescription pad or Form CMS-485 "Home Health Certification".
 - ◆ Orders must include:
 - ▶ The reason for skilled nursing
 - ▶ The duration of skilled nursing (number of months up to one year)
 - ▶ The frequency of skilled nursing visits (number per week/month)
 - ▶ Disclaimer to indicate the orders are specifically for the CCW only
 - ▶ Physician's signature
 - ▶ Must be uploaded to the EMWS before skilled nursing can be added to the plan.
 - ◆ Services provided can only happen while the order is valid
 - ◆ New orders must be obtained and provided to the case manager to upload in EMWS for any modifications to the plan
 - ◆ New orders must be obtained and uploaded to continue services prior to expiration of the previous orders
- Clinical notes
- 30-Day termination letter
- Complaint/tracking response
- Care conference notes
- Nurse supervision notes
- Personal care notes
- Advance Directive and/or Durable Power of Attorney for health care information (if applicable)
- Durable Power of Attorney (if applicable)
- Guardianship papers (if applicable)
- Release of information documentation (if applicable)
- Submit any additional required documentation to the CCW Program for approval upon request
- Complete tasks in the EMWS in a timely fashion:
- Updating demographics - ten (10) working days or less

- Acknowledgement - five (5) working days or less
- Case manager closure review - five (5) working days or less
- Selecting case manager - five (5) working days or less
- Submitting plan-of-care - forty-five (45) working days or less
- Case management documents - thirty (30) working days or less
- Indicating a change in case management – five (5) working days or less
- Each case management agency shall designate backup Case Manager(s) for each case within their caseload and maintain a backup plan to ensure continuity of care.
- Monitor the provision of services monthly, with additional visits as required to ensure quality of care as well as the safety and health of the participant
 - Verify and document during these monthly meetings that person centered plan-of-care services are being provided as indicated
- Monitor the appropriateness of services provided based on:
 - Availability in the participant's geographic area
 - Determination by the participant's person-centered team (the case manager, the participant, and any other essential individuals)
 - The LT101 functional assessment
 - Activities required to allow them to stay in their home
- Monitor service costs to ensure cost-effectiveness is maintained
- Update participant demographic changes within the EMWS (i.e.: change of address, phone number, etc.)
- Complete modifications to the person centered plan-of-care in a timely manner
- Re-assess the participant at appropriate intervals to determine if level of functioning has changed and if the participant requires additional assistance, medical, or social services, or possible Nursing Home Placement
- Assess the physical, environmental, psychological, and socioeconomic status of a participant
- Assess participant eligibility under various third-party programs
- Provide interdisciplinary and inter- and intra-agency coordination
- Supervise resource allocation
- Ensure services are delivered
- Oversee provider compliance with state standards and certification requirements
- Monitor cost containment elements in the person-centered plan of care
- Support, train, and guide the participant in becoming a successful employer if participant-directed option is chosen
- Help discharged participants identify other available services in their communities. (see additional information in the DISCHARGING A PARTICIPANT FROM THE CCW PROGRAM section (page number?))

Case Managers must not:

- Function as legal guardian, power of attorney, financial or legal representative on behalf of any:
 - Participant to whom they provide waiver service(s)
 - Waiver participant of the agency by whom they are currently employed
 - Be employed to provide services to elderly, disabled, and/or blind participants who at any time left employment because of a conviction of abuse or neglect

Case Manager Changes:

If a participant elects to change from one case manager to another, the original case manager will serve as “Case Manager of Record” and remain responsible for the participant until the change is reflected in the EMWS and both case managers have been notified of the change by the CCW program (via secure email).

Monthly Visit Requirements:

Case managers are required to complete at least one face-to-face visit with each participant, every month in their home or at the Assisted Living Facility. During this monthly visit, the case manager must complete the Monthly Evaluation Form (CCW-7) and have the participant sign the form. The purpose of the visit is to evaluate the services included in the person centered plan-of-care, identify any needed changes, assess if the environment is safe and appropriate and to support the participant.

The following information shall be discussed and documented on the monthly evaluation form during each visit:

- Appropriateness of waiver services being provided (Service Verification)
- Participant satisfaction with services received
- Depression Screening and Visit Outcomes
- Review Personal Care Notes / DSW Logs
- Incident(s) or critical event(s) and safety planning
- Verify PERS unit is set-up and functioning properly
- Reminder to participant of Adult Protection Services (APS) available through the Department of Family Services (DFS)
- Other Medicaid and/or non-Medicaid services needed / referral(s) made
- Changes to the person centered plan-of-care
- Follow-up comments

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 are required to contact the Home Care Services Program Manager for prior approval if they are unable to, for any reason, complete the face-to-face visit requirement.

Participants Forms:

Case managers must provide participants with the following documents (original or copy):

- *Person Centered plan-of-care*
- *Participant Choice of Services (CCW-1)*
- *Participant Rights and Responsibilities (CCW-3)*
- *Participant Agreement (PDO-2)*
- *Participant Profile (PDO- 3)*

Case managers shall provide any additional case documentation to the participant upon request.

If the participant decides to choose the participant-directed option, additional forms are provided to support documentation of services received/provided and employer status. These forms will be provided by the case manager and the FMS provider.

Participants should not be given a copy of their LT101 functional assessment.

Maintaining Documentation:

Consistent and complete documentation in the participant's record is an essential component of providing quality care and services. It is the case manager's responsibility to ensure that appropriate documentation is maintained in the EMWS and participant records are stored in a secure manner.

Case managers are required to document any pertinent information relevant to the current or proposed person centered plan-of-care including:

- Participant 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
- Other pertinent information as identified

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

Service Verification Requirements:

The EMWS maintains proof of service delivery. Case managers are responsible for verifying that services have been and are being delivered as outlined in the person centered plan-of-care through:

- Confirmation of service delivery in the EMWS
- Discussion with the participant during the monthly visit
- Verification during the quarterly care conference.

This could include service payments being reimbursed by the case management agency in cases where services were provided in error due avoidable delays in communication or case mismanagement (see types of services section for additional information).

TYPES OF SERVICES

The availability of waiver services varies between communities. Which services are requested and provided for each participant is based on the needs identified on the LT101 functional assessment for that participant, what service providers are available in the participant's community, what natural supports are in place, and the participant's own strengths and preferences.

❖ ASSISTED LIVING OPTION

Definition:

Adult residential services include (as medically necessary) personal care, homemaker and medication oversight (to the extent permitted under State law) provided in a home-like environment in a fully licensed community care setting in an Assisted Living Facility in conjunction with residing in the facility. This service includes twenty-four hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security based on resident needs. There are three (3) tiers of assisted living services (Level I, Level II, and Level III), based on level of care and services needed as identified on the LT101 functional assessment.

Participants can only receive services that are authorized in their Person Centered Plan-of-Care.

Services that can be provided in conjunction with residence in an ALF may include:

- Personal care
- Homemaking
- Medication oversight (to the extent permitted under state law)
- PERS
- Non-medical transportation

ALF providers must ensure that the services:

- Include twenty-four hour on-site response plans to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence
- Provide supervision to the participant
- Meet any safety and security requirements based on the resident's needs
- Are reimbursed based on a daily rate and only paid for days that the participant is at the facility

Excluded services:

- Home health care
- Physical therapy

- Occupational therapy
- Speech therapy
- Intermittent skilled nursing services
- Periodic nursing evaluations
- Transportation
- Room and board

Qualifications:

All assisted living (adult residential) services must be provided by an ALF that:

- Is fully-licensed by the Wyoming Department of Health, Office of Healthcare Licensing and Surveys
- Meets all program rule requirements for waiver residents, including appropriate:
 - Assessment and review of needs and services
 - Preparation of and updates to the person-centered plan of care
- Provides services to ALF waiver participants as long as their needs do not exceed the license scope of the assisted living facility.
- Maintains the safety and welfare of both non-waiver and waiver residents as required by their license.

As with non-waiver residents, waiver resident’s needs cannot exceed the license requirements of the facility (i.e. ability to evacuate, etc.).

Responsibilities:

- 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
- Admission of new waiver participants is prohibited if the facility license changes to provisional status or is revoked.

Setting Requirements:

All assisted living facilities shall meet the Home and Community Based Settings requirements as defined in 42 CFR §441.3011 (4)-(5).

All ALFS must ensure that the setting:

- Is integrated in, and supports the same access to the community for individuals receiving CCW Program services as individuals who are not on the CCW Program
- Includes opportunities for CCW Program participants to seek employment and work in competitive integrated settings to the same degree as individuals who are not receiving CCW Program services
- Is selected by the individual from among setting options including:
 - Non-disability specific setting

- Private unit in a residential setting
- Optimizes but does not regiment individual initiative, autonomy, and independence in making life choices
- Is physically accessible to the individual

Additionally, ALFS must ensure that:

- The individual's essential personal rights of privacy, dignity, respect, and freedom from coercion and restraint are protected
- Individuals have choices regarding services and supports, and who provides them
- A lease, residency agreement, or other form of written agreement is in place for each CCW Program participant and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
- Individuals have privacy in their sleeping or living unit. (i.e.: units have entrance doors lockable by the individual with only appropriate staff having keys to doors)
- Individuals sharing units have a choice of roommates in the setting
- Individuals have freedom to furnish and decorate their sleeping and living units within the lease or other agreement
- Individuals have the freedom and support to control their own schedules and activities and have access to food at any time
- Individuals are able to have visitors of their choosing at any time.

An ALF that is covered by the CCW may NOT include any setting that:

- Is located in a building that is also a publicly or privately operated facility that provides in-patient institutional treatment
- Is in a building or on the grounds of, or immediately adjacent to, a public institution.

For ALFs approved as CCW providers prior to April, 2014: There will be a transitional period to meet these requirements, which will be discussed during desk and site reviews.

For all newly enrolling CCW program ALF providers (after April, 2014), these requirements must be met prior to enrollment approval.

SERVICES UNDER THE IN-HOME OPTION:

❖ SKILLED NURSING

Definition:

Nursing tasks that are ordered by a physician which are within the scope of the Wyoming Nurse Practice Act and are provided by a nurse licensed to practice in the State of Wyoming are not covered as stand-alone services under the Medicare or Medicaid home health benefit.

Nursing tasks which are:

- Ordered by a physician
- Within the Wyoming Nurse Practice Act
- Provided by a nurse licensed to practice in the State of Wyoming
- Not covered as standalone services under the Medicare or Medicaid home health benefit

Services may include:

- Set up of medication box
- Administration of injection(s)
- Foot care for participants with identified risk for compromised skin, circulatory, or neurological systems.
- Intermittent care for chronic conditions
 - Cannot be used as a substitute for acute private duty nursing

Qualifications:

Services provided by a home health agency must be:

Provided by an employee of a Wyoming home health agency that is licensed by the Office of Healthcare Licensing who is:

- A professional nurse (RN) currently licensed by the Wyoming Board of Nursing
 - Meets the criminal background and central registry check requirements for the waiver program
 - Does not function as legal guardian, power of attorney, or financial / legal representative on behalf of the waiver participant to whom they are providing service; or any waiver participant of the agency or entity by which they are currently employed

Services provided by an individual must be:

- A professional, skilled nurse (RN) currently licensed by the Wyoming Board of Nursing who:
 - Maintains professional liability insurance

- Meets the criminal background and central registry check requirement for the waiver program.
- Does not function as legal guardian, power of attorney, or financial/legal representative on behalf of any waiver participant to whom they provide waiver services

Responsibilities:

- Work with the case manager to ensure appropriate and necessary services are included in the participant person-centered plan of care
- Ensure current physician's orders are in place to support provision of Skilled Nursing services as required. Orders must include:
 - The reason for skilled nursing
 - The duration of skilled nursing (number of months up to one year)
 - The frequency of skilled nursing visits (number per week/month)
 - Disclaimer to indicate the orders are specifically for the CCW only
 - Physician's signature
- The physician's orders must be provided to the case manager to upload in the EMWS before skilled nursing can be added to the plan.
 - Services provided can only happen while the order is valid
 - New orders must be obtained and provided to the case manager to upload in EMWS for any modifications to the plan
 - New orders must be obtained and uploaded to continue services prior to expiration of the previous orders

❖ PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)

Definition:

A Personal Emergency Response System (PERS) is an electronic communication link to assistance inside or outside the participant's home, enabling them to secure help in an emergency and decreasing the risk of serious injury or institutionalization.

This is available for participants who:

- Live alone
- Have a high fall risk
- Are alone for significant parts of the day
- Have no regular caregiver for extended periods of time
- Would otherwise require extensive routine supervision

Qualifications:

A PERS service provider must be a business entity that is licensed to provide, monitor, support, and respond to equipment that meets the Federal Communications Commission certification under *47CFR 15* and *47CFR 68* standards and Underwriter Laboratory testing standards for home health care signaling equipment, or digital alarm communicator system units

Responsibilities:

PERS providers are required to:

- Provide appropriate training in the use of the PERS system to the participant
- Monitor and respond to all alerts and alarms transmitted
- Maintain documentation of incidents, responses, and actions taken
- Provide such documentation to case managers as requested
- Work with the case manager to ensure appropriate and necessary services are included in the participant person-centered plan of care

Installation Service:

Installation of electronic equipment necessary to operate a PERS:

This is a one (1) time fee per participant unless the participant requires a new "start of services" due to:

- A change in residence
- A break in service caused by a hospital or nursing home stay
- A change in PERS service provider (e.g.: provider going out of business, no longer supporting necessary services, etc.)

Service Includes:

- Providing necessary activation equipment (e.g.: base unit, charging cord, etc.)
- Delivery and installation of equipment
- Training the participant how to use the system

Monthly Service:

Service Includes:

- Continuous monitoring (24/7) by live professional staff for timely response to emergent situations
- Appropriate response to all alerts and alarms transmitted
- Troubleshooting equipment and processes as needed
- Communicating with case managers and responders to ensure appropriate documentation of incidents, responses, and actions taken

Services provided by Wyoming Medicaid, including HCBS-CCW, are delivered on a fee-for-service (FFS) basis. This means the Waiver Program will only pay for services after they have been provided.

The service provider must provide documentation that the equipment was properly installed, and is operational and tested each month that the fee-for-service is billed. 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

Definition:

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 Older Americans Act. Delivery of meals must document the content of the meal and the receipt of the meal by the participant. Services may include up to two (2) nutritionally complete meals per day

Qualifications:

A Commercial Food Services Operator who:

- Maintains a current food service license or permit from the state in which the commercial food service preparation facility is located
- Complies with all Federal, State, and local food regulations
- Complies with food service facility inspections by the licensing entity
- Demonstrates the ability to produce, handle, store, prepare, and deliver food under current Federal, State, and local food handling safety guidelines
- Does not function as legal guardian, power of attorney, or financial / legal representative on behalf of the waiver participant to whom they are providing service; or any waiver participant of the agency or entity by which they are currently employed

Responsibilities:

- Deliver meals to the participant as outlined in the plan of care which meet the nutritional standards established by the waiver program
- Maintain a nutritional analysis of delivered meals that must be available to the waiver program for review upon request
- Document receipt of the meal by the participant
- Provide information to the waiver program for review upon request:
 - Nutritional analysis of delivered meals
 - Confirmation of meals received by participant
 - Licensing entity inspection results

❖ ADULT DAY CARE

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 Person-Centered Plan of Care) but for less than twenty four (24) hours each day.

Qualifications:

Is an Adult Day Care Facility that:

- Is licensed by the Wyoming Department of Health, Office of Healthcare Licensing and Surveys
- Does not function as legal guardian, power of attorney, or financial/legal representative on behalf of the waiver participant to whom they are providing service; or any waiver participant of the agency or entity by which they are currently employed

Responsibilities:

Work with the case manager to ensure appropriate and necessary services are included in the participant person-centered plan of care

Services may:

- Be provided in a community based setting by an Adult Day Care facility licensed by the Wyoming Office of Healthcare Licensing and Survey
- Encompass both health and social needs to ensure the optimal functioning of the individual
- Transportation may be reimbursed under the Non-medical Transportation waiver service (if the service is included in the participant's person-centered Plan of Care)

Adult Day Care Services must NOT:

- Be provided in the participant's home
- Occur continuously over a twenty four (24) hour period
- Include overnight stays
- Include reimbursement for transportation (transportation may be reimbursed under the non-medical transportation waiver service if the service is included in the participant's Plan of Care)
- Constitute a full nutritional regimen (three (3) meals per day)
- Include the reimbursement for the cost of meals (meals may be reimbursed under the Home Delivered Meals waiver service if included in the participant's person-centered Plan of Care and all waiver standards for that service are met)

Setting Requirements:

All Adult Day Facilities shall meet the Home and Community Based Settings requirements as defined in 42 CFR §441.301(c)(4)-(5).

All adult day facilities must ensure that the setting:

- Is integrated in, and supports the same access to the community for individuals receiving CCW Program services as individuals who are not on the CCW Program
- Includes opportunities for CCW Program participants to seek employment and work in competitive integrated settings to the same degree as individuals who are not receiving CCW Program services
- Is selected by the individual from among setting options including:
 - Non-disability specific setting
 - Private unit in a residential setting
 - Optimizes but does not regiment individual initiative, autonomy, and independence in making life choices
 - Is physically accessible to the individual

Additionally, Adult Day Facilities must ensure that:

- The individual's essential personal rights of privacy, dignity, respect, and freedom from coercion and restraint are protected
- Individuals have choices regarding services and supports, and who provides them
- A lease, residency agreement, or other form of written agreement is in place for each CCW Program participant and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
- Individuals have privacy in their sleeping or living unit. (i.e.: units have entrance doors lockable by the individual with only appropriate staff having keys to doors)
- Individuals sharing units have a choice of roommates in the setting
- Individuals have freedom to furnish and decorate their sleeping and living units within the lease or other agreement
- Individuals have the freedom and support to control their own schedules and activities and have access to food at any time
- Individuals are able to have visitors of their choosing at any time.

An Adult Day Facility that is covered by the CCW may NOT include any setting that:

- Is located in a building that is also a publicly or privately operated facility that provides in-patient institutional treatment
- Is in a building or on the grounds of, or immediately adjacent to, a public institution.

Exceptions:

For Adult Day Facilities approved as CCW providers prior to April, 2014: There will be a transitional period to meet these requirements, which will be discussed during desk and site reviews.

For all newly enrolling CCW program Adult Day Facility providers (after April, 2014), these requirements must be met prior to enrollment approval.

❖ NON-MEDICAL TRANSPORTATION

Definition:

Transportation offered to enable participants to participate in waiver and other community services, activities, and resources, as specified by the Plan of Care 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) Non-medical transportation costs are not included in the reimbursement for adult day care, personal care attendant, or respite waiver services. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized

Limited to a total reimbursement amount of \$80.00 per month

Qualifications:

Agency:

A publically or privately licensed Commercial Transportation Operator who:

- Meets all legal requirements (federal, state, or local) to operate a transportation business and is capable of safely transporting participants to access community resources
- Meets all laws and regulations (federal, state, and local) for driver licensing, liability insurance, business operation and vehicle transportation safety standards
- Maintains a current safety inspection verification report which assures prudent safety maintenance and repair for vehicles used to transport waiver participants

Individual Driver:

- Is at least eighteen (18) years of age
- Holds a current valid driver license from any state
- Is capable of safely transporting participants
- Meets all laws and regulations (federal, state, and local) for driver licensing, liability insurance, and vehicle transportation safety standards
- Maintains a current safety inspection verification report which assures prudent safety maintenance and repair for vehicles used to transport waiver participants

Responsibilities:

Work with the case manager to ensure appropriate and necessary transportation services are included in the participant person-centered plan of care

During transportation of waiver participants:

- Carry a fire extinguisher and first aid kit in the vehicle
- Demonstrate capacity to summon assistance if needed during transport

Provide to waiver program staff or case manager upon request the following documents:

- Current safety inspection verification report
- Current driving license and vehicle liability insurance
- Current vehicle transportation safety standards

IN-HOME SERVICES – AGENCY OPTION

❖ PERSONAL CARE ATTENDANT (PCA)

Definition:

A range of assistance, provided by a Certified Nursing Assistance (CNA), to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability. Tasks may include assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL). These services are provided in the home. This assistance may take the form of:

- Hands-on assistance
- Cuing to prompt the participant to perform a task
- Supervision of the task to assure the safety of the participant.

Personal care tasks 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
- Oral hygiene
- Toileting and elimination
- Bowl or bladder care beyond routine toileting
- Safe transferring and ambulating
- Normal range of motion and positioning
- Nail and skin care

Non-personal care tasks may be delivered by a PCA only when they are incidental to a personal care task. Every visit must include a personal care task.

Non-personal care services such as:

- Changing bed linens
- Assistance with preparation of meals including:
 - Grocery shopping
 - Medication pick-up and/or reminders
 - Preparing and serving food
 - Assistance with eating
 - Ensuring adequate nutrition and fluid intake
 - Meal clean-up such as
 - Washing participant dishes
 - Sorting leftovers
 - Service reimbursement does not include the cost of the meals themselves
- Household tasks that are incidental to the participant's personal care or are essential to the health and welfare of the participant
- And may be completed only if they are part of the Plan of Care and include:

- Light house cleaning
- Laundry

Excluded services:

- Services that maintain an entire household or family,
- Are not necessary to the health and welfare of the participant
- Include but are not limited to the following:
 - Phone call reminders
 - Medication administration and/or setup
 - 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
 - Chore services or heavy cleaning in the home or areas of the residence which are not frequented by the participant

Qualifications:

A qualified Personal Care Attendant (PCA) is an employee of a Home Health Agency licensed in Wyoming, who is also:

- A Certified Nursing Assistant (CNA) with current certification in good standing with the Wyoming State Board of Nursing
- Under the supervision of a Registered Nurse (RN) as provided in accordance with the Wyoming Nurse Practice act
 - Must have completed the additional Community Home Health Aid training requirement under the Wyoming State Board of Nursing
 - Must meet the criminal background and central registry check requirement for the waiver program.
 - Does not function as legal guardian, power of attorney, or financial / legal representative on behalf of the waiver participant to whom they are providing service; or any waiver participant of the agency or entity by which they are currently employed
- Registered Nurse (RN) supervision of the PCA
 - Must occur at least every sixty days
 - May occur more frequently in accordance with the home health agency policy

Responsibilities:

It is the provider's responsibility to:

- Work with the case manager to ensure appropriate and necessary services are included in the participant plan of care
- Document personal care services provided on the Personal Care Attendant Log
- Maintain a copy of the log at the CNA's home health office.
- Keep a copy of the signed log
- Provide a copy of the log and all documentation to the case manager to upload into the EMWS monthly

Services will vary and are:

- Based on the needs identified by the LT101 functional assessment
- Are on the person-centered plan of care after a review of the care needs and requirements by the case manager and participant

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 the medical transportation services within the State plan or non- medical transportation within the waiver

Multiple Respite Care Attendants cannot provide services during the same timeframe for an individual participant without pre-approval by the Home Care Services Program Manager. This applies to all personal service providers.

❖ RESPITE CARE

Definition:

Respite Care services include a range of in-home supports which enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability. Respite Care is furnished on a short-term (short-term is defined as no more than 30 days in a 12 month plan period) basis because of the absence or need for relief of those persons who normally provide care for the participant.

This may include:

- Hands-on assistance
- Cueing to prompt the participant to perform a task
- Supervision of the task to assure the safety of the participant
- Personal care tasks provided as part of respite care 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 such as:
 - Changing bed linens
 - Assistance with preparation of meals including:
 - Grocery shopping
 - Medication pick-up and/or reminders
 - Preparing and serving food
 - Assistance with eating including:
 - Ensuring adequate nutrition and fluid intake
 - Meal clean-up Washing participant dishes
 - Sorting leftovers.
 - Service reimbursement does not include the cost of the meals themselves.

Household tasks that are incidental to the participant's personal care or are essential to the health and welfare of the participant may be completed only if they are part of the Plan of Care and include:

- Light house cleaning
- Laundry

Excluded services:

- Services that maintain an entire household or family,
- Are not necessary to the health and welfare of the participant
- Include but are not limited to the following:
 - Phone call reminders
 - Medication administration and/or setup
 - 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
 - Chore services or heavy cleaning in the home or areas of the residence which are not frequented by the participant

Qualifications:

A Qualified Respite Care Attendant (RCA):

- Is an employee of a Home Health Agency licensed in Wyoming, who is:
 - A Certified Nursing Assistant (CNA) with current certification in good standing with the Wyoming State Board of Nursing
 - Under the supervision of a Registered Nurse (RN) as provided in accordance with the Wyoming Nurse Practice act
- Must have completed the additional Community Home Health Aid training requirement under the Wyoming State Board of Nursing
- Must meet the criminal background and central registry check requirement for the waiver program
- Does not function as legal guardian, power of attorney, or financial / legal representative on behalf of the waiver participant to whom they are providing service; or any waiver participant of the agency or entity by which they are currently employed
- Registered Nurse (RN) Supervision of the RCA
 - Must occur at least every sixty days
 - May occur more frequently in accordance with the home health agency policy

Responsibilities:

It is the Providers responsibility to:

- Work with the case manager to ensure appropriate and necessary services are included in the participant plan of care
- Document respite services provided on the Respite Care Attendant Log
- Maintain a copy of the log at the home health office.
- Keep a copy of the signed log
- Provide a copy of the log and all documentation to the case manager to upload into the EMWS monthly

Services will vary and are:

Based on the needs identified by the LT101 functional assessment

- Are on the person-centered plan of care after a review of the care needs and requirements by the case manager and participant
- Limited to 30 days in a 12-month plan period

Transportation costs:

- Transportation costs associated with the provision of respite 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 the medical transportation services within the State plan or non- medical transportation within the waiver

Multiple Respite Care Attendants cannot provide services during the same timeframe for an individual participant without pre-approval by the Home Care Services Program Manager. This applies to all personal service providers.

PARTICIPANT-DIRECTED IN-HOME SERVICES OPTION

When choosing the **In-Home Participant-Directed Option**, applicants must demonstrate that they are capable of directing their own care. Determining capability to direct one's own care is **NOT** the same as a determination of competency. Only a court-of-law can determine the decision-making capacity of an individual.



Capability to direct care means that the applicant must be **able and willing** to accept and perform the roles and responsibilities of an employer. 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. *The individual is not capable of directing his/her own care if:*

- There is a court ruling determining incompetence
- The participant has dementia or cognitive impairments that prevent effective communication, understanding, or evaluation of performance of tasks

Participant Capability Definition

Decision-making capability refers to an individual's ability to make an informed decision. It is possible for individuals to retain capability in some areas of their lives (treatment decisions etc.) but not in others (managing finances).

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 determination of capability and the authorized representative meets specific criteria, the authorized representative may, in the participant's place, participate in the Participant Directed Care option. An authorized representative must meet all responsibilities of the employer listed below and must attend the monthly evaluation meeting.

To request this option, the authorized representative must complete the following:

- Request for Review of Authorized Representative Status form (PDO-5)
- Authorized Representative Review form (PDO-6)
- Provide a copy of the Advance Health Care directive or Power of Attorney

Responsibilities of an employer include:

- Work with the case manager to ensure appropriate and necessary services are included in the participant plan of care
- Understanding and follow program requirements
- Writing a job description for the employee(s)
- Developing a work schedule based on authorized service units

- Developing a back-up plan for help
- Recruiting and selecting worker(s)
- Notifying selected worker(s) of their responsibilities
- Ensuring that employment forms are completed and submitted to the financial management agency
- 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 the financial management agency of any changes
- Participating in ongoing eligibility review and program oversight by the Case Manager
- Communicating with the Case Manager as necessary
- Have one (1) primary direct service worker and a back-up plan in place in the event that the primary worker is unable to perform the scheduled tasks. The back-up plan must reviewed at each monthly case manager evaluation. Failure to comply with the back-up plan may result in the loss of services.
- Recruit and hire the DIRECT SERVICE WORKER(S) that will provide care
- Develop a job description and training plan for DIRECT SERVICE WORKER(S) so they will know what is expected of them and how care will be provided.
- Ensure that none of the DIRECT SERVICE WORKERS are my spouse, legal guardian, Power of Attorney, Power of Attorney for health care, or health care directive designee.
- Ensure that the DIRECT SERVICE WORKER(S) complete and meet the established standards required for background checks, prior to beginning employment and receive approval from the fiscal management service provider. Individuals whose name is on the Central Registry or that do not pass required criminal background checks are not eligible to provide waiver services or be paid by Medicaid for services. As the employer, I am responsible for the cost of background checks.
- Ensure that each DIRECT SERVICE WORKER completes hands-on CPR Certification and First Aid Training, prior to beginning employment and has received approval from the fiscal management service provider. As the employer, I am responsible for the cost of these trainings, as well as ensuring that renewal certifications/trainings are completed.
- The back-up plan must be reviewed at each monthly case manager evaluation.
- Failure to comply with maintenance of a back-up plan may result in the loss of services
- Ensure that the personal care services, provided by my DIRECT SERVICE WORKER(S), are provided to me in my home.

- Assure that each DSW meets their employee standards and the standards of the waiver program
- Review DIRECT SERVICE WORKER(S) logs and approve them by signing off that the services/care was provided.
- Maintain a copy of the log at the participant's home.
- Provide a copy of the log to the case manager to review at the monthly visit
- Provide copy of the log to the waiver program upon request

Maintain an employee file that includes but, isn't limited to:

- The employment application
- I-9 background check information
- Payroll withholding forms
- Copies of the employee enrollment forms that were sent to the financial management services (FMS)
- Central Registry, background and reference checks;
- CPR & First Aid certifications;
- Job description;
- Schedules;
- Timesheets;
- Direct Service Worker(s)' logs and Direct Service Worker(s)' agreements.

*Documents in **this file must be maintained for 6 years**

If the participant is waiting on the hiring process of a DSW they can go on the agency option in the interim to access services.

❖ DIRECT SERVICE WORKER (DSW)

Definition:

Direct Service Worker (DSW) is a person who provides in-home supports which enables waiver participants to accomplish tasks that they would normally complete independently if they did not have a disability. DSW tasks may include assistance with activities of daily living (ADL) and instrumental ADL. This assistance may take the form of:

- Hands-on assistance
- Cuing to prompt the participant to perform a task
- Supervision of the task to assure the safety of the participant

Qualifications:

A qualified direct service worker (DSW):

- Must be at least eighteen (18) years old
- Meet the skills, experience, reference requirements, and prior employment standard set by the employer (participant)
- Must meet the criminal background and central registry check requirement of the waiver program
- Must complete a CPR certification and a first aid training
 - The CPR course must have a “hands-on” component and utilize a nationally recognized curriculum
 - The first aid training can be an on-line or in-person course
 - ◆ For information on where and when courses are being offered, contact:
 - American Heart Association at 1-877-242-4277
 - American Red Cross at 307-637-5242
- May be a family member as long as they are not the participant's:
 - Spouse
 - Legal guardian
 - Power of Attorney (POA)
 - Power of Attorney for Health Care (Medical Power of Attorney)
 - Health Care Directive Designee
- Must not be listed as participant on any waiver program or receiving waiver services

Responsibilities:

It is the DSW's responsibility to:

- Document direct services worker services provided on the direct services worker log
- Adhere to the participants job description and training plan

The DSW provides support which enables waiver participants to accomplish tasks that they would normally complete independently if they did not have a disability. This may include:

- Hands-on assistance
- Cueing to prompt the participant to perform a task
- Supervision of the task to assure the safety of the participant

Personal care tasks:

- 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
 - 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 tasks such as:

- Changing bed linens
- Assistance with preparation of meals including:
- Grocery shopping
- Medication pick-up and/or reminders
- Preparing and serving food
- Assistance with eating
- Ensuring adequate nutrition and fluid intake
- Meal clean-up
- Washing participant dishes
- Sorting leftovers

*service reimbursement does not include the cost of the meals themselves

Household tasks that are incidental to the participant's personal care or are essential to the health and welfare of the participant may be completed only if:

- They are included in the person-centered plan of care
- Personal care tasks (listed above) are being provided as outlined in the plan of care.

These household tasks may include:

- Transporting participant to non-medical activities
- Light house cleaning

- Laundry

Excluded tasks are tasks that maintain the entire household or family and are not necessary to the health and welfare of the participant. Excluded tasks will not be reimbursed. These may include but are not limited to:

- Phone call reminders
- Medication administration and/or setup
- 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
- Chore services or heavy cleaning in the home or areas of the residence which are not frequented by the participant
- Medical transportation cost – must be billed separately under medical transportation under the state plan

Services will vary and are:

- Based on the needs identified by the LT101 functional assessment
- are on the Person-Centered Plan-of-Care after a review of the care needs and requirements by the case manager and participant

Wages/Hours

- Participants who have elected the participant-directed services option determine the wage payment for their DSW(s). The pay range for services is: \$10.00 – 12.00 per hour
- A DSW cannot exceed a total of 40 hours per week, per employer to whom they provide services.
- Timesheets submitted that reflect overlapping time will not be paid and will be returned for correction. Overlapping time includes instances where:
 - A single DSW's timesheets reflect overlapping time worked for multiple employers.
 - multiple DSW's timesheets reflect the same time worked for one employer

Multiple DSW cannot provide services during the same timeframe for an individual participant without pre-approval by the Home Care Services Program Manager. This applies to all personal service providers.

❖ FINANCIAL MANAGEMENT SERVICES (FMS)

Definition

Fiscal Management Services (FMS) for participant-directed services include:

- The management and disbursement of funds contained in the participant's budget
- Facilitate the employment of the employees providing participant-directed services, such as processing payroll, withholding federal, state, and local tax, and making tax payments to the appropriate tax authorities
- Performing fiscal accounting and making expenditure reports to the participant and state authorities.

Services provided by the FMS can include:

- Assisting to establishing employer status (participant)
- Producing and processing payroll on behalf of the participant/employer
- Providing financial reports and related functions on the participant/employer's behalf including:
 - Distributing, collecting, and processing of direct-care timesheets and task documents that have been approved by the participant
 - Establishing and maintaining a record for each participant and 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
 - Provision of all W-2,1099, or wage and tax statements 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 participants/employers and DSWs/employees in accordance with applicable waiver standards
- Operation of a staffed call center that is available to resolve:
 - Participant/employer inquires
 - Payroll concerns
 - Providing support and feedback to enrolling employers or employees

Qualifications

FMS providers:

- 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
- Cannot employ any individual who functions as legal guardian, power of attorney, or financial / legal representative on behalf of a waiver participant to whom they

are providing service; or any waiver participant of the agency or entity by which they are currently employed

- Must adhere to all Federal, State and local laws and regulations concerning appropriate business operation and reporting
- Must follow an independent audit schedule and process

Financial Management Services (FMS) Responsibilities

The Financial Management Services (FMS) provider verifies:

- All required information is received from the DSW and employer
The DSW cannot be enrolled or payroll generated until all information has been received
- All employer documentation is provided to support the request
- All tax related documentation is managed and provided to the employer or the DSW as needed
- Work with the case manager to ensure appropriate and necessary services are included in the participant person-centered plan of care
- The FMS provider shall prepare and distribute all management reports to the waiver program manager as requested
- Services shall be allowable for reimbursement beginning the month that 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)

CHANGING SERVICE PROVIDERS

Definition:

Circumstances that would warrant a change in service providers include:

- An agency or a provider who can no longer serve a participant
- The participant chooses to change to another agency or provider

A participant who is transferring to another agency or provider is not considered to be a discharge.

In these instances, it is necessary to allow the participant adequate time to find another agency or provider and to provide them with contact information for all other providers of that service in their area. The participant's case manager shall assist in coordinating a change in service providers.

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.

Case Management Agency Changes:

If a participant elects to transfer from one case management agency to another, a Change in Case Management Agency form (CCW-11) must be completed and submitted to the CCW Program. This must be completed within five (5) working days of the change.

SERVICE PROVIDER DUTIES

Definition:

Case Managers are required to complete a provider duties form (CCW-6) to effectively communicate information to service providers in order to deliver appropriate and adequate service(s) to each participant based on their plan of care. The form must indicate the service(s) being requested, the estimated number of units to be delivered each month of the plan, the charge per unit, the participant information, and the Case Manager signature.

Once completed, the provider duty form is sent by the Case Manager to each of the service providers.

The agency/agencies providing the service(s) must sign the form and return a copy to the Case Manager within 10 business days, confirming intent to provide the service(s) for the amount listed.

This form acts as the agreement between the Case Manager and service provider to authorize services based on the participant's person-centered plan of care.

The provider duty form **is not** an authorization for payment. Service providers should not provide services until a prior authorization letter is received.

ADULT ABUSE AND NEGLECT

Definition:

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

Any service provider who has 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 and/or law enforcement as indicated by the nature of the incident(s).

This report must be documented, and a copy provided to the Home Care Services Unit as part of the Critical Incident form. The form to use for Critical Incident Reporting is found at http://www.health.wyo.gov/healthcarefin/medicaid/homecare_services.html

- Under reporting click on “File and incident link”
 - When you click on submit, the information is sent to the Home Care Services Unit

PLAN OF CARE

❖ PLAN OF CARE DEVELOPMENT

Upon receipt of the current LT101 functional assessment, the case manager will:

- Review the LT101 functional assessment within 90 days of plan start date
- Meet with the participant and prepare the person-centered plan of care based on the needs identified in the LT101 functional assessment and participant input. The plan of care should include services that are available or can be provided either through the waiver or outside its scope. During this meeting, the Case Manager should discuss:
 - Overall objectives and treatment plan
 - The Participant Choice of Service form (CCW-1: requires participant signature)
 - The Participant Rights and Responsibilities form (CCW-3: requires participant signature)
 - Advance Health Care Directives and Durable Power Attorney for Health Care options
 - The Participant Choice of Provider form (CCW-14) which allows the participant to choose any provider located within the participant's service area.
 - ◆ The case manager must remain unbiased and objective when offering a choice of providers to participants
- Coordination with providers to provide services
- The Provider Duty Sheet (CCW-6) which communicates the information each provider needs to have to deliver the necessary service(s):
 - The form will contain:
 - ◆ What service is being requested
 - ◆ The amount of units to be delivered each month during the plan period
 - ◆ The charge/cost per unit
 - ◆ The participant information
 - ◆ The case manager's signature
 - ◆ Approved agency representative's signature

The agency providing the service(s) must return a signed copy of the Provider Duty Sheet to the case manager to verify that they intend to provide the service(s) as outlined on the form. This is considered a contract between the case manager and agency to authorize services. This is not an authorization for payment. Providers should not begin providing services to a participant until a prior authorization (PA) is received

❖ PERSON-CENTERED PLAN OF CARE REQUIREMENTS

A participant's Person-Centered Plan of Care is a confidential document and should not be shared by the Case Manager with other service providers, as it often contains protected health information (PHI).

A case manager must submit the person-centered Plan of Care electronically in the EMWS.

The Person-centered plan of Care must:

- Identify the setting chosen by the individual and how community integration will be achieved
- Reflect the individual's strengths and preferences
- Include clinical and support needs as identified on the LT101 functional assessment
- 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
- Include risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed
- Be easily understood by the individual receiving services /supports, and the individuals who take a key role in supporting him or her consistent with 42 CFR §435.905(b)
- Identify the individual and/or entity responsible for monitoring the plan.
- Include the written, informed consent of the individual receiving services
- Be signed by all individuals and providers responsible for its implementation.
- Identify services that the individual elects to participant-direct
- Prevent the provision of unnecessary or inappropriate services and supports
- Be distributed to the individual and other people involved in the plan

Any modifications to the person-centered Plan of Care must be supported by a specifically assessed need and justified in the modification to the Plan of Care.

The following requirements must be documented when doing a modifications to the Plan of Care:

- Identification of a specific and individualized assessed need
- Documentation of positive interventions and supports used prior to recommendation of modifications
- Documentation of methods to meet the need that have been tried but did not work.
- A clear description of the condition that is directly proportionate to the specific assessed need.
- Collection and review of regularly-gathered data to measure the ongoing effectiveness of the modification.

- Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
- Informed consent of the individual.
- Affirmation that interventions and supports utilized will cause no harm to the individual.

The following requirements for Assisted Living Services must be documented in the Plan of Care:

- Setting options (e.g.: non-disability specific, private unit) as identified and based on the individual's needs and preferences
- Resources available for room and board (ALF)
- Individual has choice regarding choice of services, supports, and whom provides them

❖ **SUBMITTING THE INITIAL PLAN OF CARE**

When submitting an initial Plan of Care, notification is sent to the Case Manager through an assigned task in the EMWS (please refer to the EMWS Manual for more detailed information regarding this process).

The Initial Plan of Care start date will be the later of:

- LT 101 functional assessment completion date,
- Funding opportunity date, or
- Date plan has been submitted by the case manager in the EMWS.

If, during this process, the Plan of Care is rolled back to the Case Manager's task list, the Case Manager should check the notes section prior to resubmitting to ensure appropriate steps are taken to complete the Plan of Care.

❖ **SUBMITTING A MODIFICATION TO THE PLAN OF CARE**

After a Plan of Care has been approved by the Home Care Services Unit (either an initial or renewal) and prior authorizations have been received from the Medicaid Fiscal Agent (Conduent), modifications to the Plan of Care may be performed (please refer to the EMWS Manual for more detailed information regarding this process).

When submitting a modification in the EMWS, include notes in the comments section to indicate what the modification should accomplish. Specify any services that are being removed, changed, or added.

If, during this process, the modification is rolled back to the Case Manager's task list, the Case Manager should check the notes section prior to resubmitting to ensure appropriate steps are taken to complete the modification.

❖ SUBMITTING A PLAN OF CARE RENEWAL

Assessment of a waiver participant's level of care will be completed every twelve (12) months. Reassessments will be performed on-site by a county Public Health Nurse, using the same process and form (LT101) that is utilized during the initial assessment. When it is time to renew a participant's Plan of Care, notification is sent to the participant's Case Manager in the EMWS (please refer to the EMWS Manual for more detailed information regarding this process).

A Case Manager must submit a participant's Plan of Care no later than the 15th of the month that the participant's services will be ending (e.g.: January 15th if the Plan ends on January 31st). Monthly visits for participants who require a renewal should be scheduled and conducted at the beginning of the month to ensure renewal paperwork is completed and submitted by the 15th of the month.

If renewal Plans are not submitted by the last day of the existing plan, **units will be deducted from the Case Manager in the amount of one (1) unit for each day beyond the end of the Plan that the renewal is not received.**

Deductions will not be assessed if the delay is due to circumstances beyond the Case Manager's control, such as LT101 functional assessment extensions or Medicaid financial eligibility determination.

HIGH EXPENSE PLANS (OVER \$1,800.00/MONTH)

DEFINITION:

Plans for in-home services that include months in excess of \$1800.00 must be approved by the Home Care Services Program Manager.

A Case Manager must provide justification for, and request approval from the Program Manager by providing the following information in the notes section of the EMWS. The note must include:

- The previous Plan's highest expenditures (not necessary for new Plans)
- The submitted Plan's anticipated highest expenditures
 - If this is a renewal or modification, document any Plan changes
- The reason for the anticipated high expenditure(s)
 - Requested services should be supported by documentation of need (i.e.: assessment and documentation of changes in condition)
- Relative history of participant (e.g.: quadriplegic, has broken arm, decline in health, LT101 functional assessment has increased, etc.)
- Any additional information that will assist the Program Manager in making an informed and appropriate determination

BILLING

DEFINITION:

Services provided by Wyoming Medicaid, including HCBS CCW, are delivered on a fee-for-service (FFS) basis. This means the Waiver Program will only pay for services AFTER they have been provided.

Case Managers must ensure that Plans of Care that begin in the middle of the month reflect only the days of services the participant receives.

When referring to Personal Care, Respite Care and Adult Day Care, a “unit” is fifteen (15) minutes.

- Services provided in increments smaller than fifteen (15) minute increments should not be rounded up.
- Travel time to and from the participants home is not reimbursable.

Services cannot be billed when the participant is:

- In a nursing home
- In a hospital
- Out of state (with the exception of the DSW if there is prior approval of the Program Manager or designee.)
- Unavailable to receive services
- Deceased

**This does not apply to providers of home-delivered, mail-order meals, PERS or FMS providers.*

The following can be billed on the day a participant is admitted and discharged from a hospital or 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

The Waiver Program will not pay for Case Management services provided on the day a participant is admitted to a hospital or nursing home, but will pay for services provided on the day a participant is discharged.

If a Case Manager does not complete the monthly face-to-face visit with the participant in the participant’s home or the Assisted Living Facility, the case management agency

cannot bill for case management services provided by that Case Manager for that participant during that month.

- The Case Manager must have the signature of the participant, the participant's POA, or the participant's authorized representative on the monthly evaluation form to verify the visit was completed.

Participant assessment activities that occur prior to establishing eligibility for waiver services or an approved participant-centered plan of care will not be reimbursed under the waiver after participant is enrolled.

Service Providers must submit all billing claims electronically to the Medicaid Fiscal Agency (Conduent) in order to receive payment.

FRAUD REPORTING

Please note that any false claims or misrepresentation of time worked or services provided that results in over-payment is considered fraud and will be reported to the Wyoming Medicaid Fraud Unit.

Fraudulent statements, documents, or concealment of material facts, including making false statements regarding familial relationships, power of attorney, etc. will be prosecuted under applicable Federal and State laws.

Any service provider, including the Case Managers who suspect fraud are required to document the situation and report to one of the following:

- The Fraud Hotline: 1-855-846-2563
- The Fraud Website: <http://stopmedicaidfraud.wyo.gov>

If a participant has chosen the participant-direction option and the participant, or approved representative of the participant, or DSW signs a timesheet or provides other official verifying documentation that is determined to misrepresent services provided or time worked, the participant will lose the option to participate in the participant directed option and the DSW will be removed from providing future Community Choices waiver services.

WYOMING SERVICE RATES

❖ COMMUNITY CHOICES WAIVER PROGRAM RATE SCHEDULE:

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

❖ PARTICIPANT-DIRECTED SERVICES:

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

Total aggregate services may not to exceed \$1,800.00 per calendar month per participant without prior verbal authorization by Home Care Services Program Manager or designee.

❖ ASSISTED LIVING FACILITY WAIVER RATE SCHEDULE:

<u>T2024</u>	Case Management: \$4.00 per day, per participant
<u>T2031</u>	ALF Level I: \$42.00 per day
<u>T2031 TF</u>	ALF Level II: \$50.93 per day
<u>T2031 TG</u>	ALF Level III: \$61.25 per day

DISCHARGE AND TERMINATION

❖ DISCHARGING A PARTICIPANT FROM THE CCW PROGRAM

Discharge of a participant from the waiver program can occur for a number of reasons such as:

- Failure to re-qualify on the LT101 functional assessment
- Loss of financial eligibility
- Non-compliance
- Expired Participant-Centered Plan of Care (no current Plan submitted)
- Admission to nursing home
 - date of admission and specific nursing home information must be provided
- Other institutional admission
 - date of admission and specific institution information must be provided
- Participant choice
- Move to another waiver
- Move out of state
- Participant death
 - cause and place of death should be included in the EMWS comments
- Loss of contact
- No utilization of waiver services for 30 days or more

Discharge based on eligibility (LT101 or financial):

A discharge for eligibility reasons must be completed as early in the month as possible.

- Waiver services and Medicaid benefits will continue until the end of the month that discharge takes place.
- A participant who fails to qualify for waiver services based on the LT101 functional assessment may request reconsideration or an administrative hearing within thirty (30) days of receiving notification of the denial.
 - This request must be in writing and can be only be made by the **participant, the participant's family, or an authorized representative.**

Loss of Medicaid Eligibility:

If a participant loses Medicaid Eligibility, the Case Manager is notified through the EMWS. At that time, the Case Manager will complete closure in the EMWS (please refer to the EMWS Manual for more detailed information regarding this process).

Discharge based on Nursing Home admission:

All CCW participants who have been admitted to a nursing home must be discharged from the waiver when they have been in the nursing home for 30 days.

- If it is known that a participant's nursing home stay will exceed 30 days, they should be discharged right away.

- Failure to discharge the participant from the waiver after 30 days will cause problems with claims payments and proper implementation of the participant's contribution to the nursing home.
- A new person-centered plan of care is required for any participant who is discharged from the waiver while in the nursing home.
- If it is possible that the stay will be less than 30 days, it is recommended to wait to discharge the participant from the waiver until the end of the 30 day window.
 - If a nursing home stay is less than 30 days and the participant was not discharged, a new plan is not required.
- A waiver participant, who has been discharged while in the nursing home, will keep his/her slot and may be reinstated on the waiver when they return home.
 - Reinstatement will require submission of documentation similar to what is required for a funding opportunity

If a participant has been discharged and would like to return to the waiver, he/she must begin the application/eligibility process again, unless the discharge is due to a nursing home admission.

❖ TERMINATION OF A PARTICIPANT'S SERVICES

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

If the situation warrants, the Case Manager and/or supervisor will refer the case to Adult Protection Services or the local law enforcement agency

Unsafe situation for worker:

If an unsafe situation is identified (e.g., verbal or physical aggression, or home conditions that risk illness or injury) for a service provider, the worker will report this to his/her supervisor immediately.

- The supervisor will report this to the Case Manager immediately and document it in writing.
- It is the Case Manager's responsibility to meet and discuss the situation with the participant.
 - The participant will be advised that the unsafe situation must be rectified and that failure to do so will result in termination of services.
 - Documentation detailing the unsafe situation and outcome of the discussion with the participant will be completed within five (5) days from the incident / unsafe situation, and a copy provided to the worker's supervisor, the provider of services, and the Division of Health Care 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 send a letter to the participant to inform them that their service is terminated. The letter will include:
 - ◆ The dates of the two (2) incidents.
 - ◆ The reason services are being terminated.
 - ◆ The participant's right to reconsideration.
 - ◆ Date that services will cease.
- A copy of the letter will be sent to the worker's supervisor, the provider of the services, and DHCF.

Unsafe Situation for Participant:

In this instance, non-compliance specifically refers to when a participant fails to follow the person-centered plan of care or medical regimen which could result in significant declines in the health and well-being of the participant

If the provider feels the participant has been non-compliant with his/her person-centered 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 with the participant
- The participant will be advised that the non-compliance / unsafe situation must be rectified within the appropriate timeframe (see below). Failure to do so will result in termination of services

If the situation is an emergency:

- The proper agency will be notified and documentation of the non-compliance / unsafe situation will be sent immediately
- A notice of the emergency situation and copy of the meeting notes/findings will be sent to the provider of service(s) and the participant immediately
- If the situation does not improve within three (3) days of the meeting, the worker will report the failure to comply / ongoing unsafe situation to his/her supervisor immediately

If the situation is not life threatening:

- The meeting and notification will be documented in writing
 - A 10-day notice and copy of the findings will be sent to the provider of service(s) and the participant
 - ◆ If the situation does not improve within ten (10) days of the meeting, the worker will notify his/her supervisor immediately
- The supervisor will report to the Case Manager that the non-compliance / unsafe situation continues
- The Case Manager will inform the participant in writing of the identification of the continued non-compliance / unsafe situation, explain that services will be terminated, and referrals will be made to the proper agencies.
- A copy of the Notice must be uploaded in the Electronic Medicaid Waiver System (please refer to the EMWS Manual for more detailed information regarding this process)

Inability to contact the participant for 30 days or more will result in immediate termination from the waiver program.

Case Manager Responsibilities during Participant Discharge/Termination:

It is the Case Manager's responsibility to:

- Help discharged/terminated participants identify other available services in their communities or appropriate placement, if discharge/termination was due to identification of an unsafe situation.
- Complete the discharge/termination in the EMWS (please refer to the EMWS Manual for more detailed information regarding this process)
- Send Provider Duties Form (CCW-6) to all service providers with the date to end services as soon as identified. This will prevent unintended provision and billing for services that fall after discharge

- Costs associated with services provided past the discharge date, due to failure to send the Provider Duties Form in a timely fashion, will be the responsibility of the Case Manager's agency.

WAIVER FORMS DESCRIPTIONS

All necessary waiver forms are available on the Home Care Services website at:

<http://www.health.wyo.gov/healthcarefin/medicaid/homecareservices.html>

Participant Choice of Service (CCW-1) – This form verifies the participant’s request to receive care in the community instead of an institution and is initially completed prior to the plan of care to indicate agreement with the identified objectives and goals. This form must be completed at the initial documents, during the creation of the initial plan of care if the signature is more than 30 days and at every plan of care renewal. This form is uploaded to the EMWS

Participant Rights and Responsibilities (CCW-3) – This form details the participant’s rights and responsibilities when participating in the waiver program. This document includes information about appeal rights, right to choice, right to be informed about the care to be furnished, responsibility to inform Case Manager of changes, responsibility to be a cooperative and active participant in the development of their person-centered plan of care, etc. This form must be completed at the initial documents, during the creation of the initial plan of care if the signature is more than 30 days and at every plan of care renewal. This form is uploaded to the EMWS.

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

Monthly Evaluation (CCW-7) – The Monthly Evaluation form is completed by the Case Manager each month during the face-to-face visit conducted with the participant. It documents satisfaction of services, changes in participant’s condition, newly identified needs, and any identified modification needed for the Person-Centered plan of care. The form is then uploaded into the EMWS.

Termination Notification (CCW-10) – This form notification details a participant’s termination from the waiver program. The form is only completed if it affects a participant’s eligibility. The form is completed and sent by the Case Manager to the participant as notification of the termination, as well as being uploaded into the EMWS.

Change in Case Management Agency (CCW-11) – This form documents a participant’s decision to change agencies and any relevant information regarding the change (i.e.: original agency and case manager, new agency and case manager, participant contact information and signature). The form must be completed by the new case management agency. This must be submitted to the CCW Program and a copy must be provided to the previous case manager within five (5) working days of change.

The CCW Program will upload the form in EMWS and will notify both case managers by email when the case has been transferred in EMWS.

Community Choices Waiver Provider Application (CCW-12) – This is the application to become a service provider within the CCW Program. This form must be completed by the requesting Agency and submitted to the Home Care Services Program Manager or designee.

Community Choices Waiver Case Manager/Delegate Request Form (CCW-13) – This form should be completed when an agency is requesting a new Case Manager/Delegate be added to provide CCW Program services. This must be completed by the requesting Agency and submitted to the Home Care Services Program Manager or designee.

Community Choices Waiver Provider Update Form ((CCW-14) – This form should be updated with any changes to the provider agency information. This form must be completed by the Agency and submitted to the Home Care Services Program Manager of designee.

Participant Choice of Provider (CCW-15) - This form allows a participant to choose from providers of waivers services available in his/her community. The participant will indicate the choices he/she has made by initialing by the choice of provider. This form is located in EMWS under reports. The case manager must use the current form dated on the date the participant is initialing the services. The form must be completed at the initial plan of care, renewal plan of care or any change in services providers. The completed form is uploaded in EMWS.

Participant Capability (PDO-1) Basic consideration for reviewing the participant's capability to manage all of the components of participant- direction. This form must be completed at the initial plan of care, renewal plan or any time there is a change in the participant's ability to direct their care. The completed form is uploaded in EWMS>

Participant Agreement (PDO-2) – The form outlines the expectations and responsibilities of the participant-directed. The form must be reviewed and signed by the participant. The Case manager must provide a copy to the participant and to the CCW Waivers Program via upload into the EMWS

Participant Profile (PDO-3) – This form documents tasks that the Direct Services Worker (DSW) will be completing based off the identified needs from the LT101 and the person centered plan. The form should identify the amount of help needed for each task, the approximate amount of time needed to complete the task and who will provide the service. The completed Profile is uploaded into the EMWS.

Participant Direct Services Back-up Plan Instructions (PDO-4I) – This form is the instructions for the Participant Directed Services Back-up Plan Template (PDO-4T).

Participant Direct Services Back-up Plan Template (PDO-4T) – This form is to be completed by the participant in the event services cannot be provided by the Primary Direct Service Worker (DSW). **Request for Review of Authorized Representative Status (PDO-5)** – In cases where a participant does not successfully meet the “Determination of Capacity” for participant-direction, the *Request for review of an Authorized Representative* is completed.

An Authorized Representative must be:

- The person named in the Advance Health Care Directive or
- The participant’s Power of Attorney for Health Care

This form is then submitted to the Home Care Services Program Manager or designee for review along with the Advance Health Care Directive or Power of Attorney for Health Care.

Authorized Representative Review (PDO-6) – The PDO-6 form is completed by the Case Manager and submitted to the Home Care Services Program Manager, who reviews and indicates approval or denial of the “*Request for Review of Authorized Representative.*”

Participant Directed Direct Service Worker (DSW) Log (PDO-7) – This form is a mandatory DSW Log and must be used to document daily services provided by the DSW.

Participant Responsibility Check List (PDO-8) – This form is a check box for the participant to complete to assure that the DSW meets the required qualifications of the program.