



# Community Choices Waiver: Case Management Manual

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## Table of Contents

Section 1. Program Background and Context .....	1
1.1 Medicaid Background.....	1
1.2 Medicaid HCBS Waivers Background .....	1
1.2.1 HCBS Waiver Assurances .....	2
1.3 Other Important Policies.....	3
1.3.1 Rehabilitation Act of 1973 .....	3
1.3.2 Americans with Disabilities Act of 1990.....	3
1.3.3 Olmstead v. L.C. (1999).....	3
1.3.4 Affordable Care Act of 2010.....	4
Section 2. Community Choices Waiver Program Overview.....	5
2.1 Program Objectives.....	5
2.2 Program Administration.....	5
2.3 Program Eligibility.....	6
Section 3. Wyoming Medicaid and Other Community Resources Overview .....	8
3.1 Wyoming Medicaid State Plan Services.....	8
3.1.1 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT).....	8
3.1.2 WYhealth.....	8
3.1.3 Nurse Advice Line .....	9
3.2 Other Community Resources .....	9
3.2.1 Other Wyoming Department of Health Programs.....	9
3.2.2 Wyoming Department of Family Services Programs.....	11
3.2.3 Other Resources .....	11
Section 4. Case Management Agency Administration.....	13
4.1 Case Management Agency Qualifications.....	13
4.2 Case Management Agency Responsibilities .....	14
4.3 Case Manager Qualifications .....	15
4.3.1 Education and Experience .....	15
4.3.2 Case Manager Training.....	16
4.3.3 Criminal History and Background Screening.....	16
4.4 Conflict of Interest Safeguards .....	17

4.4.1 Anti-Kickback Standards .....	18
4.5 Quality Assurance .....	18
4.6 Complaints and Grievances .....	19
4.7 Limited English Proficiency (LEP) .....	19
Section 5. Case Management Services.....	21
5.1 Assessment.....	22
5.1.1 Assessment Modules .....	22
5.1.2 Supported Decision Making .....	24
5.1.3 Risk Assessment.....	24
5.1.4 Goal Development .....	25
5.1.5 Assessment Summary .....	26
5.2 Service Plan Development .....	26
5.2.1 Person-Centered Service Planning Requirements.....	26
5.2.2 Options Counseling.....	28
5.2.3 Estimating Frequency and Duration of Services .....	30
5.2.4 Backup Plan .....	31
5.3 Risk Mitigation .....	32
5.4 Referral and Related Activities .....	33
5.4.1 Freedom of Choice.....	33
5.4.2 Waiver Service Referrals.....	33
5.4.3 Information and Assistance in Support of Participant Direction.....	34
5.4.4 Additional Referrals.....	34
5.5 Finalizing the Service Plan .....	35
5.6 Prior Authorizations .....	36
5.7 Service Plan Review and Updates .....	36
5.8 Service Plan Monitoring.....	37
5.8.1 Monitoring the Identified Potential for Participant Risk .....	39
5.8.2 Monitoring for Abuse, Neglect and Exploitation.....	39
5.9 Case Documentation .....	41
Section 6. Service Denials, Reductions, Discontinuations, and Waiver Enrollment Terminations .....	44
Section 7. Participant Rights and Safeguards .....	46
7.1 Participant Rights and Responsibilities.....	46

7.2	Protected Health Information.....	47
7.3	Home and Community-Based Setting Requirements .....	48
7.3.1	Specific Requirements for Home and Community-Based Settings .....	49
7.3.2	Provider Owned or Controlled Residential Setting Requirements .....	49
7.4	Modifications of Participant Rights .....	50
7.4.1	Restraints .....	51
7.4.2	Restrictive Interventions .....	52
7.4.3	Seclusion.....	52
Section 8.	Incident Reporting and Response .....	53
8.1	Incident Reporting .....	53
8.2	Incident Follow-up and Follow-Through.....	54
8.3	Critical Incidents .....	54
Section 9.	Fraud, Waste, and Abuse .....	56
9.1	Prevention and Education .....	57
9.2	Reporting.....	57
Appendix A:	Definition of Terms.....	58
Appendix B:	Incident Taxonomy.....	62

## **Section 1. Program Background and Context**

The Community Choices Waiver is a Medicaid Home and Community-Based Services (HCBS) waiver program. Medicaid HCBS waivers provide services to participants in their community as an alternative to institutional care.

### **1.1 Medicaid Background**

The Medical Assistance Program, commonly known as Medicaid, is a partnership between the state and federal governments to provide public health insurance to low-income Americans. The Medicaid program was created as a companion to the Medicare program, which was primarily designed to provide public health insurance coverage for seniors. Both programs were enacted through the Social Security Amendments of 1965.

Though participation is voluntary, all 50 states, the District of Columbia, and the five United States territories operate their own Medicaid programs. Costs for Medicaid services and administration are shared by the state and federal governments. As a condition of participation, a state must agree to provide coverage to all individuals within certain categorically eligible populations and to provide a basic array of mandatory healthcare services. Beyond those requirements, the states are granted significant flexibility in the design and administration of their Medicaid programs to include optional services and expand coverage to include optional populations.

Each state must describe the administration and operations of its Medicaid program through the development and maintenance of a Medicaid State Plan. The Medicaid State Plan serves as the formal agreement between the state and federal governments and must be approved by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS).

The State of Wyoming's Medicaid program was first implemented in July of 1967 following passage of the Wyoming Medical Assistance and Services Act. The Wyoming Department of Health, Division of Healthcare Financing (the Division) is the state agency responsible for administration of the Wyoming Medicaid program.

### **1.2 Medicaid HCBS Waivers Background**

Though Medicaid was primarily designed to provide for the acute healthcare needs of low-income Americans, the program also serves older adults and individuals with physical or cognitive impairments who require long-term access to specialized supports.

In the years immediately following the program's establishment, Medicaid beneficiaries who required long-term care were able to receive that level of support exclusively in institutional settings, i.e., a nursing facility, an intermediate care facility for individuals with intellectual disabilities (ICF/IID), or a hospital. Policy changes initiated in the early 1980s have since made a profound impact on the way Medicaid beneficiaries receive needed long-term care services.

Section 1915(c) was added to the Social Security Act through the Omnibus Budget Reconciliation Act (OBRA) of 1981. Under this legislation, Congress provided the states with the option to waive certain Medicaid statutory requirements in order to offer a program of HCBS to targeted groups of individuals who would otherwise require the care provided in a Medicaid-covered institution. Individuals enrolled in an HCBS waiver program retain access to the full array of benefits provided under the Medicaid State Plan in addition to the menu of services offered under the waiver. States must apply for and receive approval from CMS to operate an HCBS waiver program, and HCBS waiver programs must be renewed at least every five years.

### 1.2.1 HCBS Waiver Assurances

CMS requires the states to make assurances and agree to other program standards within the HCBS waiver application. The assurances and standards summarized below provide the foundation for the way the state operates its HCBS waiver program.

Assurance	Requirement
<b>Level of Care</b>	Participants enrolled in the HCBS waiver meet the level of care consistent with the care provided in a hospital, nursing facility, or ICF/IID. Level of care is determined according to the process described in the waiver agreement.
<b>Qualified Providers</b>	Services are delivered by agencies and individuals who meet the credentialing requirements and qualifications in the waiver agreement
<b>Service Planning</b>	A participant's needs and preferences are assessed and reflected in a person-centered service plan. Service plans are updated annually and when needed. Services are delivered according to the service plan. Participants are provided choice among waiver services and providers.
<b>Health and Welfare</b>	Participants are protected from abuse, neglect and exploitation. Incidents where a participant has been abused, neglected, or exploited are identified, reported, and addressed
<b>Financial Accountability</b>	Only services that are approved and provided are paid. The cost for services does not exceed the cost of the equivalent institutional care on a per capita basis.

Case management agencies and case managers play a critical role in helping the Division meet the requirements of each assurance. Data related to each assurance must be collected by the Division and reported to CMS annually. CMS uses this data to determine whether the state is in compliance with federal requirements and continues to qualify for federal funding.

## **1.3 Other Important Policies**

The Community Choices Waiver program's design has been shaped by other federal laws and policies. Not only do those laws and policies set the boundaries and constraints under which the waiver program operates, but they also reflect the philosophical context for the programs. In order for case managers to be effective in their role, it's important that case managers understand those laws and policies and how they impact their work.

### **1.3.1 Rehabilitation Act of 1973**

The Rehabilitation Act prohibits discrimination on the basis of disability in programs conducted by the Federal Government, in programs receiving federal financial assistance, in federal employment, and in the employment practices of federal contractors. The Rehabilitation Act authorizes funding for grants to states for vocational rehabilitation services, supported employment programs, centers for independent living, and other services to support people with disabilities. The Rehabilitation Act also authorizes funding for research activities administered by the National Institute on Disability and Rehabilitation Research and the work of the National Council on Disability.

### **1.3.2 Americans with Disabilities Act of 1990**

The Americans with Disabilities Act (ADA) was enacted to provide a national mandate for the elimination of discrimination against individuals with disabilities; to provide enforceable standards for addressing discrimination against individuals with disabilities; and to invoke congressional authority to enforce the Fourteenth Amendment and to regulate commerce in order to address the major areas of discrimination faced daily by individuals with disabilities.

The ADA states that no qualified individual with a disability shall, because of the disability, be excluded from participation in or be denied the benefits of services, programs, or activities of a public entity, or be subjected to discrimination by any such entity. The case management agency and case manager are responsible for compliance with the ADA.

### **1.3.3 Olmstead v. L.C. (1999)**

Olmstead v. L.C. is a landmark United States Supreme Court decision. The Olmstead ruling requires states eliminate unnecessary segregation of persons with disabilities and ensure that persons with disabilities receive services in the most integrated setting appropriate to their needs.

The Olmstead case began with two women who were voluntarily admitted to the psychiatric unit in a state-run psychiatric hospital. Following the women's medical treatment there, mental health professionals stated that each was ready to move to a community-based program. However, the women remained confined in the institution, each for several years after the initial treatment was concluded. The women alleged that



the State of Georgia had failed to provide adequate support for people in the community. They filed a suit claiming the state was violating Title II of the Americans with Disabilities Act, which guarantees non-discrimination based on disability for the services, programs, or activities provided by a public entity.

The Supreme Court found that ‘unjustified institutional isolation’ is indeed a form of discrimination. The decision contained these two key findings:

- “institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life”
- “confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.”

The Court established a three-part test for evaluating the right of individuals with disabilities to receive support in the community, these areas can be summarized as:

- Appropriateness of community support should be based on an assessment
- The individual in an institutional setting has the choice to request and consent to a less restrictive setting
- Services provided in the community must accommodate the needs of the person receiving them and the state resources available to fund those services must be similar to those provided to other individuals with disabilities in a similar situation

#### **1.3.4 Affordable Care Act of 2010**

The Affordable Care Act (ACA) includes a number of health insurance coverage and reform provisions, some of which include establishing exchanges where previously uninsured people could purchase health insurance and providing states the ability to expand Medicaid eligibility to individuals with incomes up to 133% of the Federal Poverty Level through an optional coverage group.

The ACA also provided states with additional flexibilities in HCBS program administration and requires that states:

- Are responsive to the needs and choices of HCBS participants
- Maximize independence and self-direction
- Provide support coordination to assist with community-supported life
- Achieve a more consistent and coordinated approach to the administration of policies and procedures across HCBS programs

Embedded within the above requirements are the requirements for states administering HCBS waivers to meet person-centered planning standards that were published in March 2014. In order for states to continue receiving federal funds for HCBS programs, states must comply with person-centered planning regulations.

## Section 2. Community Choices Waiver Program Overview

The Community Choices Waiver program provides older adults and adults with disabilities a community-based alternative to nursing facility care. Participants are supported to achieve independence, maintain health and safety, and fully participate in community living through access to high-quality, cost-effective community-based services.

### 2.1 Program Objectives

Objective	Description
<b>Individual Authority Over Services &amp; Supports</b>	Provide program participants with the opportunity and authority to exert control over his/her services, supports, and other life circumstances to the greatest extent possible.
<b>Person-Centered Service Planning &amp; Service Delivery</b>	Acknowledge and promote the participant's strengths, goals, preferences, needs, and desires through a person-centered service planning process. Respect and support the participant's strengths, goals, preferences, needs, and desires through person-centered service delivery.
<b>Promote Community Relationships</b>	Support and encourage the participant's self-determined goals to be active members of their communities. Recognize that the nature and quality of community relationships are central to participant health and wellness.
<b>Health &amp; Safety</b>	Effectively manage risk and balance the participant's ability to achieve independence and maintain health and safety.
<b>Service Array</b>	Offer services which are responsive to the needs of the target population and complement and/or supplement the services that are available through the Medicaid State Plan and other federal, state, and local public programs as well as the supports that families and communities provide to individuals.
<b>Responsible Use of Public Dollars</b>	Demonstrate sound stewardship of limited public resources.

### 2.2 Program Administration

The Division retains the ultimate administrative authority and responsibility for the operation of the waiver program through memoranda of understanding (MOUs) with other governmental agencies and contracts with vendors who conduct delegated administrative functions. Community Choices Waiver services are delivered through a

statewide network of providers and are reimbursed according to a standard fee schedule on a fee-for-service basis.

The Division allows for the open, continuous enrollment of all willing and qualified service providers. Case managers can access additional program information, including detailed descriptions of the services available, in the Community Choices Waiver Provider Manual.

### 2.3 Program Eligibility

Before a participant can receive services through the Community Choices Waiver, he/she must be determined eligible for the program. Eligibility begins with a referral, followed by an application and a determination of eligibility.

Referrals for the Community Choices Waiver can come from many sources; however, most referrals are made by the Division’s Client Services Unit when an individual applies for Medicaid. Case management agencies, hospitals, senior centers, family members, friends, and any other persons or agencies may also make a referral on behalf of an individual. Persons or agencies who want to make a referral should call the Division’s Home and Community-Based Services Section.

Any individual who wishes to receive services through the Community Choices Waiver must complete an application for Medicaid as well as the application for the Community Choices Waiver. To qualify for enrollment, an individual must meet all three categories of target population criteria detailed below:

Group	Description
<b>Financial Eligibility Group</b>	The individual must be otherwise eligible for Wyoming Medicaid (such as a Supplemental Security Income recipient) or must meet income and resource requirements to qualify for the “Special HCBS Waiver Group.”
<b>Target Group</b>	The individual must be determined by the Division to be: <ul style="list-style-type: none"> <li>• Aged (65 years or older), or</li> <li>• An adult (19 to 64 years old) with a disability. Disability is demonstrated by a disability determination by the Social Security Administration (SSA) or by the Division or its agent using SSA guidelines</li> </ul>
<b>Nursing Facility Level of Care</b>	The individual must be evaluated by a trained public health nurse using the LT-101 assessment and be determined by the Division to require the services and level of care provided by a nursing facility.

While a case management agency may be the applicant’s first point of contact, the case management agency does not have a role in the eligibility determination process. The Division is the only entity with the authority to determine if the applicant meets the target

population criteria or to make Medicaid eligibility and program enrollment decisions. The case management agency must provide the individual with information on the application process and make a referral to the Division for any additional questions.

As part of the application process, all applicants are provided freedom of choice to select a case management agency from a list of the qualified case management agencies serving the applicant's county of residence. If requested by the applicant, the participant's chosen case management agency may assist the applicant in completing and submitting the Medicaid and/or Community Choices Waiver program application documents.

At the case management agency's discretion, case managers may offer assistance with obtaining and filling out forms and/or explaining the process and the additional documentation that may be required. However, case managers must maintain professional boundaries and must never be given access to an applicant's personal accounts, be given authority to communicate directly with banking or other financial institutions, or be empowered to make any healthcare or financial decisions on behalf of the applicant.

## **Section 3. Wyoming Medicaid and Other Community Resources Overview**

Medicaid and HCBS waiver programs are part of a network of programs that support individuals with low income or disabilities. Participants enrolled in the Community Choices Waiver may also be eligible for other programs offered throughout the state. Case managers have a responsibility to be familiar with statewide resources as well as those local to the communities in which the participant resides.

### **3.1 Wyoming Medicaid State Plan Services**

Every participant enrolled in the Community Choices Waiver is also eligible for Wyoming Medicaid. Wyoming Medicaid State Plan benefits include, but are not limited to:

- Inpatient/Outpatient Hospital Services
- Primary Care/Physician Services
- Prescription Drugs
- Durable Medical Equipment
- Mental Health and Substance Use Services
- Medical Supplies and Equipment
- Non-Emergent Medical Transportation
- Home Health Services
- Nursing Facility Services
- Hospice Care

The case manager's role is to be familiar with the benefits offered through the Medicaid State Plan and know how to assist participants in accessing the benefits. Case managers should also refer participants to the Wyoming Medicaid Client Handbook for more information on their Medicaid State Plan benefits.

#### **3.1.1 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)**

Medicaid EPSDT standards require that Medicaid-eligible beneficiaries under the age of 21 receive coverage of all services necessary to diagnose, treat, or ameliorate conditions identified by an EPSDT screening. Under the EPSDT coverage provisions, a state must cover any medically necessary services irrespective of whether the state explicitly includes such benefits in its state plan.

#### **3.1.2 WYhealth**

WYhealth is Wyoming Medicaid's health management program designed to remove barriers to medical care and to encourage Wyoming Medicaid members to be actively engaged in managing their own health. Referrals to this program may be beneficial to participants who need assistance managing complex care needs or who could benefit from education or assistance with managing a chronic health condition. Case managers

should visit the Division's website for information on how to make a referral to the WYhealth program.

### **3.1.3 Nurse Advice Line**

The Division provides a free nurse advice line for participants. This resource is available 24 hours a day, 7 days per week and can be used by participants to help them:

- Understand care options for symptoms and conditions
- Decide when and how to seek care for an urgent problem
- Make decisions about tests, medications, and treatments
- Learn about ways to improve their health
- Understand their medications
- Learn more about a diagnosis they've received from their doctor

Case managers should be familiar with this resource and provide information to participants on how to access it.

## **3.2 Other Community Resources**

The following is not an exhaustive list of resources available to residents of Wyoming but is provided as a starting point for case managers to reference. In order to provide accurate information and support to participants, case managers must become familiar with the resources available in the communities he or she provides case management. Case managers should establish relationships, or at minimum know how to contact local community resources, such as:

- Churches and faith-based organizations – Can provide financial or food support along with support groups, or volunteer activities
- Local food pantries – Can provide food items and other household necessities
- Community services organizations such as the Salvation Army and Catholic Charities of Wyoming – Can provide various types of support and referrals for support
- Fraternal organizations such as the Eagles or Elks Club, Knights of Columbus or the Kiwanis, Junior League
- Aging and disability associations such as the Multiple Sclerosis Society and the Alzheimer's Association.

### **3.2.1 Other Wyoming Department of Health Programs**

The Aging Division administers the Older Americans Act (OAA) services that help keep older adults healthy and independent. Services include:

- Congregate and home-delivered meals
- Job training
- Senior centers
- Health promotion

- Benefits enrollment
- Caregiver support
- Transportation

#### Long-Term Care Ombudsman

- The Long-Term Care Ombudsman program is authorized by the OAA and exists to promote policies and consumer protections to improve long-term services and supports at a facility, local, state, and national levels. The role of the Long-Term Care Ombudsman is to investigate, advocate, and mediate on behalf of adults applying for or receiving long term care services, in an effort to resolve complaints concerning a participant's health, safety, welfare, or rights.

The Behavioral Health Division oversees an integrated continuum of care and providers. Services provided by the Behavioral Health Division include:

- Mental Health and Substance Use Treatment – Provides individual treatment, children and family treatment, court supervised treatment, mental health crisis support, and gambling support
- Early Intervention and Education Program (EIEP) – Provides early childhood development screenings for children ages 0-5

Case managers should access the Behavioral Health Division's website for more information or call 1-800-535-4006.

The Public Health Division manages a statewide network of Public Health Nursing agencies. The Public Health Nursing agencies focus on preventing illness and improving health of groups of people. Services are located in county health offices throughout Wyoming. For additional information, case managers should access the Public Health Division's website or call 1-307-777-7275.

The Wyoming Department of Health also collaborates with the University of Wyoming's Center on Aging to host an online resource information website called the Wyoming Aging and Disability Resource Center ([www.adrcwyoming.org](http://www.adrcwyoming.org)) to help locate agencies that can provide assistance for many types of support.

### 3.2.2 Wyoming Department of Family Services Programs

Program	Overview
Supplemental Nutrition Assistance Program (SNAP)	Provides monthly benefits to help low-income households buy the food they need for good health
Supplemental Nutrition Assistance Program Education (SNAP-Ed)	Offers free cooking and nutrition education classes for both children and adults throughout Wyoming.
Wyoming Homeless Services Program	Assists individuals and families experiencing homelessness.
Low Income Energy Assistance Program (LIEAP)	Pays part of winter home heating bills for eligible people; seniors and those with disabilities are given program priority.
Weatherization Assistance Program (WAP)	Makes homes more energy efficient and further lower home heating costs (those approved for LIEAP may also be eligible for weatherization services)
Telephone Assistance – Lifeline	Lowers the monthly cost of phone or internet service (open to anyone enrolled in SNAP, LIEAP, Supplemental Security Income, Medicaid, or Federal Public Housing Assistance)
The Emergency Food Assistance Program (TEFAP)	Supplies a food box to those who are eligible. Wyoming Department of Family Services works with the Food Bank of the Rockies to help supply food to food banks across the state
Commodity Supplemental Food Program (CSF)	Provides a monthly food box, at no charge, for individuals age 60 or older and re income eligible
Temporary Assistance for Needy Families (TANF)	Provides temporary cash assistance for families in need

### 3.2.3 Other Resources

Centers for Independent Living (CILs) are community-based, cross-disability, non-profit organizations operated and designed by people with disabilities. CILs provide the following services:

- Peer support
- Information and referral
- Individual and systems advocacy
- Independent living skills training
- Services that facilitate transition from nursing homes and other institutions to the community

The Wyoming Department of Workforce Services, Vocational Rehabilitation Division provides Vocational Rehabilitation services. These services assist people with



disabilities to establish goals for and obtain employment. The Vocational Rehabilitation Division can only provide services that are necessary for eligible individuals to reach employment goals. Services include, but are not limited to:

- Eligibility Assessment
- Counseling and Guidance
- Referral Services
- Job Search and Placement Assistance
- Deaf and Blind Interpretive Services
- Vocational and Other Training Services

Case managers can find a complete list of services and eligibility information on the Vocational Rehabilitation Division's website.

Protection and Advocacy System, Inc. is Wyoming's protection and advocacy network, authorized by Congress to implement federal laws to protect the human, civil, and legal rights of people with disabilities, including veterans with disabilities. The Wyoming Protection and Advocacy office employs attorneys and other professional staff who provide a variety of services. Case managers can contact Wyoming Protection and Advocacy by calling 1-307-632-3496 or access their website for a complete listing of programs.

Legal Aid of Wyoming is a federally funded, non-profit law firm providing legal assistance to low-income individuals living in WY. Legal aid provides representation in many, though not all, types of civil cases. Legal Aid of Wyoming cannot represent defendants in criminal cases. Case managers should access Legal Aid of Wyoming's website for additional information.

## **Section 4. Case Management Agency Administration**

Case management agencies are essential community partners which provide a system and structure for the delivery of Community Choices Waiver services. Although a case management agency may be one person who is a case manager or an organization that hires case managers, the agency itself is enrolled as a Wyoming Medicaid provider and is therefore subject to the provisions of the Wyoming Department of Health's Provider Participation Agreement. The case management agency retains the responsibility for the oversight of the services it provides and for ensuring those services are delivered by qualified case managers who have received adequate training and supervision to conduct the required case management activities.

By submitting claims for Medicaid reimbursement, the case management agency attests to the integrity of those claims and confirms that its services were delivered in accordance with the service specifications and program requirements set forth in this manual.

### **4.1 Case Management Agency Qualifications**

Case management agencies must be one of the following:

- A County Public Health Nursing Agency designated by the Wyoming Department of Health, Public Health Division; or
- A corporation, Limited Liability Corporation (LLC), non-profit organization, sole proprietorship, or other business entity registered in good standing with the Wyoming Secretary of State.

A case management agency must complete the following enrollment steps:

- Obtain a National Provider Identifier (NPI) Number
  - The NPI is a single provider identifier and is a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The NPI must be used by most HIPAA covered entities, to include those that conduct electronic transactions (such as claims billing). If a case management agency has a physical office in more than one location, a separate NPI is required for each location. However, if an agency only has one physical location but serves participants in multiple counties in WY, only one NPI is required. The NPI must be obtained prior to the case management agency submitting the Wyoming Medicaid Provider Participation Agreement.
- Complete and submit a Wyoming Medicaid provider application and enter into a Provider Participation Agreement
  - For complete information on the provider application process, agencies should visit the Division's website or contact the Division directly

## 4.2 Case Management Agency Responsibilities

Once approved as a case management agency, the agency is responsible for providing quality case management services to the participants they serve. A case management agency must:

- Assign one (1) person to act as the Division's primary contact and assume responsibility for the case management agency's administration and operation
- Protect participant rights
- Provide case management services for participants without discrimination based on race, religion, political affiliation, gender, national origin, age, sexual orientation, gender expression, or disability
- Provide a person-centered approach to case management activities
- Ensure all case managers meet the requirements outlined in the approved Community Choices Waiver and this manual, including all training required to deliver case management services
- Maintain adequate administrative and staffing resources and emergency backup systems to deliver case management services in accordance with all federal and state requirements
- Assign one (1) person to serve as the participant's primary case manager, reasonable efforts must be made to include the participant's preferences in this assignment
- Ensure all participants have a backup case manager, should the primary case manager not be able to provide case management services for any reason
- Maintain, or have access to up-to-date information about public and private state and local services, supports, and resources, and make this information available to the participant and/or persons inquiring upon their behalf
- Establish and maintain working relationships with community-based resources, supports, organizations, hospitals, service providers, and other organizations that assist in meeting the participant's needs
- Collaborate with other entities, as needed to support participants
- Ensure that case managers have access to federal and state statutes, regulations, and other documents and information relevant to the provision of case management services
- Ensure that case managers maintain a working knowledge of the Community Choices Waiver policies and procedures
- Overcome any geographic barriers, including distance to the participant, to provide timely case management services
- Ensure that case management services are, at minimum, available during normal business hours (Monday through Friday, 9:00 AM to 5:00 PM, excluding state holidays)

- Provide access to a telephone system and trained staff to ensure timely responses to messages and telephone calls received outside of normal business hours
- Facilitate access to telecommunication devices and/or interpreters for participants with hearing and/or vocal impairments and access to foreign language interpreters as necessary to conduct all required case management activities
- Ensure the agency does not bill for case management services prior to a participant being determined eligible for the Community Choices Waiver. Any services provided prior to eligibility shall not be submitted to the Division for reimbursement
- Maintain sufficient documentation to substantiate claims for reimbursement of case management services for six (6) years after the date of service, including all documents, records, communications, notes, case manager qualifications, and other materials related to services provided and work performed

As a best practice, case management agencies should develop written procedures sufficient to execute case management services according to the requirements in the waiver and this manual. Should a case management agency develop written procedures, the procedures could include:

- Assessment
- Service plan development
- Referral and related activities
- Service plan monitoring
- Authorization of services
- Service denials, reductions, discontinuations, and waiver terminations
- Complaints and grievances
- Critical incident reporting and follow-up

### **4.3 Case Manager Qualifications**

In order to qualify as a case manager, the case manager must be employed or contracted by a qualified case management agency. The case management agency is responsible for verifying and maintaining documentation that employed or contracted case managers meet all qualifications within this manual. The Division may request evidence of case manager qualifications at any time, and services delivered by an unqualified case manager may be subject to payment recovery.

#### **4.3.1 Education and Experience**

Case managers must meet the following education and experience requirements:

- A master's degree from an accredited college or university in human services, social services, or a related field of study;

- A bachelor's degree from an accredited college or university in human services, social services, or a related field of study and one (1) year of related work experience in human or social services; or
- An associate's degree from an accredited college or university in human services, social services, or a related field of study and four (4) years of related work experience in human or social services.

A case manager who was employed by a case management agency prior to July 1, 2016 may continue to provide case management services without meeting the above criteria as long as the case manager has a high school diploma or high school equivalency certificate and six (6) years of experience as a case manager.

### **4.3.2 Case Manager Training**

Prior to delivering case management services, the case manager must demonstrate the requisite knowledge, skills, and abilities through successful completion of the Division's approved case management training curriculum.

Along with the required training, new case managers should observe other case managers providing, and then be observed providing case management services. Case managers should demonstrate knowledge and competency prior to providing case management services independently.

New case managers must complete and document the required training within 90 days from the date of hire and prior to providing case management services independently. Any additional training should also be documented. All other case managers must receive refresher training annually. Division staff may also require a case manager to retake any training at the Division's discretion. The case management agency is responsible for ensuring all case managers receive all requisite training to deliver case management services and for maintaining documentation of all case manager training, to include at minimum the date and title/topic of training.

Case managers must attend any mandatory training required by the Wyoming Department of Health or Division of Healthcare Financing.

### **4.3.3 Criminal History and Background Screening**

A criminal history and background investigation must be conducted for those employees, contractors, and volunteers who may have unsupervised direct contact with waiver participants in the regular course of their work delivering case management services. The criminal history and background investigation must include screening against federal and state databases, including:

- United States Department of Health and Human Services, Office of Inspector General, List of Excluded Individuals/Entities
- United States Department of Justice, National Sex Offender Public Website

- Wyoming Attorney General's Office, Division of Criminal Investigation (DCI), Western Identification Network
- Federal Bureau of Investigation (FBI), Identity History Summary Check
- Wyoming Department of Family Services, Central Registry of Abuse and Neglect

The screening must confirm that the individual has not been excluded from federally-funded healthcare programs, is not currently under investigation for/has not been substantiated for abuse and/or neglect, and has not been convicted of, has not pleaded "no contest" to, and does not have a pending deferred prosecution of any of the following barrier crimes:

- Homicide
- Kidnapping
- Sexual assault
- Robbery
- Blackmail
- Assault and Battery
- Bigamy
- Incest
- Abandoning or endangering children
- Violation of an order of protection
- Human trafficking

Case management agencies may choose to permit individuals to begin delivering case management services pending the results of the criminal history and background investigation if that individual has signed an attestation affirming that he/she has not been convicted of, has not pleaded "no contest" to, and does not have a pending deferred prosecution of any barrier crime and is not currently under investigation and has not been substantiated by the Wyoming Department of Family Services for abuse and/or neglect.

#### **4.4 Conflict of Interest Safeguards**

Federal regulations [42 CFR §431.301(c)(1)(vi)] require that case management activities, including the development of the service plan, cannot be conducted by any individual or entity who is employed by or has an interest in a provider of the waiver services included in the service plan.

To ensure compliance with this requirement, the Division has established the following conflict of interest standards:

- The case manager must not be related by blood or marriage to the participant or to any person paid to provide Medicaid HCBS to the participant
- The case manager must not share a residence with the participant or with any person paid to provide Medicaid HCBS to the participant

- The case manager/case management agency must not be financially responsible for the participant
- The case manager/case management agency must not be empowered to make financial or health-related decisions on behalf of the participant
- The case manager/case management agency must not own, operate, be employed by, or have a financial interest in any entity that is paid to provide Medicaid HCBS to the participant. Financial interest includes a direct or indirect ownership or investment interest and/or any direct or indirect compensation arrangement

Should a conflict arise, it is the case manager's duty to inform the participant and assist the participant in finding a new case manager, case management agency, and/or provider agency as necessary to eliminate potential conflicts of interest.

#### **4.4.1 Anti-Kickback Standards**

In addition to the conflict of interest safeguards for HCBS waivers, federal law prohibits the use of kickbacks. A kickback is offering, paying, soliciting, or receiving anything of value to induce or reward any person for purchasing, ordering, or recommending or arranging for the purchasing or ordering of federally-funded medical goods or services. Criminal penalties for violation of the Anti-Kickback Statute include fines up to \$25,000 per violation and up to five years in prison per violation. Violations can also result in civil penalties including the exclusion from participation in federal healthcare programs, civil monetary penalties of up to \$50,000 per violation, and civil assessments up to three times the amount of the kickback.

The HIPAA Beneficiary Inducement Prohibition forbids providers from providing or offering any remuneration, including free or discounted items, to any Medicare or Medicaid beneficiary that is likely to influence the beneficiary's selection of a particular provider, practitioner, or supplier of Medicare or Medicaid payable items or services. Violations of the HIPAA Beneficiary Inducement Prohibition may result in civil monetary penalties of up to \$10,000 per wrongful act.

Therefore, case managers and case management agencies are prohibited from using kickbacks or inducements to incentivize or reward individuals to choose their case management agency and from receiving items or compensation for influencing a participant's choice of the providers included in the service plan.

#### **4.5 Quality Assurance**

The case management agency is responsible for managing the performance of case managers employed by or contracted with the agency. Each case management agency should have internal mechanisms for assessing and managing the performance of each case manager. Should the case management agency fail to address case manager performance concerns to the Division's satisfaction, the Division may require retraining or other progressive disciplinary actions, up to and including termination of the case

manager's status as a Community Choices Waiver program case manager. Managing case management service quality could include such methods as:

- New case managers shadowing and observing case management services prior to providing services independently
- Regular, systemic review and remediation of case records and other case management services documentation, on at least a sample basis. The review should ensure that case managers meet all established timelines identified in this manual and that all required information is entered into the case management information system. This review would ensure compliance with the requirements in the waiver and this manual
- Allocation and monitoring of staff to assure that all standards and time frames are met
- Addressing and rectifying participant complaints about a case manager
- Partnering with another case management agency for review of case management services when the case management agency is an agency of one

#### **4.6 Complaints and Grievances**

Complaints and grievances may be initiated by the participant or anyone involved or working with the participant. The case management agency should have internal policies and procedures for the resolution of complaints and grievances.

At minimum, case managers must provide the participant with contact information for the case manager, the case manager's supervisor (if applicable), and the Long-Term Care Ombudsman during the initial enrollment and annual service plan meetings. The case manager should also explain the role of the Long-Term Care Ombudsman.

In the event a case manager receives a complaint or grievance from a participant or another individual, the case manager should work with the participant and others to resolve the complaint. Resolution may include, but is not limited to:

- Finding a new provider agency
- Contacting the provider agency to request a change of caregiver
- Assisting the participant in selecting a new case management agency
- Assigning a new case manager
- Revising the service plan based on the participant's needs
- Conducting an internal investigation and reporting findings to the Division

The case management agency or case manager must document all complaints and grievances received as it relates to the services provided by the agency or those authorized to provide services for the participant.

#### **4.7 Limited English Proficiency (LEP)**

To ensure that waiver applicants and waiver participants with limited English language proficiency are not denied access to waiver services, the Division maintains a contract



with a translation and interpretation provider. The contactor offers translation services for documents and telephonic interpretation services in over 160 languages. Case managers assist applicants/participants with limited English language proficiency in accessing the telephonic translation services to support enrollment and service plan development activities, free of charge.

## **Section 5. Case Management Services**

Once enrolled in the Community Choices Waiver, the participant is eligible to receive case management services. Case management services are the cornerstone of Community Choices Waiver service delivery. Case management facilitates the development of a service plan and coordinates the implementation of that service plan. To be effective in this work, the case manager's role is to provide education and information to support participants in the service plan development process. Case managers accomplish this in a multitude of ways, however, at minimum case managers:

- Ensure participants are afforded the authority to determine who is included and/or excluded from the service plan development process
- Provide and explain participant materials, including the Participant Handbook, which includes:
  - Program overview
  - Participation agreement
  - Introduction to person-centered planning
  - Participant rights and responsibilities
  - Information on freedom of choice between institutional care and waiver services; among all feasible service alternatives within the waiver; and among all willing and qualified service providers
- Support participants to lead the process to the maximum extent possible unless the participant's decision-making authority has been conferred to a legal representative, such as a guardian

This work enables participants to access necessary services and supports, navigate a complex system, and address concerns with providers.

Case managers are also responsible for maintaining a professional and appropriate relationship with participants to whom they provide case management. Case managers should maintain professional boundaries and limit social interactions with participants outside of performing case management activities. Case managers must use respectful language in all communication, verbal and written, with participants, family members, providers, the Division, and others supporting the participant.

Case management services consist of deliberate activities to organize and facilitate the appropriate delivery of Community Choices Waiver services and can be broken into four key components:

- Assessment
- Service plan development
- Referral and related activities
- Service plan monitoring

## **5.1 Assessment**

In order to develop a service plan that meets the participant's needs, case managers must conduct a comprehensive assessment of the participant. This assessment helps the case manager and participant identify any medical, educational, social, or other service needs that should be addressed in the service plan. Assessment activities include obtaining participant history, identifying needs, identifying risks, completing related documentation, and gathering information from other sources when available and/or applicable.

Upon initial enrollment, case managers must contact the participant to schedule the assessment within five (5) business days following notification of participant enrollment approval. Case managers must complete the initial assessment process within ten (10) business days from the date the case management agency is notified the participant meets all eligibility criteria for the Community Choices Waiver. The annual reassessment should be conducted no sooner than 60 calendar days and no later than 15 calendar days prior to the service plan end date. Every attempt should be made to schedule the assessment at a time and location convenient for the participant and with anyone else the participant wishes to have present.

When conducting the assessment process, case managers should at minimum include the following:

- Obtain participant history
- Review level of care assessment (LT-101) results
- Review diagnoses and other relevant medical information, if available
- Information provided by others who know the participant, when available or based on participant request
- Completion of the participant assessment modules

Through the assessment process, the participant and case manager identify risks to the participant's health and welfare. Examples of risks include, but are not limited to:

- Dependency on medical devices that require electricity
- Assessed needs which have not been addressed by the service plan
- Health or safety issues the participant chooses not to address

### **5.1.1 Assessment Modules**

As previously mentioned, the assessment process consists of modules. All participants must be assessed with the first module, the Participant Profile. Conducting this assessment will provide the case manager with information to determine if additional assessments are needed based on the identified needs, risks, goals, and preferences.

The Participant Profile is an assessment module used to gather basic information on the participant's background, family/natural support system, home environment, participation in the community, interest in participant-directed service options, and

overall health status. This module also helps the case manager build rapport with the participant; identify participant strengths, preferences, support needs, and potential risk factors; and facilitate the development of meaningful goals.

The Participant Profile assesses participant needs, preferences, and risks at a high level. The assessment is designed to identify areas that require a more in-depth assessment. Based on information obtained in the Participant Profile, case managers may be required to conduct additional assessment modules, including:

Assessment	Description
<b>Supported-Decision Making Assessment</b>	Assess the participant’s ability and comfort in making decisions regarding their service plan and other life circumstances
<b>Community Relationships Assessment</b>	Assesses the participant’s level of engagement and interest in employment, educational, and/or other social/cultural opportunities
<b>Housing and Environment Assessment</b>	Assesses the stability of the participant’s living conditions and whether those conditions are supportive of the participant’s overall health and welfare
<b>Caregiver Assessment</b>	Assesses the availability, strength, and stability of the participant’s natural support system as well as identifies potential support needs for the natural support system
<b>Participant-Direction Assessment</b>	Assesses the participant’s desire, comfort, and capability to direct his or her own care

While each assessment module has specific questions that need to be addressed, case managers should conduct the assessment process as a conversation, rather than a series of questions and answers. As often as possible, case managers should ask open ended questions to start the conversation which may then lead to more closed ended questions. When and where applicable, case managers should ask questions that provide information related to the scope, frequency, and duration of supports the participant receives or needs to complete tasks or achieve goals.

For example, if the assessment process indicates a participant needs assistance with bathing, the case manager should review the information obtained during the level of care determination process with the participant. This will ensure that nothing has changed since the participant was first assessed. Once the case manager has verified or updated the information, the case manager should now ask questions to obtain additional information about the participant’s preferences. Case managers should ask questions such as:

- Who does the participant want to provide support?
- What frequency would the participant like to have support?
- Is the frequency of bathing adequate for the participant?
- What does the participant do if support is not available?

- How long does it take to complete bathing?
- Or any other questions that will give the case manager a complete picture of how the participant accomplishes bathing and what are his or her preferences

These additional questions will provide information that will help the case manager and participant build a service plan to address the participant's needs and preferences. In addition, information obtained with these questions will help the case manager determine the number of units to authorize for services.

Case managers must enter all assessment information into the case management information system within five (5) business days from the date of assessment completion.

While the Community Choices Waiver requires case managers to use the assessment modules identified in this manual, it is important for case managers to know that assessment is a process and may include other activities to determine the need for any medical, educational, social, or other services. Assessments must be reviewed at least annually and updated when a participant experiences significant changes in condition or circumstances.

### **5.1.2 Supported Decision Making**

Supported decision making is defined as a way for an adult to make his or her own decisions. This can be done by working/collaborating with friends, family members, professionals, and other people he or she trusts to understand issues and choices; ask questions; receive explanations in a language or manner which she/he understands; and to communicate her/his wishes to others.

Case managers have an important role in identifying when a participant may need and/or want assistance with decision making. Not everyone needs a full guardian and the various options such as temporary/partial guardianship or use of a power of attorney for specific decisions and/or financial matters should be explored. Case managers should revisit this at least annually or more often as needed based on the participant's circumstances.

The Supported Decision-Making assessment module can be used to provide support for participants to explore options available to them to assist with decision making. The case manager will take the lead in connecting the waiver participant to necessary advocacy or legal services to ensure that the person can access necessary supports in the most cost effective and efficient manner available to them. This information can and should be used in the service plan development and throughout the service plan year.

### **5.1.3 Risk Assessment**

Effective risk management begins with a comprehensive assessment process. A participant's potential and perceived risks are identified initially in the modular assessments conducted prior to the service plan development process. At times, a

situation such as in a participant's condition or life circumstances may require new assessments. Additionally, case managers include assessing for risk during their on-going monitoring process. Risk assessment includes regular and targeted conversations with a participant and the participant's family, providers, and others to discern where a participant's health and safety may be at risk.

#### **5.1.4 Goal Development**

The development of goals is critical component in the assessment process. The case manager's role is to guide the conversation so that participants develop meaningful goals for themselves. Participants may have more than one goal and others attending the assessment and/or service plan development meetings may also have goals for the participant. However, the participant must agree to include those goals in the assessment and service plan.

While some goals may seem unattainable, the case manager's role is to help the participant identify steps that can be taken to achieve the goal. The case manager should never tell a participant a goal is unattainable or unrealistic. For example:

- A participant states their goal is to obtain a job at the local grocery store as a cashier. The participant had a recent hip replacement and has been home from the hospital and rehabilitation facility for one week. The participant has reported, and doctor's notes confirm that the participant is unable to stand for more than 20 minutes at a time and must have some type of support while standing (e.g. durable medical equipment). The case manager knows that most cashiers stand for longer than 20 minutes at a time, which may impede participant's ability to obtain this specific job.
  - The case manager should facilitate a conversation to identify and prioritize the steps which can be taken to gain employment as a cashier, such as:
    - Agree to attend physical therapy appointments and follow through on the at-home exercises to increase strength
    - Explore potential employment or training opportunities
    - Accept assistance with bathing and dressing to maintain good health and hygiene and avoid another fall

The case manager must keep the goals in mind for the service planning process as additional actions may be required to by the case manager to support a participant in achieving a goal. For example, the case manager may consider:

- Referral to the Wyoming Department of Workforce Services, Vocational Rehabilitation Division to provide job seeking assistance
- Authorization of non-medical transportation via the waiver to provide transportation to vocational rehabilitation appointments and any subsequent job interviews or related activities (that can't be provided by Vocational Rehabilitation)

- Referral for non-emergent medical transportation to provide transportation to and from physical therapy appointments if they can't be provided in the home
- Authorization of waiver services to assist with bathing and dressing

It is important to note that a participant's goals may not be directly tied to the receipt of waiver services. In the previous example, the participant's goal provided an opportunity for the case manager to refer the participant to the Wyoming Department of Workforce Services to explore employment opportunities and supports.

### **5.1.5 Assessment Summary**

The Assessment Summary is critical for the case manager and participant to develop the service plan. The Assessment Summary gathers the information obtained throughout the assessment process and guides the rest of the service plan development. The Assessment Summary is automatically generated once all required assessment modules are complete in the case management information system.

The case manager will use the assessment summary to facilitate a conversation with the participant and others present at the service plan development meeting. Before a case manager discusses the potential services, the case manager should review the information from the assessment summary with all in attendance and confirm that it accurately reflects the participant's goals, strengths, preferences, needs, and risks. Confirmation of this information is critical to developing a comprehensive service plan.

## **5.2 Service Plan Development**

Development of a thorough and accurate service plan helps assure the health and welfare of participants. The service plan must be based upon the information obtained from the assessment process. A well-executed and person-centered service planning process is crucial to ensuring participants have a good experience with the Community Choices Waiver program.

### **5.2.1 Person-Centered Service Planning Requirements**

The service plan meeting and development cannot be conducted until the assessment process is complete and should be conducted within five (5) business days from the date the assessment(s) took place (if it did not occur at the same time). Pursuant to 42 CFR §441.301(c)(1), the person-centered service planning process must:

- Include people chosen by the participant
  - The case manager must ask the participant who he or she wants to have present at the service plan meeting and make reasonable efforts to schedule and organize the meeting to include those individuals
  - The case manager must also ask the participant if there are individuals or organizations that should be excluded from service plan meeting and respect the participant's wishes, unless decision making authority has been designated to the individual or entity the participant wishes to exclude

- Provide information and support to ensure the participant directs the process to the maximum extent possible and is enabled to make informed choices and decisions.
  - The case manager must support the participant in leading the service plan meeting
- Be timely and conducted at times and locations convenient to the participant
- Reflect cultural considerations of the participant and provide information in plain language and in a manner that is accessible to participants, including those who are limited English proficient
- Include methods for solving conflict or disagreement within the process
- Ensure compliance with conflict of interest standards outlined in this manual
- Offer informed choices to participants regarding the services and supports the participant receives and from whom, including the freedom of choice between institutional or community-based services, among all feasible service alternatives within the waiver, and among all willing and qualified service providers
- Include methods for the participant to request updates to the service plan as needed
- Record the alternative home and community-based settings that the participant considered

The written service plan must reflect the services and supports that are important for the participant to meet the needs identified in the assessment process, as well as what is important to the participant with regard to preferences for the delivery of services and supports. The case manager must ensure the service plan documents assessed needs and identifies the services and supports that will address those needs. Pursuant to 42 CFR §441.301(c)(2), the written service plan must:

- Reflect that the setting in which the participant resides is chosen by the participant
- Reflect the participant's strengths and preferences
- Reflect the clinical and support needs as identified through a functional assessment
- Include goals and desired outcomes identified by the participant
- Reflect both paid and unpaid services and supports that will assist the participant to achieve his or her goals, and document the providers for those services and supports, including natural supports in the participant's life
- Document risk factors and strategies in place to minimize them, including the backup plans for interruptions in service delivery
- Be understandable to the participant and those important in supporting the participant. The plan must be written in plain language and in a manner that is accessible to participants with disabilities and those who are limited English proficient



- Identify the case manager or case management agency responsible for monitoring the service plan
- Be finalized and agreed to, with informed consent of the participant in writing, and signed by all individuals and waiver service providers responsible for its implementation
- Be distributed to the participant and other people or agencies involved in the plan
- Document those services the participant has elected to self-direct
- Prevent the provision of unnecessary or inappropriate services and supports
- Document that any modification of rights is supported by an assessed need and justified in the service plan

### **5.2.2 Options Counseling**

As part of the service plan development process, the case manager has the responsibility to provide education and support to participants regarding the options available to him or her. Case managers must review the Participant Handbook with the participant while explaining key components of the Community Choices Waiver, such as:

- The participant's right to choose between nursing facility or community-based services
  - Case managers must explain the difference in settings and services
- The services available within the waiver, for which the participant has an identified need
  - Case managers should refer to the Community Choices Waiver Provider Manual for detailed benefit coverage standards
- The participant's right to choose among community-based service settings
  - Case managers must explain the difference between a provider owned/operated residential setting such as an assisted living facility, or services received in the participant's own home and community
- The difference between agency-based and participant-directed service delivery options

While all of these may have been discussed during the assessment process, discussing during service plan development allows the case manager the opportunity to provide more detailed information about each option and provides the participant with the information necessary to make choices that best address the participant's needs.

#### **5.2.2.1 Service and Support Selection**

The case manager is responsible for the development of a comprehensive service plan which reasonably assures the health and welfare of the participant; acknowledges participant's strengths; promotes the participant's self-determined goals; addresses all of the participant's assessed needs; includes a plan to mitigate all identified risks, and accommodates participant preferences to the extent possible within the established service limitations and the availability of local resources.

As such, the service plan is not limited to the services available through the waiver and case managers must consider additional services and supports available through the Medicaid State Plan; other federal, state, and local public programs; the participant's family/natural support system; and/or any other relevant community resources prior to offering waiver services.

Community Choices Waiver services cannot duplicate or supplant the services available through the Medicaid State Plan. Case managers should pay particular attention to avoid potential service duplication for participants under the age of 21 to ensure waiver services are not offered in such a manner that duplicates medically necessary services which must be delivered under EPSDT coverage provisions.

For each service and support to be included in the service plan, the case manager must also write a brief description of the specific tasks to be performed by the service/support provider, as well as documenting the participant's specific needs, preferences, and goals to be addressed by that service/support.

#### **5.2.2.2 Agency-Based Services**

The agency-based service option means that the participant selects a qualified service provider agency, and that agency delivers waiver services through its own employees or contractors. The participant has limited authority to select caregivers, train caregivers on specific needs or preferences, or to schedule and manage service delivery. The agency is responsible for delivering services in accordance with the service plan.

#### **5.2.2.3 Participant-Directed Services**

The participant-directed service option affords the participant the authority to exercise decision making authority over select waiver services and accepts the responsibility for taking a direct role in managing them. Case managers must inform participants of participant direction opportunities available under the Community Choices Waiver and ensure participants who express an interest in participant direction are informed of the potential benefits, liabilities, risks, and responsibilities associated with that service delivery option.

The participant may choose to direct their own services or to appoint another individual to serve as the designated employer of record and direct services on behalf of the participant. For participants considering the participant-directed service option, the case manager must determine whether the participant or designated employer of record demonstrates the ability to:

- Understand and monitor conditions of basic health, and recognize how, when, and where to seek appropriate medical assistance
- Direct his/her own care, including the ability to train caregivers to meet his/her specific needs
- Make informed decisions about interviewing, selecting, disciplining, terminating, and otherwise managing caregivers

- Develop and maintain a budget and establish caregiver wages and schedules

The Division contracts with a private corporation to act as its Financial Management Services (FMS) agency to support the participant or designated employer of record by performing financial administrative activities such as withholding taxes and processing payroll.

If it is determined that the participant is not/no longer capable of managing the responsibilities associated with participant-directed care, the participant must designate another individual to act as the employer of record or receive services through the agency-based services option.

Case managers must ensure the Participant-Directed Assessment module has been completed and provide the Participant-Direction Employer Manual to participant's interested in participant direction.

The participant (designated employer of record, if applicable) must be able to manage participant-direction responsibilities and activities independently. Case managers may assist with obtaining and completing enrollment paperwork but must not participate in employment decisions or conduct the employer activities on behalf of the participant. Case managers who engage in employment decisions or conduct these activities on behalf of the participant can be considered a co-employer and be held legally responsible for the employees.

### **5.2.3 Estimating Frequency and Duration of Services**

The frequency and duration at which services are authorized on the service plan must correspond with the needs of the participant. Frequency refers to the number of days and number of times per day a service or support is provided to a participant (e.g. 3 days each week, 1 visit each day). Duration refers to how long that service or support is provided at each frequency (e.g. 2 hours each visit). It is the case manager's responsibility to ensure waiver services are authorized in accordance with the benefit coverage standards and limitations as described in the Community Choices Waiver Provider Manual.

For example, if a participant states that he or she bathes three times a week and it takes one hour each time, with the support of a family member, the family member is able and willing to continue to provide this support, and the participant does not wish to nor has a medical reason to bathe more regularly, waiver services should not be authorized to provide bathing support.

Similarly, if a participant states that he or she bathes three times a week and wishes to bathe daily due to bladder incontinence, but the family member is not able to provide more support, the case manager may authorize waiver services to support the participant with bathing. The frequency of waiver services authorized for bathing support should correspond to the number of remaining days that support is needed (no more than 4) and the length (duration) of time the participant stated it takes to complete bathing (4 days each week, one hour each day).

Activity	Frequency	Duration for Activity
Bathing Assistance	4 Times Per Week	1 Hour

This method of authorizing services should be applied to each service authorized on the service plan. The case manager must reference the benefit coverage standards to determine what method the services are authorized (e.g. converting hours into 15 minute units for personal support services).

Once scope, frequency, and duration are agreed to, the case manager will document a draft schedule of when the service will be provided, based on the participant’s needs and preferences as well as the frequency and duration. As much as possible, the case manager should integrate the participant’s preferences for service frequency and duration, such as taking into account the days of the week and times of day.

Case managers must also ensure that services authorized do not exceed any service caps or limitations for the specific service, and that services are authorized within the scope of the service. For example, if respite is needed to provide caregiver support, case managers cannot authorize more than 30 calendar days of respite in a service plan year nor can they authorize respite for companionship or recreational activities. Case managers should refer to the Community Choices Waiver Provider Manual to verify service caps or limitations and any other benefit coverage standards.

### 5.2.4 Backup Plan

The case manager must develop and document a backup plan for those critical waiver services in which a temporary disruption of service delivery would jeopardize the participant’s health or welfare. The arrangements and strategies used for backup are tailored to the participant’s needs, preferences, and available resources. Backup plans may include, but are not limited to:

- Seeking temporary assistance from a member of the participant’s natural support network
- Contacting the provider agency for assignment of an on-call or alternate caregiver
- Contacting the case manager to coordinate delivery of an alternate service or support
- Employing an on-call or alternate caregiver under the participant-directed service delivery option

A backup plan should never consist of the participant calling 911, as emergency response services cannot provide waiver services. Should a participant state that 911 is their backup plan, case managers should remind participants that the backup plan is in regard to the participant's ability to receive the waiver services and supports. Case managers should also discuss the importance of having more than one person or option for a backup plan to assure the participant has the most options available to receive services and supports.

Case managers should review the backup plan with the participant no less than annually or as necessary to respond to changes in the participant's needs or circumstances. Case managers must then update the backup plan, as necessary.

### **5.3 Risk Mitigation**

During service plan development, case managers document the risks identified throughout the assessment process. Once all risks are identified and documented, case managers must create a risk mitigation plan for all potential risks identified and included in the Assessment Summary. The risk mitigation plan describes each of the identified risks and lays out the strategies, services, and supports to minimize the potential for harm to the participant from those risks.

Participant involvement and choice are important aspects of creating effective risk mitigation strategies. Minimizing risk involves the effort to ensure participant health and safety while also honoring participant choice and self-determination. Understanding the dignity of risk and supporting the participant to make sound decisions contribute to developing an effective risk mitigation plan.

The possibility exists that a participant will choose not to accept or receive services and supports for an identified need. This is known as dignity of risk. Dignity of risk is the idea that all people have the right to take reasonable risks, and that right should not be impeded by or taken away from someone because he or she has a disability. When a participant decides to not receive services or supports for an identified need, the case manager's job is to ensure the participant understands the risks associated with that decision. The case manager will then document in the service plan that the participant (or legal representative, as appropriate) has chosen not to address an identified need, that he or she understands the risks, and is choosing to accept those risks. The participant has the right at a later time to decide to address the unmet need and as such the case manager would work with the participant to revise the service plan.

Families, providers, and others in the participant's support network also play an essential role in implementing effective risk mitigation strategies. The case manager and participant work with these individuals to determine what support is available and how that support can be used to mitigate risk. The case manager must document the steps that will be taken to address or mitigate those risks as necessary to reasonably assure the health and welfare of the participant.

## **5.4 Referral and Related Activities**

Referral and related activities are part of the case manager's role in assigning who is responsible for implementing the service plan and coordinating the implementation of the service plan. When referring for services, it is imperative that case managers ensure all participants have the right to choose among willing and qualified providers and that the case manager provides enough information in each referral so that providers can make an informed decision on the provider's ability to meet the participant's specific needs and preferences.

### **5.4.1 Freedom of Choice**

All participants enrolled in the Community Choices Waiver have the freedom to choose from any qualified and willing provider agency. As part of this process, the case manager must provide a list of all enrolled providers serving the participant's county of residence. If a participant does not know which provider agency to choose, the case manager can offer to assist the participant by providing resources for accessing information about the provider agency's quality, location, or other information based on the participant's preferences.

If a participant has selected a provider agency in which the case management agency and/or case manager has any ownership, affiliation, or financial interest, the case manager must disclose this and give the participant the option to select a new case management agency or a new provider agency.

### **5.4.2 Waiver Service Referrals**

For each waiver service, the case manager must submit a referral to the participant's chosen service provider(s). This referral includes the specific service requested, a brief description of the tasks to be performed by the service provider, the requested service frequency and duration, and any other relevant information regarding the participant's specific needs and preferences. Waiver service referrals must be sent to providers within two (2) business days from the date of the participant's selection.

Case managers must document in the case management information system each referral sent and to which providers. Case managers should follow-up with providers within two (2) business days from the date the referral was sent if a response has not been received. Case managers may need to discuss the referral over the phone with providers to clarify the information contained on the referral form.

The provider is required to review the services requested by the participant and indicate whether the provider accepts, declines, or accepts with modification (e.g. the participant prefers a male caregiver, but the service provider only has a female caregiver available). The case manager may be required to obtain additional documentation from the provider (e.g. the participant's assistance plan and resident agreement from an assisted living facility) and must confirm the participant's acceptance of any modifications proposed by the provider.

Once the case manager receives communication back from the provider, the case manager must document the outcome (accepted, denied, request for modifications) in the case management information system. Case managers must then follow-up with the participant as well, as new providers may be needed if the request was denied. For any requests where the provider indicated a modification was needed, the case manager must discuss this with the participant and receive the participant's approval or denial of the modification.

The case manager must assist the participant in choosing a new provider for any referrals denied by the provider or when modifications requested by the provider are denied by the participant.

Participants can change providers at any time during the service plan year. Participants do not need to provide advance notice to current providers but must coordinate with their case manager before a new provider can begin services.

### **5.4.3 Information and Assistance in Support of Participant Direction**

For participants who have chosen the participant direction service delivery option and have been determined to meet the participant direction criteria, the case manager is responsible for providing information and assistance. This consists of, but is not limited to:

- Assisting the participant in obtaining and completing the required documents for participant direction
- Determining the participant-directed budget amount
- Coordinating with the FMS agency
- Monitoring participant-directed service effectiveness, quality, and expenditures

Case managers should be familiar with the Participant Direction Employer Manual and ensure the participant has a copy. The manual provides detailed information for the role and responsibilities of the employer under the participant-directed service option.

### **5.4.4 Additional Referrals**

The case manager must conduct additional referral and outreach activities as necessary to confirm availability and coordinate the delivery of non-waiver services and supports included in the service plan. Case managers must provide information and/or additional referral assistance to participants as necessary to ensure all needs and risks identified by the assessment process have been addressed. Referral assistance may be required to facilitate the participant's access to Medicaid State Plan benefits, the Supplemental Nutrition Assistance Program (SNAP), a local food bank, the Low-Income Energy Assistance Program (LIEAP), a senior center, the local housing authority, or other community resources.

Referral assistance could consist of providing the participant with the appropriate contact information or by contacting the entity on behalf of the participant if the

participant requires or requests that level of assistance. Case Managers may not be able to determine the scope, frequency, or duration of non-waiver services that are available to the participant. However, the case manager must document all non-waiver services in the service plan and include the following:

- Specific service/support to be provided
- Brief description of the tasks to be performed

For example, a participant has a need for social interaction and wishes to attend the local senior center three days each week, which does not accept Medicaid. The Medicaid approved non-medical transportation provider in the participant's county of residence is only able to provide this service one day each week. The participant informs the case manager that he or she has a friend who attends the same senior center and the friend's daughter has offered to drive the participant if he or she would like. With this information, the case manager would document in the service plan that a waiver service, natural support, and non-Medicaid community resource are being used to address the participant's needs for social interaction and transportation. Additionally, the case manager would assist, if requested by the participant, in contacting the local senior center and friend's daughter to discuss participant's needs.

All referrals to non-waiver services and follow-up regarding the referrals must be documented in the case management information system.

## **5.5 Finalizing the Service Plan**

The service plan cannot be finalized until all assessment, service plan development, and referral activities are complete. Prior to finalizing the service plan, the case manager must ensure that he or she has reviewed the participant's rights and responsibilities and that all signatures are obtained. At minimum, the participant, case manager, and all waiver service providers must sign the service plan. Additional signatures from a legal representative or anyone else involved in implementing the service plan may be obtained, as appropriate.

All service plans are subject to Division approval. The completed service plan must be entered into the case management information system within ten (10) business days from the date of the service plan meeting and all waiver service referrals have been accepted by the provider(s). Service plans are screened through an automated review process and may be subject to a manual review by Division staff. This review may require additional information from the case manager. If this occurs, the case manager has two (2) business days to respond and enter the additional information into the service plan. Upon Division approval of the service plan, it is finalized in the case management information system and can be reviewed by Division staff at any time.

Once finalized, the case manager must provide a copy of the service plan to the participant and role-based copies to the providers authorized to provide waiver services. The participant must receive a complete copy of the service plan while the versions sent



to waiver service providers include only the necessary information for the coordination, provision, and reimbursement of waiver services as to assure the privacy of the participant.

## **5.6 Prior Authorizations**

All Community Choices Waiver services require a prior authorization and approval before the provider agency can be reimbursed to render services. Prior authorization reviews facilitate coordination and minimize the duplication of Medicaid benefits to ensure the most effective use of public resources. Certain services also require review from the Division's contracted Utilization Management (UM) vendor. The UM vendor conducts a review of the requested services to ensure they are authorized within the scope and limitations of benefit coverage standards, according to the assessed needs of the waiver participant, consistent with the provider's scope of practice, and in such a manner that does not duplicate other services provided under the waiver program or the Medicaid State Plan.

Once a service plan is finalized, the case management information system exchanges data with the Medicaid Management Information System (MMIS). The MMIS has system edits in place to review the service plan data. These edits verify participant Medicaid eligibility, waiver program enrollment status, maximum allowable reimbursement rates, service provider enrollment status, and any other service line authorization edits. Once these checks and edits are complete, the MMIS generates a prior authorization file.

Once the MMIS approves the prior authorization, the service prior authorization data is transmitted from the MMIS to the case management information system to confirm prior authorization of services included in the participant's service plan. Providers, including the case management agency/case manager are notified of waiver service prior authorization approval via an online provider portal and/or by mail.

## **5.7 Service Plan Review and Updates**

The service plan must be reviewed and updated at least annually but may be reviewed more frequently upon request by the participant or in response to a significant change in the participant's condition or circumstances.

The case manager, the participant, and any other individuals freely chosen by the participant may participate in the service plan review and update process. The case manager facilitates a discussion among the individuals participating in the service plan review process to confirm/update the participant's assessed needs, preferences, goals, and overall health status and to identify any necessary modifications to the participant's existing service plan. The case manager may conduct any of the assessment module(s) as needed to document changes in the participant's condition or circumstances. Modifications to the service plan are made and the services and supports are

coordinated in accordance with the initial service plan development and referral procedures.

## **5.8 Service Plan Monitoring**

Service plan monitoring and follow-up activities are necessary to ensure that the service plan is effectively implemented and adequately addresses the needs of the participant. While discussing the participant rights and responsibilities, case managers should also inform participants of the monitoring requirements and the purpose.

At minimum, monitoring must occur monthly; however, monitoring activities and contacts may occur with the participant, family members, service providers, or other entities or individuals as frequently as necessary to:

- Ensure services are being furnished in accordance with the participant's service plan
- Evaluate the effectiveness of the service plan in meeting the participant's needs
- Identify any changes in the participant's condition or circumstances
- Periodically screen for any potential risks or concerns
- Periodically assess the participant's satisfaction with the services and supports
- Identify any necessary adjustments in the service plan or service arrangements with providers

At minimum, case managers must conduct service plan monitoring every month. Service plan monitoring activities may be conducted via phone or HIPAA compliant video conference. However, face-to-face monitoring must occur at least once per quarter, and case managers may need to conduct additional face-to-face monitoring based on the participant's needs. This should be documented in the service plan. All attempts should be made by the case manager to schedule service plan monitoring visits at a time and place convenient to the participant.

Service utilization data is available in the case management information system and case managers must compare this data against the authorized amounts in the service plan to identify any potential problems with service access or delivery.

It is important for case managers to note that concerns with service authorization versus utilization should be documented and addressed when a trend is noticed, typically over a three (3) month period. Waiver providers have 365 days to bill from the date of service, which may impact the utilization the case manager sees in the case management information system.

Additionally, the Division does not expect that participants receive 100% of his or her services 100% of the time. Participants have the right to decide they do not want to receive a service on any given day, participants get sick, or other life activities occur that prevent a participant from receiving a service exactly as described in the service plan. Case managers are responsible for monitoring these occurrences and addressing when concerns or trends are identified.

When a concern is identified, the case manager must talk with both the participant and provider(s) to understand the nature of the variance. Common factors that impact service authorization versus utilization may include, but are not limited to:

- Participant not adhering to the service plan
  - This could manifest as the participant refusing services completely or agreeing to receive fewer services than planned
- Provider not adhering to the service plan
  - This could manifest as the provider not providing the service at all or providing less than what was authorized
- Participant does not want/need the service

Regardless of the reason, it is the case manager's job to address the concerns, which may result in revising the service plan to more accurately reflect the participant's needs; add a new provider; find non-waiver resources to meet the participant's needs; or adjust the units authorized.

While the Division requires specific information to be collected on a monthly basis, the case manager should use the Division's prescribed questions to guide the conversation, not as a checklist or interview. Monitoring should be a natural conversation with the participant about services and his or her satisfaction with those services, a review of the participant's goals and progress towards those goals, a review of utilization of authorized services, and a review or discussion of any other information received since the last monitoring visit.

Any monitoring conducted may lead to follow-up activities that the case manager must complete. As a result of a monitoring activity, case managers may need to contact providers or update the service plan in order to change providers; modify the scope, frequency, or duration of services; or add additional services to meet the participant's needs. Monitoring activities may also necessitate that the case manager take additional actions such as reporting a critical incident and/or making a referral to Adult Protective Services, Child Protective Services, law enforcement, the Medicaid Fraud Control Unit, or any other regulatory agency.

Case managers may also conduct monitoring for a participant who is temporarily admitted (30 days or less) to a hospital or nursing facility. When this occurs, case managers should contact the facility and coordinate with the participant as well as facility staff regarding the participant's discharge. This coordination will help to assure the participant has services in place upon discharge and that the services address the needs of the participant, which may have changed.

Monitoring is not a social interaction with a participant. While it may be likely that a case manager and participant see each other out in the community in which they live, this incidental contact does not count as monitoring and should not be documented as such. For example, a case manager sees a participant while grocery shopping and they discuss weekend plans. This does not constitute a monitoring activity and should not be

documented. As previously stated, monitoring is purposeful and relates back to the participant's service plan and health and welfare.

All monitoring and follow-up activities must be documented in the case management information system no later than five (5) business days from the date of activity.

### **5.8.1 Monitoring the Identified Potential for Participant Risk**

Case managers must be familiar with the participant's assessments and know the participant's service plan, risk mitigation plan, and any other relevant information about the participant to effectively monitor for health and safety. The service plan and risk mitigation plan are key to ensuring a participant is receiving the right kind of support, in the right amount, and at the right time to minimize identified risks.

Following are several tasks conducted during regular monitoring that assist case managers in determining whether a service plan is being implemented effectively or if modifications to the service plan or other plans are needed:

- Check regularly to ensure that support is provided according to the service plan
- Engage regularly with the participant, their family, significant others, and providers.
- Pay attention to the participant's mood and observe their physical state. Notice the environment and atmosphere of the home or place of service and observe the other people who are there
- Notice the stress level for the participant, family, and providers. Are those working directly with the participant using their own processes to proactively determine if risks are being identified and addressed? Look for evidence that the participant is healthy, safe, and shows a sense of well-being
- Periodically reassess the participant's risk, monitor the risk mitigation plan, and modify it when necessary
- Discuss what's working and what's not with the participant and when appropriate, with the provider and significant others
- Provide the necessary resources to anticipate and address situations of risk
- Maintain on-going coordination of services to support risk mitigation
- Engage participants in managing their own risk

### **5.8.2 Monitoring for Abuse, Neglect and Exploitation**

Participants have a right to be treated with dignity and respect and to receive services and supports in an environment that is safe and free from abuse, neglect, and exploitation. These terms are defined in Appendix A. Case managers must know what these terms mean to recognize different types of abuse, neglect, and exploitation when conducting regular monitoring activities.

Thorough knowledge of a participant's assessments and risk mitigation plan makes a case manager's ability to monitor that person's health, safety, and well-being stronger. With that knowledge, the case manager can best recognize how well the risk mitigation

plan is supporting the participant and be aware of when the participant’s service plan needs modification. However, that’s not enough to ensure participants’ well-being. A vigilant attitude when monitoring supports the case manager’s ability to recognize when a participant is at risk for abuse, neglect, and exploitation.

Monitoring needs to occur more frequently for some participants than others, and more frequent monitoring is needed during different times in a participant’s life. Some examples of the need for heightened monitoring include when a participant is showing more stress or behavioral issues than usual; has unexplained injuries or is injured repeatedly; lives with a family member who is overworked, ill, abuses drugs or alcohol, has been laid off their job or has other stressors; or is absent from scheduled activities more frequently than usual or exhibits behavioral signs that indicate problems in their living situation. In short, any time a participant’s condition, behavior, or environment is out of the ordinary is the time to be alert for signs of abuse, neglect, or exploitation.

Some other monitoring activities that can help identify abuse, neglect, or exploitation include:

Activity	Considerations
<p align="center"><b>Observe Home or Provider Site</b></p>	<ul style="list-style-type: none"> <li>• Are staff consistently working multiple shifts</li> <li>• Is a supervisor on-site or immediately available</li> <li>• Does the staff work well together</li> <li>• Is the site clean and well cared for</li> <li>• Visit at mealtimes and different times of the day to see how well participants are supported during transition times</li> <li>• Visit when the participants are getting ready to leave for the day or arriving back home at day’s end</li> <li>• Are there orderly routines in place, including at shift change</li> </ul>
<p align="center"><b>Observe and Talk with Direct Support Staff or Family Members</b></p>	<ul style="list-style-type: none"> <li>• Is the environment calm or stressful</li> <li>• Are participants treated with respect</li> <li>• Look for appropriate professional and personal boundaries from staff and others at the site</li> <li>• Consider how participants are supported when transferring or receiving assistance</li> <li>• Are they treated roughly or with impatience when they receive assistance</li> </ul>
<p align="center"><b>Consider Participant’s Vulnerabilities</b></p>	<ul style="list-style-type: none"> <li>• Such as those who have restricted movement, are unable to communicate, or who don’t have family support</li> <li>• Is the participant dressed appropriately for activities and the weather</li> </ul>

	<ul style="list-style-type: none"> <li>• Observe whether the participant’s personal hygiene is adequate</li> <li>• Review the participant’s appointments and activities</li> <li>• Have appointments been kept and are absences from activities and appointments reasonably explained</li> </ul>
<b>Talk with Participant</b>	<ul style="list-style-type: none"> <li>• Ask how they are doing</li> <li>• Are they getting enough to eat</li> <li>• Are they getting along with direct service staff and others who live or work with them</li> </ul>
<b>Pay Attention to Your Feelings about a Situation</b>	<ul style="list-style-type: none"> <li>• Whenever you notice something that gives you concern, follow up to determine if there is a reasonable explanation</li> <li>• Do not try to conduct an investigation or confront an abuser. If you suspect abuse, neglect, or exploitation, you are required to report it</li> </ul>

When a case manager is interacting with a participant, either in-person or via phone or video conference, and has concerns related to abuse that present an immediate danger, the case manager should call for emergency services or local law enforcement officials.

Any person who has reasonable suspicion or knowledge that an adult is being abused, abandoned, exploited, neglected, intimidated, or is self-neglecting is required by law to make a report to the Wyoming Department of Family Services and/or law enforcement as indicated by the nature of the incident(s).

**5.9 Case Documentation**

The Division’s case management information system serves as the official case record for Community Choices Waiver participants. The case management agency and case manager are responsible for completing and maintaining case documentation and for ensuring case records are complete, accurate, and timely. Activities that case managers must document include, but are not limited to:

- Waiver required contacts (monitoring)
- Assessment activities
- Service plan development and update activities
- Referral activities
- Attempts to contact participant to schedule a visit
- Attempts to contact persons/agencies working with the participant
- Phone conversations
- Email conversations regarding participant
- Receipt of documents related to participant

It is not enough for the case management information system to reflect changes to specific documents (e.g. assessment or service plan), the case manager must document a summary of activities the case manager performed.

All required documents and notes must be uploaded into the system no later than five (5) business days from the date of receipt/completion. Case documentation must:

- Be objective and understandable
- Be dated according to the date of the activity
- Be concise and include all pertinent information
- Include the source of all information and clarify whether the information is an observable and objective fact or a person's judgment, conclusion, or report
- Identify all referenced persons and agencies by name and relationship to the participant
- Avoid acronyms that are not common or unknown

If a case manager is unable to comply with the required timeframes for documentation due to circumstances outside of the case manager's control, the circumstances must be documented in the case management information system.

Case documentation is a professional record and should provide enough information for anyone reading to understand what has been done in the past, what is currently happening, and what may be needed in the future. Case managers should remember that case documentation is part of the participant's health record, can be obtained by the participant if requested, and may be discoverable in legal proceedings.

Case management agencies may maintain records in addition to those required by the Division and must maintain sufficient documentation to substantiate case management services rendered for at least six (6) years from the date of service.

#### **Case Documentation**

Case manager met with Julie in her home for a monthly monitoring. Julie's daughter Beth was also present. Julie has been receiving services from the CCW for 3 months. Julie goes to the adult day center 2 full days each week and uses non-medical transportation to get to/from adult day center and home. Julie and Beth did not report any concerns or changes in health.

Julie lives with Beth who is Julie's employee through participant direction. Beth provides hands on assistance for Julie to bathe and dress and minimal hands on assistance for toileting. Beth also manages all of Julie's laundry and cleaning of her room. Beth did not report any concerns with the FMS.

Julie stated she is very happy with her services and enjoys the adult day center she attends. Julie stated she has begun to make friends there and it is nice to not be in the house every day, which also allows Beth to work part-time. Julie also stated her non-medical transportation provider is always on time and help Julie get in/out of the vehicle.

Beth stated she is also happy with Julie's services and that staff seem friendly and attentive.

Case manager observed Julie's environment to be clean and free of clutter, no health or safety concerns identified. Case manager observed Julie engaged in the conversation and Beth provided information when asked or to support Julie's statements.

Case manager spoke with adult day services and non-medical transportation provider who did not report any concerns regarding Julie or her services. Case manager also spoke with FMS who stated time sheets for Julie's services are always on time and there aren't any concerns with budget management. No follow-up needed at this time.



## **Section 6. Service Denials, Reductions, Discontinuations, and Waiver Enrollment Terminations**

Throughout the course of providing case management services, the case manager may need to deny, reduce, or discontinue a waiver service or terminate a participant's waiver enrollment. Service denials, reductions, and discontinuations may occur for many reasons, including:

- Lack of demonstrated need for the waiver service or for the frequency and duration of the waiver service
- Waiver service request which is outside the scope of the benefit or exceeds the service coverage limitations
- Duplication of a Medicaid State Plan or other waiver service
- Participant requests a service reduction or declines a service

A participant's waiver enrollment may be terminated for many reasons, including:

- The participant is a resident of or has been admitted to a nursing facility, hospital, ICF/IID, or other institution for greater than thirty (30) consecutive days
- The participant no longer qualifies as a member of the waiver's target group
- The participant no longer demonstrates a need for the nursing facility level of care
- The participant no longer demonstrates a need for waiver services
  - The participant has not received at least two (2) waiver services for a period greater than thirty (30) consecutive days
- The participant is no longer eligible for Wyoming Medicaid
  - The participant is no longer a Wyoming resident
  - The participant no longer meets the income or resource requirements for a Medicaid financial eligibility group covered by the waiver program
- The participant's health and welfare cannot be reasonably assured within the limits of the waiver
- The participant refuses to comply with the participant responsibilities
  - The participant's service plan expires, and the participant fails to cooperate with the review and update process
- The participant cannot be located and/or refuses to cooperate with monthly service plan monitoring activities
- The participant voluntarily terminates waiver enrollment
- The participant is deceased

When a case manager denies, reduces, or discontinues a service or terminates a participant's waiver enrollment, the case manager must provide the participant with a Notice of Adverse Action in accordance with Chapter 4 of the Rules and Regulations for

Wyoming Medicaid. The Notice of Adverse Action must be provided at least ten (10) business days prior to the effective date of the adverse action and must include:

- An explanation of the participant's rights to request a hearing
- The methods and instructions for requesting a fair hearing
- A description of the intended adverse action
- The reason(s) for the intended action
- The specific regulations or changes in federal/state law that require the adverse action
- Where applicable, an explanation of the circumstances under which benefits may be continued if a hearing is requested pursuant to 42 CFR §431.231

A case manager does not send a Notice of Adverse Action when the participant dies, declines services, or voluntarily terminates from the waiver.

The case manager must notify all affected waiver service provider(s) of any changes to services within two (2) business days of the notice of service denial, reduction, or discontinuation and/or the participant's waiver enrollment termination. Notification to the provider(s) must include the effective date of the change so that the provider(s) can prepare for service transition/termination and reduce the likelihood of uncompensated service delivery.

Failure by the case manager to notify providers prior to the effective date, will result in the case management agency's responsibility to reimburse the affected waiver service provider(s) for any services delivered after the effective date. Case managers must provide the participant with information on any alternative community resources and conduct appropriate referrals within five (5) business days from the date of notice.

The case manager is responsible for ensuring the participant understands his/her rights to request a fair hearing and may assist the participant in submitting required documents. However, a case manager may not complete and submit a request for fair hearing on behalf of a participant or act as the participant's representative in the hearing process as case managers may have a vested interest in the outcome of the hearing.

In the event that a participant requests and is granted the opportunity for a fair hearing, the case manager will receive notice from the Division. Participants may have the right to continue receiving services pending the outcome of the fair hearing. Under these circumstances, the case manager cannot make changes to the service(s) already authorized in the service plan until a final agency decision is rendered. The case manager must notify all affected waiver service provider(s) of the participant's decision to continue benefits pending the hearing outcome within one (1) business day of the Division's notice of hearing request approval.

The case manager may also be required to produce documentation or information related to the adverse action and/or to testify as a witness in the hearing.

## **Section 7. Participant Rights and Safeguards**

Participants receiving services through the Community Choices Waiver have the same basic legal, civil, and human rights as people not receiving services through an HCBS waiver. All participants must be assured of their individual rights to privacy, dignity, respect, and freedom from coercion and restraint in any setting and in conjunction with the delivery of any Community Choices Waiver service.

The Division supports a culture of safety and safeguards the health and welfare of participants. The Community Choices Waiver agreement identifies the Division's activities which protect participants and contains information about the case manager's role in safeguarding participants. It details how the work of the case manager is essential to safeguard participants in two ways:

- The case manager is a key player in maintaining a culture of safety, keeping participants safe and healthy through assessments, planning, monitoring and reporting
- The case manager helps assure that the Community Choice Waivers operates according to the CMS requirements for participant health and safety

### **7.1 Participant Rights and Responsibilities**

Case managers are responsible for ensuring participants are informed of their rights and responsibilities, providing participants the support needed to exercise them, and documenting that participants have been provided this information. Case managers must explain these rights to participants in such a manner as to ensure they understand them. Participants may need accommodation, protection, and support to enable them to exercise their rights, and their rights should never be limited or restricted without due process.

Participant rights and responsibilities are included in the Participant Handbook and on the participant's copy of the service plan. Case managers must review each right and responsibility with the participant and answer any questions that may arise as part of the service planning process on at least an annual basis. The participant has a right to:

- Be informed of their rights prior to receiving waiver services
- Be supported to exercise their rights as a participant in the waiver program
- Voice grievances, without fear of discrimination or reprisal
- Have their property treated respectfully by those providing services
- Choose to receive their services in a nursing facility or in the community
- Exercise freedom of choice to receive services from any approved, qualified, and willing provider
- Request a fair hearing in response to any adverse action and be informed of how to make such a request
- Receive services without regard to their race, religion, creed, gender, national origin, sexual orientation, marital status, age, or disability

- Privacy, including confidentiality of personal information
- Consent to the release of confidential information
- Submit complaints or grievances related to rights violations or provision of services and have the complaints responded to
- Participate in the development, review, approval, and any changes of the service plan
- Have input into who, when, where, and how services are provided
- Be informed about the services to be provided and about any subsequent changes in service amount (increase or decrease) and/or the discontinuation of services
- Refuse services or treatment and to be informed of the consequences of their decision
- Assume reasonable risks and have the opportunity to learn from these experiences

In addition to participant rights, participants also have responsibilities while participating in the Community Choices Waiver. Participants have the responsibility to:

- Promptly apply for Medicaid and respond to correspondence from the Division's Client Services Unit
- Provide complete and accurate records for the Client Services Unit to determine and maintain eligibility for Medicaid and the waiver
- Keep providers and the Client Services Unit aware of their current residence location or changes in Medicaid eligibility or program enrollment status
- Be a cooperative, active participant in the development of their service plan and in following the plan
- Provide complete and accurate monthly information to the case manager when he/she visits or calls
- Keep appointments or notify all providers when they are unable to keep them
- Use the services properly and as indicated on their service plan
- Be respectful and maintain a safe environment for those entering the home to deliver services

## **7.2 Protected Health Information**

Case management agencies and case managers must ensure compliance with all federal and state privacy laws and regulations regarding the treatment of Protected Health Information (PHI). The HIPAA Privacy Rule sets national standards for the treatment of PHI by three types of covered entities: health plans, health care clearinghouses, and health care providers who conduct standard health care transactions electronically. Case management agencies and other waiver service providers are considered covered entities.

Any data created, received, stored, or transmitted by the covered entities and their business associates in relation to the provision of healthcare, healthcare operations, and payment for healthcare services is PHI, including:

- Names (full or last name and initial)
- All geographical identifiers smaller than a state, except for the initial three digits of a zip code if, according to the current publicly available data from the U.S. Bureau of the Census, the geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and the initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000
- Dates (other than year) directly related to an individual
- Phone Numbers
- Fax numbers
- Email addresses
- Social Security numbers
- Medical record numbers
- Health insurance beneficiary numbers
- Account numbers
- Certificate/license numbers
- Vehicle identifiers (including serial numbers and license plate numbers)
- Device identifiers and serial numbers
- Web Uniform Resource Locators (URLs)
- Internet Protocol (IP) address numbers
- Biometric identifiers, including finger, retinal and voice prints
- Full face photographic images and any comparable images
- Any other unique identifying number, characteristic, or code except the unique code assigned by the investigator to code the data

The HIPAA Privacy Rule also provides participants an array of rights with respect to the availability and use of their PHI. At the same time, the Privacy Rule permits the disclosure of personal health information as needed for participant care and other important purposes.

### **7.3 Home and Community-Based Setting Requirements**

In 2014, CMS published changes to the federal regulations which govern the administration of Medicaid HCBS programs. These rule changes were designed to enhance the quality of Medicaid HCBS, provide additional protections to participants, and ensure participants have full access to benefits of community living and the opportunity to receive services in the most integrated setting appropriate. In short, the settings in which waiver services are rendered must mirror the settings in which people who do not receive HCBS waiver services live, work, and recreate.

The federal regulations [42 CFR §441.300, et seq.] define, describe, and align setting requirements for all Medicaid HCBS waiver programs. The focus of the setting requirements is on how people participating in Medicaid HCBS waivers experience those services. A participant's experience can be evaluated by looking at a number of factors which include, but are not limited to:

- The participant's interests, needs, and goals are identified and incorporated into a person-centered service plan
- The participant benefits from living in the community in the same way as others in the community
- The participant is supported and encouraged to be an active member of his/her community
- The participant's HCBS do not have the effect of isolating or segregating him/her from the greater community

### **7.3.1 Specific Requirements for Home and Community-Based Settings**

The federal regulations establish a list of requirements for the settings in which waiver services may be provided. In order to qualify for Medicaid reimbursement, the setting must:

- Be integrated in and support access to the greater community
- Provide opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources
- Ensure the individual receives services in the community to the same degree of access as individuals not receiving Medicaid HCBS
- Be selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting
- Ensure an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint
- Optimize individual initiative, autonomy, and independence in making life choices
- Facilitate individual choice regarding services and supports, and who provides them

### **7.3.2 Provider Owned or Controlled Residential Setting Requirements**

Residential settings that are owned or controlled by the HCBS provider, such as an assisted living facility, must also comply with the following:

- The participant's specific unit/dwelling is owned, rented, or occupied under a legally enforceable agreement
- Participants have the same responsibilities/protections from eviction as all tenants under landlord tenant law of state, county, city or other designated entity
- If tenant laws do not apply, a lease, residency agreement, or other written agreement must address eviction processes and appeals and must provide

participants protections comparable to those provided under the jurisdiction's landlord tenant law

- Each individual has privacy in their sleeping or living unit
- Units have lockable entrance doors, with the participant and appropriate staff having keys to doors as needed
- Participants sharing units have a choice of roommates
- Participants have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement
- Participants have freedom and support to control their schedules and activities and have access to food at any time
- Participants may have visitors at any time
- The setting is physically accessible to the participant

### **7.3.2.1 Room and Board Costs**

Medicaid funds cannot be used to reimburse room and board costs in accordance with 42 CFR §441.310(a)(2). Participants who receive services in a provider owned or controlled residential settings are therefore responsible for all room and board costs pursuant to the provisions of the participant's lease or similarly enforceable residential agreement. The term "room" includes any shelter-type expenses, including all property-related costs such as rental or purchase of real estate, and basic furnishings, maintenance, utilities, and related administrative services. The term "board" means three meals per day or any other full nutritional regimen.

Providers accept Medicaid reimbursement as payment in full for covered waiver services and may not collect or attempt to collect additional payments from the participant or participant's family. The lease/resident agreement must not include charges for covered waiver services include an itemized list of any additional charges and charges for items of comfort or convenience, such as:

- Move in/out fees
- Security deposits
- Cable television subscriptions
- Personal telephone lines
- Recreational activity fees

Case managers must upload a copy of the lease/resident agreement in the case management information system for all participants who receive services in a provider owned or controlled residential setting.

## **7.4 Modifications of Participant Rights**

Some participants may require a modification to their rights and/or the setting requirements in order to safely receive Medicaid HCBS. Rights modifications include restraints, restrictive interventions, use of aversive methods to modify the participant's

behavior, or any other action or intervention which otherwise limits a participant's rights in any way.

While the Community Choices Waiver program does allow for modification of rights, it does not allow for blanket restrictions to be put in place across an entire setting. Instead, any restrictions must be imposed on an individual basis. For example, an assisted living facility cannot impose a blanket restriction that no participant is allowed to have a lock and key for their bedroom door. This type of restriction or modification can only be implemented based on a participant's individually assessed needs. Similarly, an assisted living facility which has a locked unit for participants with memory impairments must document a modification of rights for each participant who has an assessed need for that type of restriction.

When a provider must implement a modification to a participant's rights, the case manager is responsible for documenting the modification in the service plan. Prior to any modification of rights being implemented, the following information must be documented:

- Specific, individualized, and assessed need(s) for the modification
- Positive interventions and supports that were considered prior to the modification, including any less intrusive methods that were tried but did not work
- Description of how the right modification is proportionate to assessed need
- Ongoing data measuring effectiveness of modification
- Established time limits for periodic review of modifications
- Assurance that interventions and supports will not cause harm
- Participant's informed consent

At minimum, case managers must review the rights modification every six months during an in-person service plan monitoring visit and follow-up with the provider.

Participants also have the right to refuse a modification. If the provider is unable or unwilling to provide services to the participant without a modification, the case manager must discuss this with the participant. The case manager's role is to help the participant understand the options available to them and assist in finding a new provider if the participant wishes.

Should a participant agree to a right modification, the case manager is responsible for obtaining the informed consent and providing documentation of that consent to the provider. Case managers must also ensure the modification is documented in the service plan and a copy is provided to the participant and the provider(s).

#### **7.4.1 Restraints**

In limited situations, when a participant poses a significant danger to self or others, it may be appropriate to restrain the participant. Physical, chemical, and mechanical restraints are permitted in the provision of assisted living facility services or respite services delivered in assisted living or nursing facilities. Restraints must be ordered by a



physician and required by the participant's medical symptoms. Providers may not impose restraints for purposes of discipline or convenience.

#### **7.4.1.1 Monitoring for the Use of Restraints**

When restraints are authorized in a participant's service plan, the least restrictive restraint reasonable should be implemented. As part of the regular service plan monitoring activities, the case manager must ensure special attention is paid to identify the unauthorized use or misapplication of restraints. When a restraint is used appropriately, the participant must be kept clean, get the food and fluids they need, be able to have a bowel movement or urinate when needed, be as comfortable as possible, and not injure him/herself. Case managers must report any known or suspected use or misapplication of restraints as an incident.

#### **7.4.2 Restrictive Interventions**

A restrictive intervention is an action or procedure which limits or restricts the participant's:

- Movement
- Privacy
- Full access to the greater community
- Access to other individuals, locations, or activities
- Access to food
- Freedom to control his/her own schedules, activities, and resources
- Independence in making life choices
- Ability to have visitors of his/her choosing at any time

Restrictive interventions may be permitted in the delivery of assisted living facility services, adult day services (health model), and respite services delivered in an assisted living or nursing facility.

#### **7.4.2.1 Monitoring for the Use of Restrictive Interventions**

Participants have the right to live in the least restrictive environment appropriate to meet their needs for health, safety, and well-being. Participants who display challenging behaviors may be subjected to restrictive practices in a variety of contexts. Restrictive interventions may not be imposed as a means of coercion, discipline, convenience, or retaliation by provider staff, family members, or others. Case managers must report the unauthorized use or misapplication of restrictive interventions as an incident.

#### **7.4.3 Seclusion**

Seclusion is a type of restrictive intervention which includes the involuntary confinement of a participant alone in a room or an area from which the participant is physically prevented from having contact with others or leaving. The use of seclusion for any reason is prohibited in the Community Choices Waiver. Case managers must report any known or suspected use of seclusion as an incident.

## Section 8. Incident Reporting and Response

Supporting participants to make choices about living among family and friends in their own communities requires diligent support from case managers, providers, and natural supports. Even with thorough assessments, service planning, and risk mitigation strategies, incidents will occur. Reporting incidents is an important method to manage participant health and safety. Reporting is not conducted as a means for punitive action, but rather as an activity essential for a strong system that safeguards participants' well-being. Case managers are mandatory reporters and must report all incidents they observe or suspect.

Assuring the health and safety of the participant is always the first priority. Not only must individual concerns be identified and addressed through incident reporting, but aggregating data from incident reports allows the Division to identify system-wide issues. Identifying and reporting incidents is a joint effort by case managers and providers to build and maintain a culture of safety that operates with integrity. When an incident occurs, case managers must report it as soon as practicable following any actions needed to remove the participant from a potentially harmful situation.

### 8.1 Incident Reporting

Case managers must report all incidents, even when others have reported the same incident. Case managers must describe the circumstances of the incident and the actions taken in the incident report. Case managers enter reports into the Division's web-based reporting system.

The major categories of incidents which require reporting are listed below. Many of these terms are defined in Appendix A, and a detailed list of situations that constitute a reportable incident are included in Appendix B.

<b>Incident Type</b>	<b>Examples</b>
<b>Abuse</b>	Physical Abuse Verbal/Emotional Abuse Sexual Abuse Intimidation
<b>Neglect</b>	Self-Neglect Neglect of participant by a service provider Neglect of participant by family or natural supports
<b>Exploitation</b>	Financial exploitation Sexual exploitation Prescription drug theft/diversion Other material exploitation
<b>Death</b>	Expected Death Unexpected Death
<b>Restraints &amp; Restrictive Interventions</b>	Restraint Restrictive Intervention, including seclusion
<b>Serious Injury/Illness</b>	Injury/Illness

	Cause of Injury/Illness
<b>Serious Behavioral/Mental Health Concern</b>	Behavioral/emotional crisis Self-injurious behavior Substance Abuse
<b>Medication Error or Adverse Reaction</b>	Medication error or adverse reaction requiring emergency medical treatment Medication error or adverse reaction not requiring emergency medical treatment

## 8.2 Incident Follow-up and Follow-Through

Case managers must always take immediate action to reasonably assure the health and welfare of the participant. Actions within the authority and responsibility of the case manager could include:

- Notifying the participant's family
- Transferring the participant from the place of the incident
- Making a referral for a medical examination or mental/behavioral health evaluation
- Implementing the participant's backup plan to provide needed support
- Assisting the participant to change providers
- Modifying services or scope, frequency, or duration of services in the service plan
- Referring the participant to other support agencies such as the Wyoming Long-Term Care Ombudsman Program or Wyoming Protection and Advocacy

The case manager must monitor the issues related to an incident until they are resolved. New assessments, risk mitigation plans, and/or service plan updates may be required, and all information must be documented in the case management information system. The case manager must document the participant's current status, any outstanding issues related to the incident, how issues will be resolved, by whom, when, and specific expected outcomes. An incident is not considered resolved until all the necessary follow-up activities have been conducted.

## 8.3 Critical Incidents

Critical incidents are a subset of the reportable incidents which warrant further investigation by the Division. Any incident which includes observed or suspected instances of abuse, neglect, exploitation, unexpected death, use of restraint, and/or unauthorized use of restrictive interventions are considered critical. The Division's investigation consists of a desk review of the incident report and other relevant documentation. Instances are substantiated when there is a preponderance of evidence to support the allegation.

For substantiated instances, the Division reviews the actions taken by the provider agency, case manager, and/or other responsible parties to assure the health and safety of the participant(s) and to determine if those actions constitute an adequate and timely

response commensurate with the circumstances of the incident. If those actions are insufficient, the Division requires immediate follow-up actions. The Division may conduct those follow up actions directly and/or direct the case manager, provider agency, and/or other responsible parties to conduct additional follow-up actions. These actions may include, but are not limited to:

- Notifying a family member/guardian of the participant(s)
- Recommending the removal of the participant(s) from the place of incident
- Making a referral for a medical examination of the participant(s)
- Making a referral for a mental/behavioral health evaluation of the participant(s)
- Coordinating with the case manager to identify home and community-based service alternatives and/or alternate waiver service providers
- Making a referral to and/or recommending an on-site investigation be conducted by the applicable regulatory agencies or boards with the professional or agency licensure/certification oversight authority
- Making a referral to the applicable law enforcement agency
- Making a referral to another regulatory/oversight agency (e.g. Wyoming Department of Family Services, Adult Protective Services; Wyoming Long-Term Care Ombudsman Program; or Wyoming Protection and Advocacy System)
- Making a referral to the Division's Program Integrity Unit
- Making a referral to the Medicaid Fraud Control Unit

Case managers must follow up on all incidents. The Division also follows up and conducts investigations. Case managers are required to cooperate with any investigation conducted by the Division and may be required to supply documentation or take additional follow-up actions as requested by the Division. Investigations are not considered concluded until all required follow-up actions have been taken to reasonably assure the health and safety of the participant(s). The duration of an investigation varies based on circumstances and follow-up actions required.

## Section 9. Fraud, Waste, and Abuse

Case managers play a vital role in protecting the integrity of the Community Choices Waiver program. Not only must case managers not engage in abusive practices and violations, but through providing case management services, case managers may also detect or suspect fraud, waste, and abuse, and must report this to the applicable agency.

Medicaid fraud is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. Simply put, fraud is the intentional providing of false information to get Medicaid to pay for medical care or services. Medicaid fraud can involve physicians, pharmacists, other Medicaid providers, and even beneficiaries.

Provider fraud may include, but is not limited to:

Activity	Explanation
<b>Card Sharing</b>	Knowingly treating and claiming reimbursement for someone other than the eligible beneficiary
<b>Collusion</b>	Knowingly collaborating with beneficiaries to file false claims for reimbursement Submitted time sheets for services not rendered (participant-directed)
<b>Kickbacks</b>	Offering, soliciting, or paying for beneficiary referrals for services or items
<b>Program Eligibility</b>	Knowingly billing for an ineligible beneficiary
<b>Billing Discrepancies</b>	Intentionally billing for unnecessary services or items Intentionally billing for services or items not provided

Beneficiary fraud may include, but is not limited to:

Activity	Explanation
<b>Card Sharing</b>	Sharing a Medicaid identification card with someone else so they can obtain services
<b>Collusion</b>	Helping a provider file false claims by having unnecessary tests conducted that are not needed Approving time sheets for services not rendered (participant-directed)
<b>Kickbacks</b>	Accepting payment from a provider for referring other beneficiaries for services
<b>Program Eligibility</b>	Providing incorrect information to qualify for Medicaid

Waste encompasses overutilization of resources and inaccurate payment for services, such as intentional duplicate payments or services in excess of what is necessary to meet the participant's needs. Abuse includes any practice that is inconsistent with acceptable fiscal, business, or medical practices that unnecessarily increase costs.

## 9.1 Prevention and Education

Federally and at the state level, initiatives are underway to combat Medicaid fraud, waste, and abuse. Initiatives include data mining, audits, investigations, enforcement actions, technical assistance, and provider and member outreach and education. These initiatives ensure that:

- Eligibility decisions are made correctly
- Prospective and enrolled providers meet federal and state participation requirements
- Delivered services are necessary and appropriate
- Provider payments are made in the right amount and for appropriate services

Case managers play a crucial role in the prevention of fraud, waste, and abuse. Authorizing services based on the assessed needs of the participant is one way in which case managers can prevent fraud, waste, and abuse. Monthly monitoring, which includes a review of service authorization and utilization is another.

Services provided by the Community Choices Waiver and authorized on the participant's service plan can only be reimbursed after they have been provided to the participant. Providers can only deliver services to and submit claims on behalf of participants who are eligible for the waiver and are residing in the community. Providers cannot submit claims for services when a participant is:

- In a nursing facility
- In a hospital
- Deceased
- Otherwise unable to receive services

Case managers cannot bill for case management services provided on the day a participant is admitted to a hospital or nursing home.

## 9.2 Reporting

The Division's Program Integrity Unit is responsible for ensuring the integrity and accountability of all payments made for Wyoming Medicaid services. Case managers must report any suspected Medicaid fraud, waste, or abuse to the Division. For more information or to file a report online, visit the Division's website.

## Appendix A: Definition of Terms

**Abuse** – The intentional or reckless infliction of injury or physical/emotional harm.

**Adult Protective Services (APS)** – The unit within the Wyoming Department of Family Services that serves vulnerable individuals aged 18 and older who are unable to manage and take care of themselves without assistance as a result of advanced age or physical or mental disability.

**Applicant** – An individual applying for Medicaid services.

**Assessment** – An initial evaluation or periodic reevaluation of a participant in order to determine the need for any medical, educational, social, or other services.

**Behavioral/Emotional Crisis** – Volatile actions or behaviors, such as extreme agitation, irrational thoughts, threatening language, or property destruction, which place the participant at imminent risk of harming self/others.

**Case Management Agency** – An agency that meets all requirements set forth by the Division and is enrolled and approved as a Medicaid provider in the state of Wyoming.

**Case Management Information System** – The automated data management system designated by the Division for the creation and maintenance of participant case records.

**Case Manager** – A person who provides case management services, is employed or contracted by a qualified CMA, and meets all requirements set forth in this manual.

**Centers for Medicare and Medicaid Services (CMS)** – The agency within the United States Department of Health and Human Services responsible for the administration and oversight of the Medicare and Medicaid programs.

**Child Protective Services (CPS)** – The unit within the Wyoming Department of Family Services that serves families, children, and juveniles with the goal of children remaining home safely.

**Home and Community Based Services (HCBS) Waiver** – Means a program of services and supports authorized under §1915(c) waiver of the Social Security Act and provided to individuals who would otherwise care in a Medicaid-covered institution.

**Code of Federal Regulations (CFR)** – The codification of the general and permanent rules and regulations published in the Federal Register by the executive departments and agencies of the Federal Government of the United States.

**Conflict of Interest** – A real or appearance of incompatibility between one's private interests and one's public or fiduciary duties.

**Critical Incident** – Incidents or potential incidents of abuse, neglect, exploitation, unexpected death, use of restraint, and/or unauthorized use of restrictive interventions.

**Exploitation** – Fraudulent, unauthorized, or improper acts or processes of an individual who uses the resources of the participant for monetary or personal benefit, profit, or gain or that results in depriving the participant of his/her rightful access to, or use of, benefits, resources, belongings, or assets.

**Financial Exploitation** – The illegal or improper use of an older adult's or vulnerable adult's funds or assets.

**Intimidation** – Communication by word or act that the individual subject to intimidation, or his/her family, friends, or pets will suffer physical violence or will be deprived of food, shelter, clothing, financial support, supervision, prescribed medication, physical or mental health care, and/or other medical care necessary to maintain health.

**Medication Error or Adverse Reaction**– A mistake in medication administration that includes, but is not necessarily limited to, the following:

- Wrong medication
  - An individual receives and takes medication which is intended for another person
  - Discontinued medication
  - Inappropriately labeled
- Wrong dose
  - An individual receives the incorrect amount of medication.
- Wrong time
  - An individual receives medication dose at an incorrect time interval); and
- Omission of medicine
  - A missed dose, when an individual does not receive a prescribed dose of medication
  - Not including when an individual refuses to take medication

This also includes an adverse reaction, such as an allergic reaction or suspected side effects.

**Neglect** – The deprivation of, or failure to provide, the minimum food, shelter, clothing, supervision, physical and mental health care, and/or other care and prescribed medication as necessary to maintain the participant's life or health, or which may result in a life threatening situation.

**Other Material Exploitation** – The illegal or improper use of an older adult's or vulnerable adult's property or possessions.

**Participant** – An individual who meets the eligibility requirements for and has agreed to receive services through the waiver. For the purposes of this manual, participant also means legally authorized representative, as appropriate.

**Physical Abuse** – Intentional or reckless infliction of physical injury, harm, or pain.



**Prescription Drug Theft/Diversio**n – The theft of another’s prescription medications for one’s own personal use, often committed by someone the victim knows well and has unfettered access to the home.

**Provider** – Any person, group, or entity with an approved Wyoming Medicaid Provider Participation Agreement, approved to render services or provide items to a participant.

**Restraint** – Any physical, chemical, or mechanical intervention that is used to control acute, episodic behavior that restricts the movement or function of the participant or a portion of the participant’s body.

**Restrictive Intervention** – An action or procedure that limits the participant’s movement; limits the participant’s access to other individuals, locations, or activities; or restricts participant rights.

**Seclusion** – The involuntary confinement of a participant alone in a room or an area from which the participant is physically prevented from having contact with others or leaving.

**Self-Injurious Behavior** – The occurrence of behavior that results in physical injury to one’s own body.

**Self-Neglect** – Refusal to perform or accept assistance with performing essential self-care tasks, such as: providing essential food, clothing, hygiene, shelter, or medical care; obtaining goods and services necessary to maintain physical health, mental health, emotional well-being and general safety; or managing financial affairs.

**Serious Behavioral/Mental Health Concern** - Any situation in which the participant's behavior puts them at risk of hurting themselves or others and or prevents them from being able to care for themselves or function effectively in the community.

**Serious Injury/Illness** – An injury or illness for which the participant is provided emergency medical treatment and/or is hospitalized.

**Service Plan** – The written document that specifies assessed needs and services, to include Medicaid and non-Medicaid services regardless of funding source, to assist a participant to remain safely in the community and developed in accordance with Division requirements.

**Sexual Abuse** – Sexual contact including, but not limited to, unwanted touching, all types of sexual assault or battery, sexual exploitation, and sexual photographing.

**Sexual Exploitation** – Acts committed through non-consensual abuse or exploitation of another person’s sexuality for the purpose of sexual gratification, financial gain, personal benefit or advantage, or any other non-legitimate purpose.

**Substance Abuse** – Overindulgence in or dependence on an addictive substance, especially alcohol or drugs.

**Unexpected Death** – The death of a participant when not a result of an expected medical prognosis.

**Verbal/Emotional Abuse** – Presence of behaviors, such as threatening or demeaning language, resulting in displays of fear, unwillingness to communicate, or sudden changes in behavior.

**Waiver Services** – Those optional Medicaid services defined in the current federally approved Community Choices Waiver agreement and do not include Medicaid state plan services.

# Appendix B: Incident Taxonomy

## 1. Abuse

### 1.1. Physical Abuse

- 1.1.1. Physical abuse of the participant by a family member or natural support
- 1.1.2. Physical abuse of the participant by a service provider
- 1.1.3. Physical abuse of the participant by another participant
- 1.1.4. Physical abuse of the participant by an unknown/other person
- 1.1.5. Physical abuse of another person by the participant

### 1.2. Verbal/Emotional Abuse

- 1.2.1. Verbal/emotional abuse of the participant by a family member or natural support
- 1.2.2. Verbal/emotional abuse of the participant by a service provider
- 1.2.3. Verbal/emotional abuse of the participant by another participant
- 1.2.4. Verbal/emotional abuse of the participant by an unknown/other person
- 1.2.5. Verbal/emotional abuse of another person by the participant

### 1.3. Sexual Abuse

- 1.3.1. Sexual abuse of the participant by a family member or natural support
- 1.3.2. Sexual abuse of the participant by a service provider
- 1.3.3. Sexual abuse of the participant by another participant
- 1.3.4. Sexual abuse of the participant by an unknown/other person
- 1.3.5. Sexual abuse of another person by the participant

### 1.4. Intimidation

- 1.4.1. Intimidation of the participant by a family member or natural support
- 1.4.2. Intimidation of the participant by a service provider
- 1.4.3. Intimidation of the participant by another participant
- 1.4.4. Intimidation of the participant by an unknown/other person
- 1.4.5. Intimidation of another person by the participant

## 2. Neglect

### 2.1. Self-Neglect

### 2.2. Neglect of participant by a service provider

- 2.2.1. Failure to provide adequate supervision/monitoring
  - 2.2.1.1. Failure to adequately monitor and intervene for a known medical condition
  - 2.2.1.2. Failure to provide adequate supervision to a participant with cognitive impairment
  - 2.2.1.3. Failure to provide adequate supervision to a participant with a known risk of elopement
  - 2.2.1.4. Failure to provide adequate supervision to a participant with known self-injurious behavior
  - 2.2.1.5. Failure to provide adequate supervision to prevent physical altercations
- 2.2.2. Failure to provide a safe/healthy environment

- 2.2.2.1. Failure to provide adequate nutrition/hydration
- 2.2.2.2. Failure to provide a clean, comfortable environment
- 2.2.2.3. Lack of a functioning ventilation, heating, or cooling system
- 2.2.2.4. Widespread infestation of insects/rodents
- 2.2.2.5. Failure to protect a participant at risk from a physical or chemical hazard
- 2.3. Neglect of participant by family or natural supports
  - 2.3.1. Failure to provide adequate supervision/monitoring
    - 2.3.1.1. Failure to adequately monitor and intervene for a known medical condition
    - 2.3.1.2. Failure to provide adequate supervision to a participant with cognitive impairment
    - 2.3.1.3. Failure to provide adequate supervision to a participant with a known risk of elopement
    - 2.3.1.4. Failure to provide adequate supervision to a participant with known self-injurious behavior
    - 2.3.1.5. Failure to provide adequate supervision to prevent physical altercations
  - 2.3.2. Failure to provide a safe/healthy environment
    - 2.3.2.1. Failure to provide adequate nutrition/hydration
    - 2.3.2.2. Failure to provide a clean, comfortable environment
    - 2.3.2.3. Lack of a functioning ventilation, heating, or cooling system
    - 2.3.2.4. Widespread infestation of insects/rodents
    - 2.3.2.5. Failure to protect a participant at risk from a physical or chemical hazard

### **3. Exploitation**

- 3.1. Financial exploitation
  - 3.1.1. Financial exploitation of the participant by a family member or natural support
  - 3.1.2. Financial exploitation of the participant by a service provider
  - 3.1.3. Financial exploitation of the participant by another participant
  - 3.1.4. Financial exploitation of the participant by an unknown/other person
  - 3.1.5. Financial exploitation of another person by the participant
- 3.2. Sexual exploitation
  - 3.2.1. Sexual exploitation of the participant by a family member or natural support
  - 3.2.2. Sexual exploitation of the participant by a service provider
  - 3.2.3. Sexual exploitation of the participant by another participant
  - 3.2.4. Sexual exploitation of the participant by an unknown/other person
  - 3.2.5. Sexual exploitation of another person by the participant
- 3.3. Prescription drug theft/diversion
  - 3.3.1. Theft/diversion of the participant's prescription drugs by a family member or natural support

- 3.3.2. Theft/diversion of the participant's prescription drugs by a service provider
- 3.3.3. Theft/diversion of the participant's prescription drugs by another participant
- 3.3.4. Theft/diversion of the participant's prescription drugs an unknown/other person
- 3.3.5. Theft/diversion of another person's prescription drugs by the participant
- 3.4. Other material exploitation
  - 3.4.1. Other material exploitation of the participant by a family member or natural support
  - 3.4.2. Other material exploitation of the participant by a service provider
  - 3.4.3. Other material exploitation of the participant by another participant
  - 3.4.4. Other material exploitation of the participant by an unknown/other person
  - 3.4.5. Other material exploitation of another person by the participant

#### **4. Death**

- 4.1. Expected Death
- 4.2. Unexpected Death
  - 4.2.1. Death as a result of an unexpected natural cause, illness, or disease
  - 4.2.2. Death as a result of neglect
  - 4.2.3. Death as a result of trauma inflicted by another person
  - 4.2.4. Death as a result of a medication error
  - 4.2.5. Death as a result of an accident
  - 4.2.6. Suicide
  - 4.2.7. Death of an unknown/other cause

#### **5. Restraints & Restrictive Interventions**

- 5.1. Restraint
  - 5.1.1. Physical restraint
    - 5.1.1.1. Manual restraint
    - 5.1.1.2. Mechanical restraint
  - 5.1.2. Chemical restraint
- 5.2. Restrictive Intervention
  - 5.2.1. Seclusion
  - 5.2.2. Unauthorized use of restricted egress
  - 5.2.3. Unauthorized limitation of participant rights
    - 5.2.3.1. Full access to the greater community
    - 5.2.3.2. Privacy
    - 5.2.3.3. Independence in making life choices
    - 5.2.3.4. Freedom to control own schedules and activities
    - 5.2.3.5. Access to food
    - 5.2.3.6. Ability to have visitors of their choosing at any time

#### **6. Serious Injury/Illness**

- 6.1. Injury/Illness Description
  - 6.1.1. Laceration requiring sutures/staples
  - 6.1.2. Bone fracture

- 6.1.3. Joint dislocation
- 6.1.4. Serious burn
- 6.1.5. Concussion/head injury
- 6.1.6. Seizure
- 6.1.7. Pressure ulcer/skin degradation
- 6.1.8. Serious illness resulting in hospitalization
- 6.1.9. Other
- 6.2. Cause of Injury/Illness
  - 6.2.1. Abuse
  - 6.2.2. Neglect
  - 6.2.3. Exploitation
  - 6.2.4. Self-injurious behavior
  - 6.2.5. Suicide attempt
  - 6.2.6. Fall
  - 6.2.7. Accident
  - 6.2.8. Medication/treatment error
  - 6.2.9. Other/unknown
- 7. Serious Behavioral/Mental Health Concern**
  - 7.1. Behavioral/emotional crisis
    - 7.1.1. Homicidal thoughts/ideations
    - 7.1.2. Irrational/delusional thoughts or actions
  - 7.2. Self-injurious behavior
    - 7.2.1. Resulting in an injury
    - 7.2.2. Not resulting in an injury
    - 7.2.3. Suicidal thoughts/ideations
    - 7.2.4. Suicide attempt
  - 7.3. Substance Abuse
    - 7.3.1. Alcohol abuse
    - 7.3.2. Marijuana abuse
    - 7.3.3. Stimulant abuse (e.g. cocaine or methamphetamine)
    - 7.3.4. Hallucinogen abuse (e.g. LSD, psilocybin mushrooms, or peyote)
    - 7.3.5. Opioid abuse (e.g. heroin, oxycodone, or hydrocodone)
    - 7.3.6. Other/unknown substance abuse
- 8. Medication Error or Adverse Reaction**
  - 8.1. Medication error or adverse reaction requiring emergency medical treatment
    - 8.1.1. Incorrect medication administered to participant
    - 8.1.2. Medication not administered
    - 8.1.3. Medication not administered timely
    - 8.1.4. Medication administered in wrong dosage
    - 8.1.5. Medication administered via wrong route
    - 8.1.6. Allergic or adverse reaction to a medication
      - 8.1.6.1. Medication administered to a participant with a known history of allergic/adverse reaction to that medication

- 8.1.6.2. Medication administered to a participant with a unknown history of allergic/adverse reaction to that medication
- 8.2. Medication error or adverse reaction not requiring emergency medical treatment
  - 8.2.1. Incorrect medication administered to participant
  - 8.2.2. Medication not administered
  - 8.2.3. Medication not administered timely
  - 8.2.4. Medication administered in wrong dosage
  - 8.2.5. Medication administered via wrong route
  - 8.2.6. Allergic or adverse reaction to a medication
    - 8.2.6.1. Medication administered to a participant with a known history of allergic/adverse reaction to that medication
    - 8.2.6.2. Medication administered to a participant with a unknown history of allergic/adverse reaction to that medication