Case Manager Support Call

Individual Plan of Care

PLAN STATUS AND INDIVIDUAL PREFERENCES

WYOMING DEPARTMENT OF HEALTH
DIVISION OF HEALTHCARE FINANCING
DEVELOPMENTAL DISABILITIES SECTION
JANUARY 13, 2020

Wyoming Department of Health

For the next few months the Participant Support Unit will be providing small trainings covering the Plan Mod Links in the Electronic Medicaid Waiver System (EMWS) during the Case Manager Support Calls. These topics are located to the left of the individualized plan of care. We will be going through each section and explaining what is expected to be completed. We encourage case managers to provide us with feedback, as well as any preferences on areas in the plan you would like covered. All recommendations or comments can be referred to Alex Brooks at cm.consultant@wyo.gov.

Person Centered Planning

- 42 CFR 441.301(c) – Federal Law establishing criteria for person-centered planning and a participant's individualized plan of care.
- Wyoming Medicaid Rule - Chapter 45, Section 9 - Case Management Services
  - **Section 9(c)** - *The case manager shall use person-centered planning to understand the needs, preferences, goals, and desired accomplishments of the participant. The case manager shall coordinate and assist the participant in accessing all needed and available resources, such as natural, paid, and community support. The case manager shall develop and monitor the implementation of an individualized plan of care.*
- Wyoming Medicaid Rule - Chapter 45, Section 10 – Individualized Plan of Care

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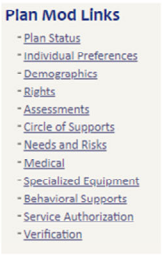
Participants of the Comprehensive and Supports Waivers are entitled to have an individualized plan of care that is person centered and reflects the person's preferences and desires, as well as their support needs.

Person centered planning and the criteria for an individualized plan of care is established in federal law. It is mirrored in Wyoming Medicaid Rules. Chapter 45, Section 9 establishes the requirements for case managers. Section 9(c) specifically states "The case manager shall use person-centered planning to understand the needs, preferences, goals, and desired accomplishments of the participant. The case manager shall coordinate and assist the participant in accessing all needed and available resources, such as natural, paid, and community support. The case manager shall develop and monitor the implementation of an individualized plan of care."

The specific requirements for the individualized plan of care can be found in Chapter 45, Section 10, which establishes the requirements of an individualized plan of care.

Plan Mod Links



- *Plan Status*
- *Individual Preferences*

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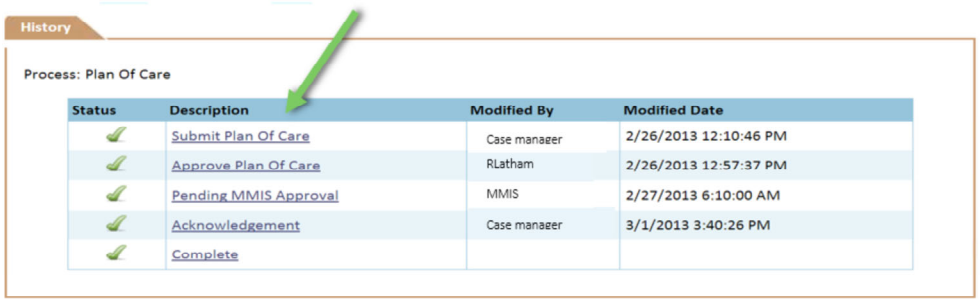
Today we are going to focus on the plan status and individual preferences links. Individual preferences are critical in developing a person centered plan of care.

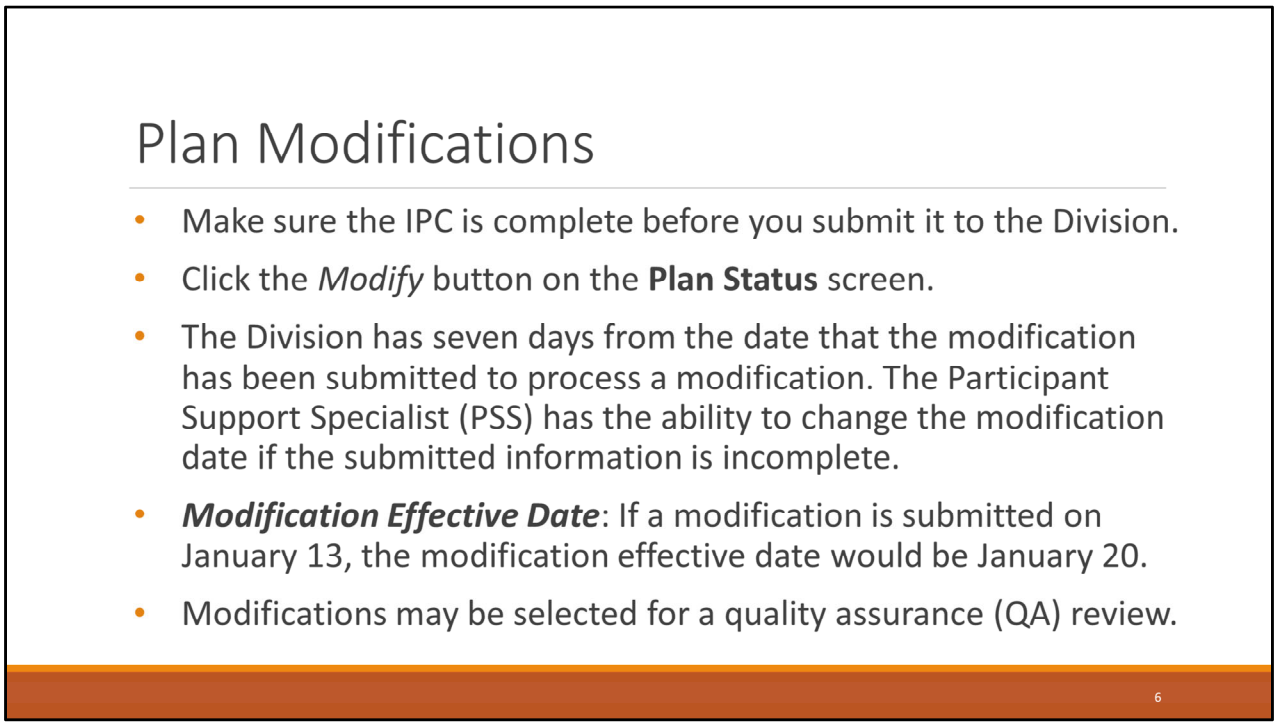
Plan Status

The status of the individualized plan of care (IPC) can be monitored through the **Plan Status** screen under Waiver Links. This screen shows the IPC progress from plan submission to completion.



IPC Work Flow

The workflow diagram below illustrates the steps required for the IPC to be considered complete. The same workflow process is necessary for a modification to the IPC.



Prior to plan or modification submission, the Division expects the plan to be complete. Contact the appropriate PSS with any questions about rules or processes prior to submission.

A modification is initiated by the case manager by clicking the Modify button on the Plan Status screen.

An explanation of the modification should be detailed in the box provided on the Plan Status screen. Note the date the modification is effective on the Plan Status screen. This date must be at least seven calendar days after the submission date of the modification. The modification effective date must be at least one day after the IPC start date or the last plan modification.

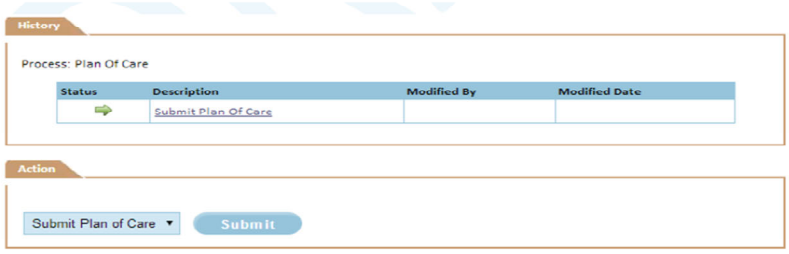
- For example, If a modification is submitted on January 13th, the modification effective date would be January 20th.

If an exception to this timeline is necessary, notify the assigned PSS via email or phone call, that an exception is needed.

Please note that plans or modifications may be selected for a quality assurance (QA) review once submitted instead of being rolled back.

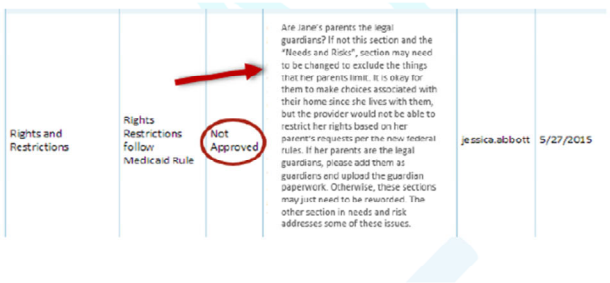
Finalizing the IPC or Modification

After all the required steps have been completed to finalize the IPC, return to the Plan Status screen and click the Submit button under the Action tab.



IPC and Modification Rollbacks

If the plan is rolled back review the PSS' comments regarding needed corrections, access the Plan Status link to review the PSS' comments regarding needed corrections.



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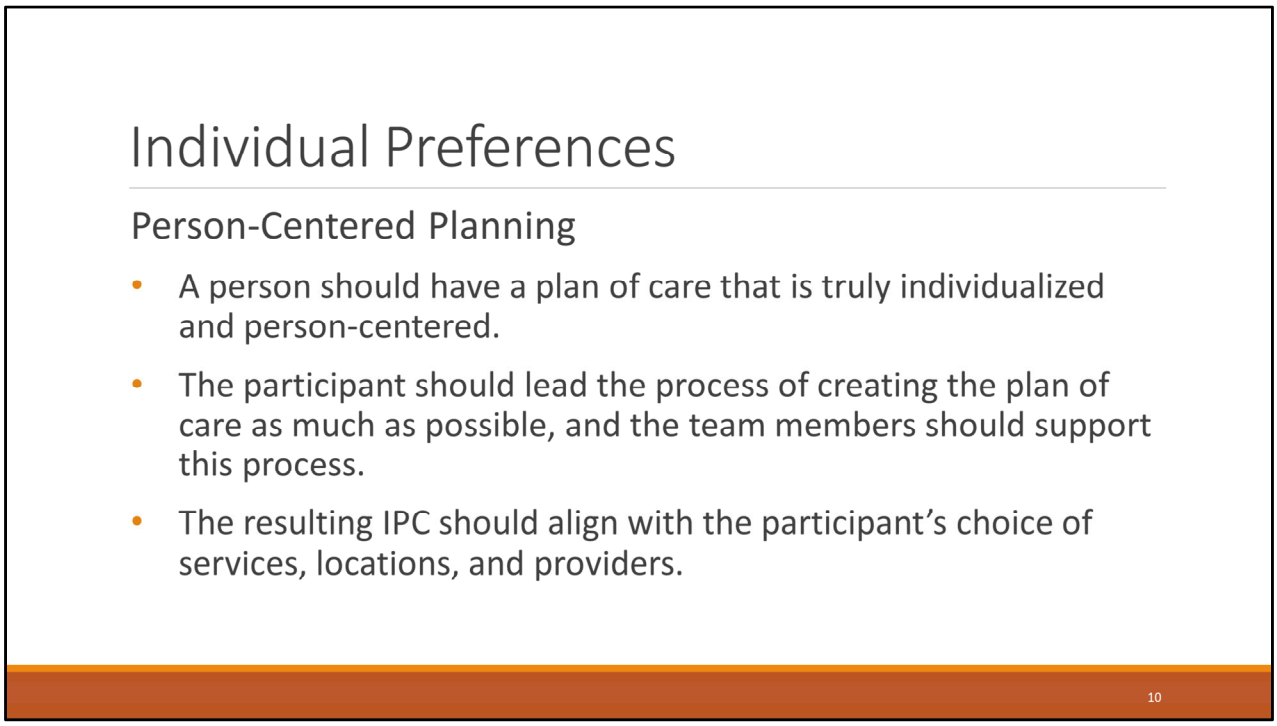
The PSS may roll back the IPC for corrections or clarifications.

Review the PSS' comments regarding needed corrections. The case manager should make the necessary corrections and/or clarifications throughout the IPC, as requested, and then click Submit on the Plan Status screen to submit the corrected IPC. If an incomplete IPC is rolled back to the case manager for corrections, case managers must resubmit the IPC at least seven business days prior to the end of the month to ensure enough time for plan review.

MMIS Approval

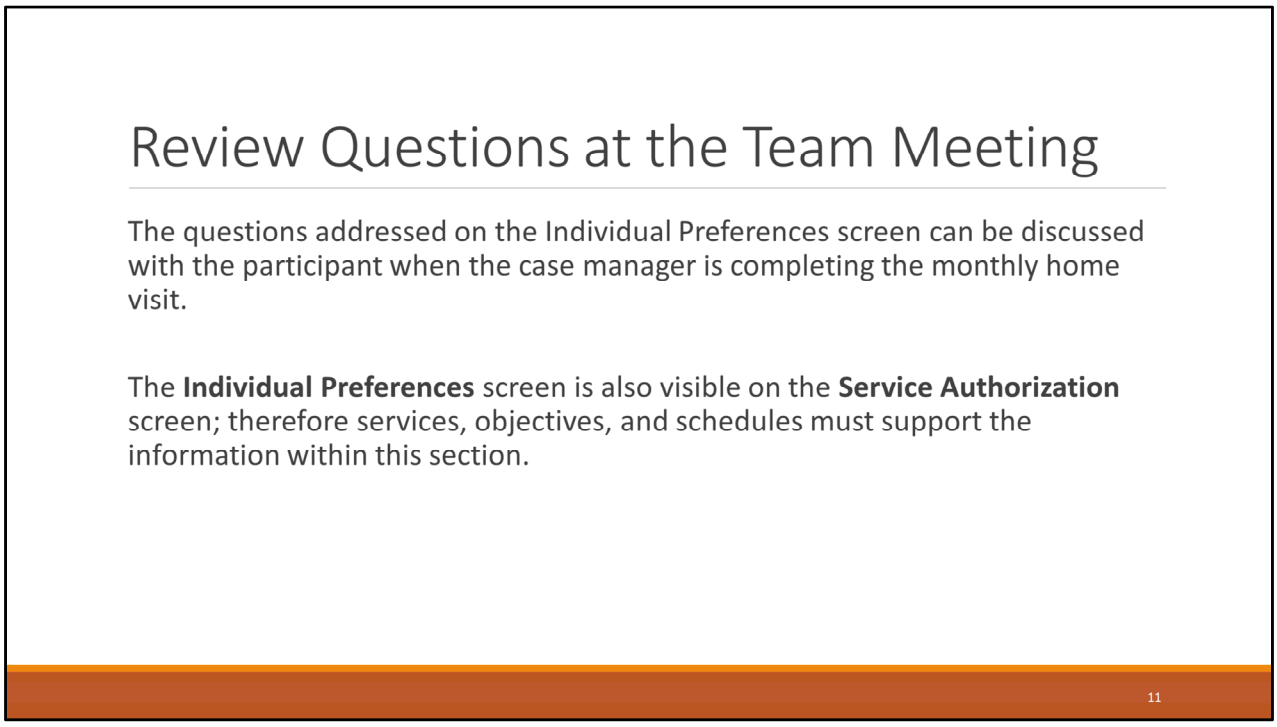
- Once the IPC has been reviewed, the **Plan Status** screen will indicate *Pending MMIS Approva*l.
- *Pending MMIS Approval* means that the IPC has completed the Division's review process and is awaiting prior authorization numbers from the Medicaid Management Information System (MMIS)
  - MMIS is the system that processes all provider billing claims and adjustments.



Under the Home and Community Based (HCB) Settings rule through the Center of Medicaid Services (CMS), a person should have a plan of care that is truly individualized and person-centered. The participant should lead the process of creating the plan of care as much as possible, and the team members should support this process.

The planning discussions should capture ways in which the participant wants to be involved in the community, and should include information about the person's strengths and preferences, support needs, goals, and existing safety risks.

The resulting IPC should align with the participant's choice of services, locations, and providers. Information must portray a comprehensive picture of the participant so the team and providers working with the participant will understand how to deliver services and supports around their individualized needs and preferences.



The questions addressed on the Individual Preferences screen can be discussed with the participant, with help from the provider or family member, when the case manager is completing the monthly home visit. This information should also be reviewed at the annual and six month review team meetings. Use the Team Meeting Checklist for guidance.

- The Individual Preferences screen is also visible on the Service Authorization screen; therefore services, objectives, and schedules must support the information within this section.

Individual Preferences

- Enter the dates for the six month review and annual team planning meeting.
- Do not include references to rights restrictions in this section.
- At a minimum, this section must be updated annually.

Identify the accomplishments the participant would like to achieve over the upcoming year.

Example of a question the participant can answer: What would I like to be able to do this year that I have not been able to do previously?

- Summarize progress made on habilitation objectives in the past year, and include the participant's new habilitation service objectives. Habilitative service objectives need to be person-centered, and must meet the service definition.
- Include an overview of important events that occurred in the past year, which are relevant to the participant's goals and planning.

Participant's Personal Preferences

Activities identified in this section should be reflected in the schedules of the services the participant is receiving.

Examples of questions the participant can answer:

a) Who do I like to spend time with?

b) What things do I do or like to do?

c) What help do I need to get to where I want to go?

Important Things to Know About the Participant

Assist the participant in answering the following questions:

a) What causes me to feel sad, hurt, angry, or scared?

b) What can providers do to help me when I feel these things?

c) What are the things I absolutely need in my life?

d) What are my interests? (e.g. hobbies, cultural, or religious traditions, sports teams, local events, etc.)

e) What are the things I do not like or want?

Questions?

Please use the chat box feature!

We encourage case managers to provide us with feedback, as well as any preferences on areas in the plan you would like covered. All recommendations or comments can be referred to Alex Brooks at cm.consultant@wyo.gov.

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Thank you for attending this training. It will be added to the Division's website for you to review. If you have any questions regarding this training, please enter them into the chat box.