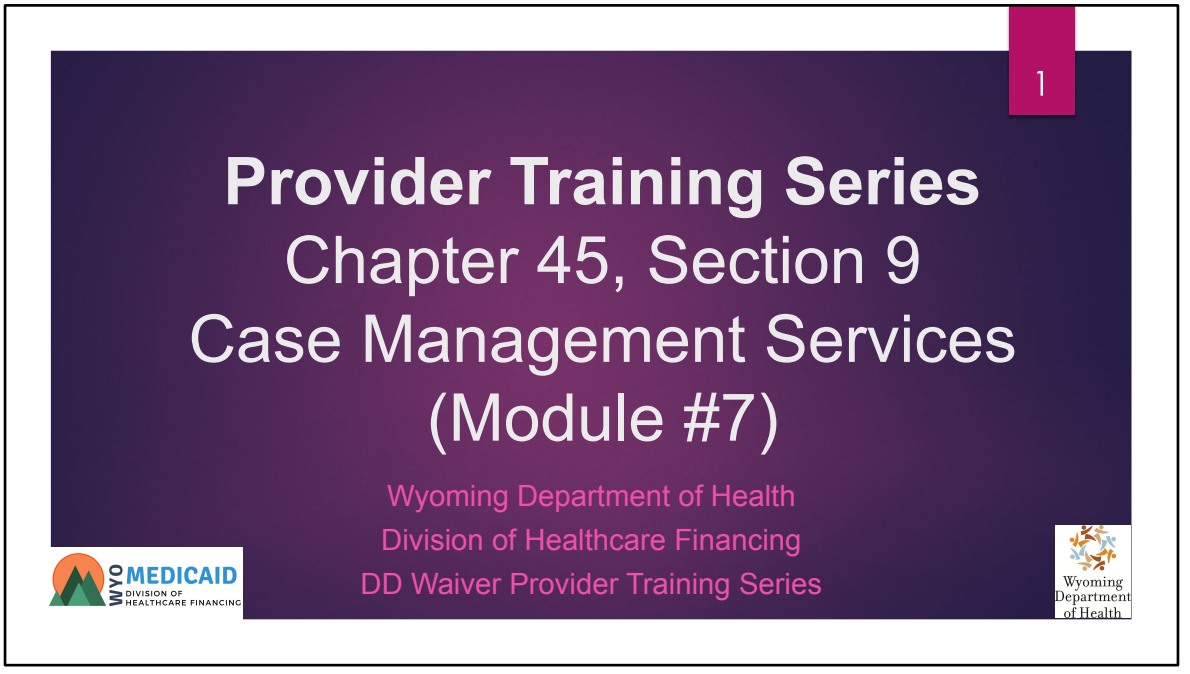


Welcome to the Division of Healthcare Financing (Division), Home and Community Based Services Section's Provider Training Series for Chapter 45 of the Department of Health's Medicaid Rules (Rules). These rules govern the home and community based Comprehensive and Supports Waivers, hereinafter referred to as the DD Waivers.

Chapter 45, Section 15(d) states that all persons qualified to provide waiver services shall complete training in specific areas prior to delivering services. Although some provider organizations may choose to develop their own training modules, individuals who complete all of the Series training modules and associated training summaries will be in compliance with this specific requirement. Please note that there are provider training requirements established throughout Chapter 45, and it is the responsibility of providers to ensure they meet **all** training requirements prior to delivering waiver services.

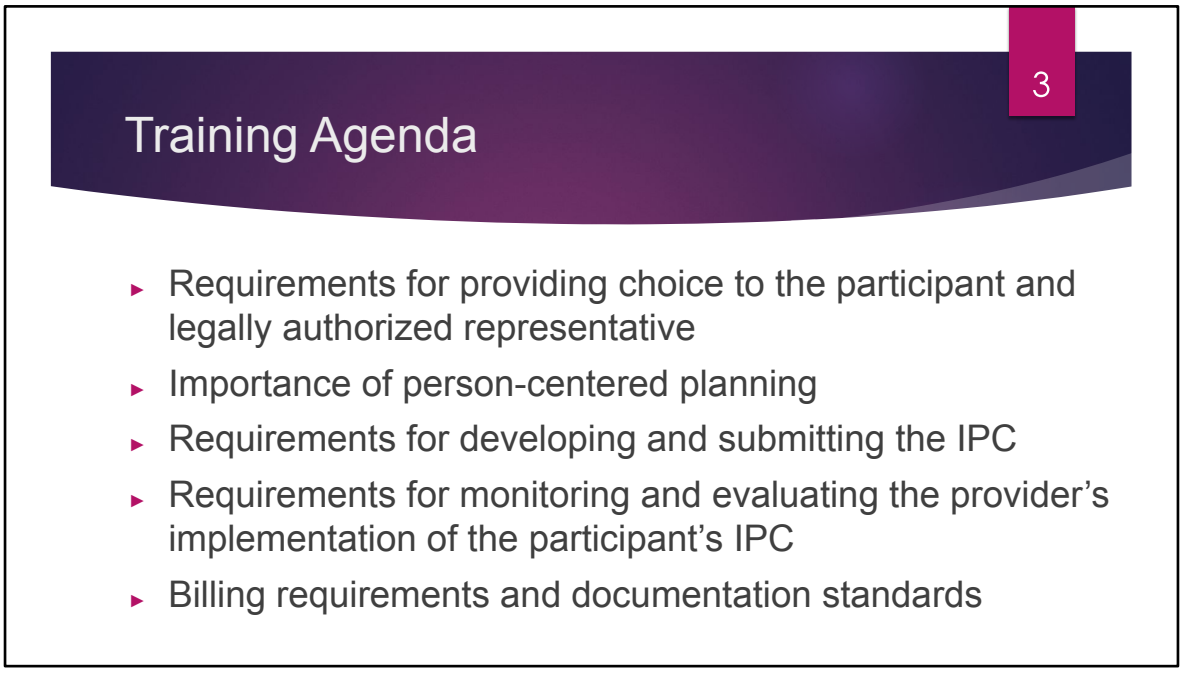
This module covers Section 9, which addresses case management services.

2

Purpose of This Training

To familiarize case managers and providers of other DD Waiver services with the responsibilities of case managers. Responsibilities include developing the participant's individualized plan of care (IPC) and monitoring the provider's implementation of the participant's services.

The purpose of this training is to familiarize case managers and providers of other DD Waiver services with the responsibilities of case managers. Responsibilities include developing the participant's individualized plan of care (IPC) and monitoring the implementation of the participant's services.



At the end of the module addressing case management services, the following topics will have been introduced and explained.

- The requirements the case manager must meet in providing choice to the participant and legally authorized representative;
- The importance of using person-centered planning when developing the participant's IPC in order to understand their needs, preferences, goals, and desired accomplishments;
- The requirements and timelines the case manager must meet when developing and submitting the IPC;
- The case manager's responsibilities for monitoring the implementation of the IPC in order to ensure that participants are receiving the services they want and need; and
- Other case manager responsibilities, including documentation standards and requirements that must be met in order to bill for services.

4

Case management is a mandatory service for all participants enrolled in DD Waiver services.

Chapter 45, Section 9(a)

Case management is the only required DD waiver service, which means that every DD Waiver participant must have a case manager. The case manager is the key to effectively delivering waiver services. From developing an IPC that clearly addresses the participant's wants and needs to assessing participant satisfaction, the case manager plays a critical role in assuring that the participant receives quality services.

Because case management is the only mandatory service, each DD Waiver participant must receive services from their case manager or back-up case manager every month. At a minimum, a 15-minute unit must be provided in order to discuss participant satisfaction and address any needs or concerns the participant may have. A case manager's failure to provide case management services on a monthly basis could put a participant's waiver services in jeopardy.

Case management is a lynchpin service. The individualized plan of care (IPC) that the case manager develops can determine the success or failure of participants receiving waiver services, and the excellence or mediocrity of their quality of life.

Conflict Free Case Management

- A conflict of interest occurs when an individual has competing interests or loyalties because of their obligations to more than one person or organization.
- Intended to ensure that IPCs are developed, implemented, and monitored in the best interest of the participant.
- Rules are established in Chapter 45, Section 5.
- Additional information can be found on the Conflict Free Case Management Information document.

A conflict of interest occurs when an individual has competing interests or loyalties because of their obligations to more than one person or organization. In order for the case manager to have the authority to develop, implement, and monitor IPCs in the best interest of the participant, the case manager must not have a conflict of interest with participants, legally authorized representatives, or providers listed on the IPC. The Division has established rules related to conflict free case management, which can be found in Chapter 45, Section 5 of the Department of Health's Medicaid Rules. The Division has also created a quick reference document entitled Conflict Free Case Management Information, which can be found on the Providers and Case Managers page of the Division website, under the *Case Manager and Provider Reference Materials* toggle.

6

Choice

Participants of DD Waiver services have the right to choose the services they want on their plan, and the providers that will provide those services.

Home and community-based waiver services are based on the tenet that people have the freedom to make choices that impact their lives. Case managers play a crucial role in assuring that participants have choice. Assuring choice starts with offering the participant choice in services and providers, and continues with developing an IPC that clearly and specifically outlines what the participant wants and does not want in their life. Finally, the case manager assures choice by monitoring the participant's services to ensure their choices are being respected during the delivery of waiver services.

It is important for case managers to understand their role in assuring choice, but it is also necessary for providers of other waiver services to understand the case manager's role. Case managers are required to offer participants choice in services and providers. Additionally, case managers are obligated to notify the Division if they find areas of provider non-compliance or observe services that are not being delivered in accordance with the IPC.

Participant Choice in Services and Providers

7

- The case manager shall provide a list of all providers available in the participant's community.
- Choice should include any certified waiver provider, participant-directed options, Medicaid State Plan services, and natural supports.
- Choice should be offered at least every six months.

Chapter 45, Section 9(e)(iii)

As established in Chapter 45, Section 9(e)(iii), case managers are responsible for providing the participant and legally authorized representative with a list of all providers available in the participant's community every six months in order to ensure that participants have a choice in provider. Remember, participants do not have to be tied to one community, and can elect to move to a different community to receive services.

Although traditional waiver providers and services are an obvious option when considering services, there are other alternatives as well. Case managers are obligated to offer all of the choices that are available to the participant. Choices could include:

- Participant-directed services, which allow the participant or the employer of record to hire their own employees;
- Services offered through the Medicaid State Plan; and
- Supports that naturally result from the associations and relationships that participants develop in other environments, such as the family, school, work, and community. Wyoming 211 is a great resource for identifying natural supports.

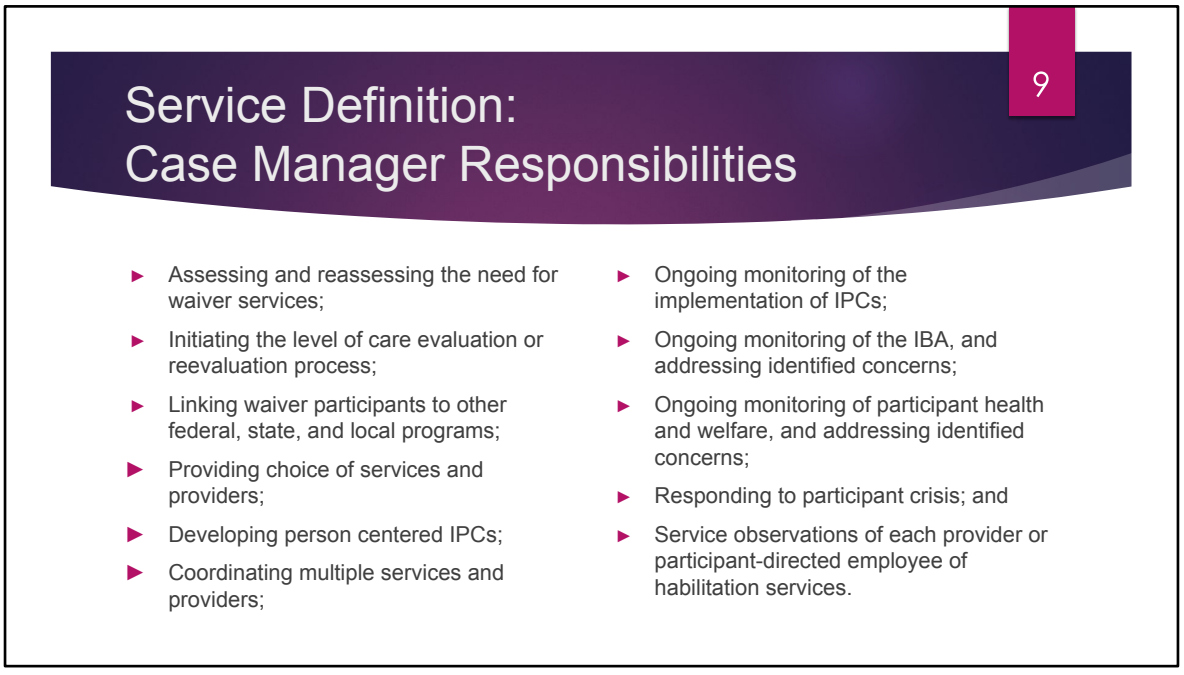
8

Case Management Service Definition

The definition of case management services establishes case management responsibilities, monthly requirements, and billable and non-billable activities.

In addition to Chapter 45, Section 9, the case management service definition, which can be found in the Comprehensive and Supports Waiver Service Index (Service Index), provides significant information on case management services. The Service Index, which is incorporated into rule by reference, is located on the Service Definitions and Rates page of the Division website.

More information on the case management service definition is available on the next slide.



The Service Index lists specific responsibilities that the case manager must fulfill. These responsibilities include:

- Scheduling necessary assessments in order to determine the participant's need for waiver services;
- Initiating the level of care evaluation or reevaluation process, which is a critical element in determining the participant's eligibility for waiver services;
- Linking participants to other non-waiver federal, state, and local resources;
- Offering choice of services and providers;
- Developing the participant's IPC, using person-centered planning;
- Coordinating multiple services and providers, including non-waiver resources;
- Conducting ongoing monitoring of the provider to ensure they are implementing the IPC in accordance with the participant's wishes and needs;
- Conducting ongoing monitoring of the participant's individual budget amount (IBA) to ensure that services are being used as identified in the IPC, and will last the entire plan year;
- Conducting ongoing monitoring of participant's health and welfare, and addressing identified concerns;
- Addressing concerns that are identified in monitoring efforts, and advocating for the participant;
- Responding to participant crisis; and
- Performing service observations of each provider or participant-directed employee of

- habilitation services.

10

Requirements for Participant Eligibility

Case managers play a vital role in helping applicants through the application and eligibility process.

The case manager plays a vital role in helping applicants for Supports Waiver services through the application and eligibility determination process.

The Supports Waiver Application Guide, which can be found on the Participant Services and Eligibility page of the Division website, explains the step-by-step process and specific case manager responsibilities.

Responsibilities Related to Participant Eligibility

11

- Case Managers shall complete all eligibility paperwork within thirty (30) calendar days
  - Level of care assessment
  - Clinical eligibility
  - Financial eligibility

Case managers are responsible for arranging and coordinating eligibility for applicants and participants of waiver services. As established in Chapter 45, Section 9(b), the case manager must complete all eligibility paperwork established in Chapter 46 of the Department of Health's Medicaid Rules within thirty (30) calendar days. Required paperwork includes the level of care assessment and scheduling an appointment to determine clinical eligibility.

Case managers are also responsible for assuring that current waiver participants are aware of the steps that they need to take in order to maintain eligibility, and help them through that process. Case managers should be knowledgeable of the level of care determination process, as well as what is required for the participant to maintain clinical and financial eligibility, and then work with all parties to ensure paperwork is filed and deadlines are met.

Remember, the case manager is the professional. The participant and legally authorized representative must be able to count on the case manager to know what steps need to be taken, and how to work through each necessary process in order to ensure the participant ultimately gets the services they need.

13

Targeted Case Management

Case managers must provide targeted case management services to an applicant who is working through the eligibility process or awaiting a funding opportunity.

- Gather information;
- Link participants to services;
- Conduct monitoring and follow-up;
- Advocacy; and
- Crisis intervention.

Chapter 45, Section 9(e)(ii)(A)

Chapter 45, Section 9(e)(ii) establishes that case managers must provide targeted case management (TCM) services to applicants who are in the eligibility process or awaiting funding. TCM is a 15-minute unit, and up to 120 can be billed annually.

TCM is different from waiver case management services. It is a Medicaid State Plan service that allows a case manager to be paid for the time they spend working with a waiver applicant who is on the waiting list but has not received funding for waiver services. It is critical for case managers to work closely and stay in contact with applicants during this time. TCM services are outlined in the Service Index, but generally include:

- Completing the level of care assessment and helping the applicant to gather the information necessary to complete the eligibility process;
- Working with applicants and providers to secure services, which may include arranging initial appointments - remember, creativity and knowing local community non-waiver resources is a key element that the case manager brings to the plan of care team - these resources may be critical in supporting the applicant while they are waiting for waiver services;
- Contacting the applicant and others to ensure the individual's needs are being met during the interim;
- Advocating for the applicant throughout the eligibility process, and as needed while they wait for a funding opportunity; and
- Providing crisis intervention and stabilization in situations requiring immediate

- attention.

If an applicant is not currently receiving Medicaid services, then the case manager must create a Targeted Case Management Plan in order for the psychological evaluation, which is needed to determine clinical eligibility, to be to be paid.

13

Person-Centered Planning

The case manager shall use person-centered planning to understand the needs, preferences, goals, and desired accomplishments of the participant.

Chapter 45, Section 9(c)

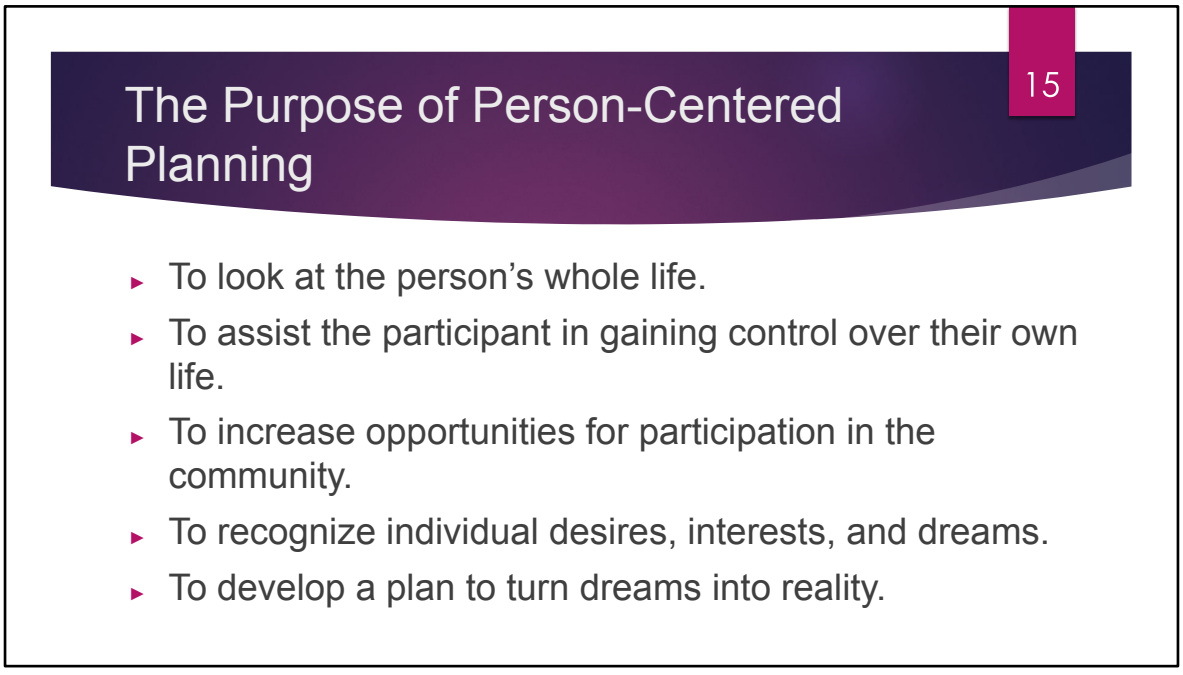
In accordance with Chapter 45, Section 9(c), the case manager shall use person-centered planning to understand the needs, preferences, goals, and desired accomplishments of the participant.

What is Person-Centered Planning?

An ongoing process used to help people with disabilities plan for their future. In person-centered planning, the plan of care team focuses on the participant and that person's vision of what they want their life to be.

Person-centered planning is an ongoing process used to help people with disabilities plan for their future. In person centered planning, the plan of care team focuses on the participant and that person's vision of what they want their life to be. The plan of care team identifies opportunities for the participant to develop personal relationships, participate in their community, increase control over their own life, and develop the skills and abilities needed to achieve these goals. Person centered planning relies on the commitment of the team to make sure that the strategies discussed in the IPC meeting are implemented.

The participant is the team leader, and can choose anyone they'd like to be involved in the person-centered planning process, including direct support staff members who work directly with them on a day-to-day basis. The case manager serves as the meeting facilitator, and leads the team through the process, handles any conflicts that arise, and assures equal opportunity for all to participate.



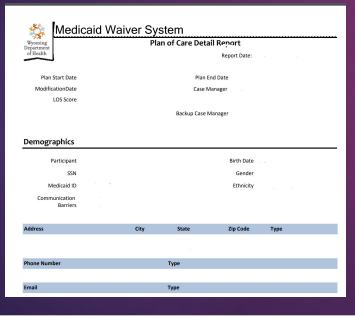
When facilitating a person-centered planning meeting, it is up to the case manager to ensure that the meeting is conducted in a way that includes the participant and addresses the participant's life as a whole...not just their waiver services. There will be a need to talk about areas of concern, but the meeting should focus on the participant's strengths, how they can exercise control over their life, and how they can be an active and participating member of their community. The team needs to acknowledge the participants desires, interests, and dreams, and work as a team to identify ways for the participant to get what they want out of their life.

The result of the person-centered planning process is an IPC, developed by the case manager with the input of the participant and plan of care team, that includes supports, activities, and skill development that will help the participant turn their dreams into reality.

The Division has developed the IPC Planning Workbook to help the participant and case manager develop a person-centered plan. The IPC Planning Workbook can be found on the Forms and Documents page of the Division website, under the *References/Tools* tab.

16

Developing the IPC


Medicaid Waiver System

Plan of Care Detail Report

Report Date:

Plan Start Date
Modification Date
LOS Score

Plan End Date
Case Manager

Backup Case Manager

Demographics

Participant
SSN
Medicaid ID
Communication Barriers

Birth Date
Gender
Ethnicity

Address	City	State	Zip Code	Type

Phone Number	Type

Email	Type

The case manager shall complete and submit the individualized plan of care at least thirty (30) calendar days before the intended plan start date.

Chapter 45, Section 9(e)(v)

The case manager is responsible for developing and submitting an IPC for each participant on their caseload, and for submitting modifications to each participant's IPC as the participant's supports and circumstances change. The details of the IPC will be covered in Module #8, but Section 9 covers more of the logistical requirements that each case manager must meet when submitting an IPC.

19

Requirements for Developing the IPC

- Help the plan of care team plan, budget, and prioritize services in order to create a person-centered IPC.
- Help participant access all needed and available resources.
- Provide a 20 calendar day written notice of meetings.
- Develop and submit the IPC at least 30 calendar days before the plan is scheduled to start.

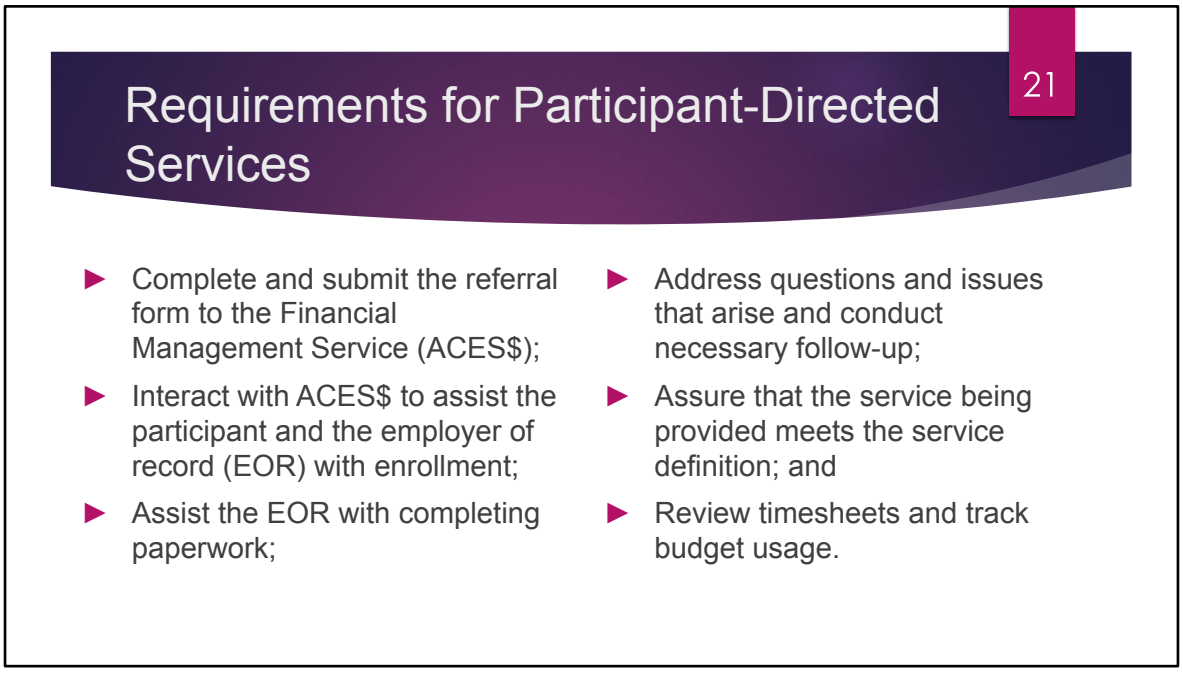
As mentioned earlier, the case manager is obligated to involve and assist the participant's plan of care team with developing a person-centered IPC. The development of the IPC includes planning, budgeting, and prioritizing services for the participant, and staying within the assigned individual budget amount.

The case manager is responsible for coordinating and assisting participants in accessing all needed and available resources. This includes natural, paid, and community supports and resources.

The case manager is responsible for notifying all plan of care team members, in writing, of upcoming team meetings within 20 calendar days. The 20 day meeting notice must be uploaded into the *Document Library* in the Electronic Medicaid Waiver System (EMWS). This requirement is specifically outlined in Section 10(c). While case managers have a responsibility to notify providers of plan of care team meetings, it is the provider's responsibility to attend and actively participate as a member of the plan of care team. Please remember, Division personnel are not part of the plan of care team. They do not need to be invited to meetings, and will not attend meetings if they are invited.

The case manager must submit all required components of the IPC into EMWS at least 30 calendar days before the intended plan start date. If the case manager is submitting a modification, it must be submitted at least seven calendar days before the intended effective

date.



As established in Chapter 45, Section 9(e)(vi), if the participant chooses to direct services on the waiver through participant-direction, the case manager must assist the participant in making necessary modifications to the IPC, and monitor the financial management services offered through ACES$.

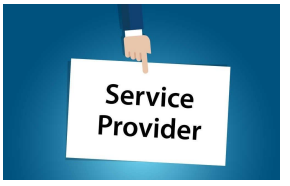
This assistance includes a myriad of tasks.

- The case manager must work with the employer of record (EOR) to ensure that the referral form is completed, and submit it to ACES$.
- The case manager must communicate with ACES$ to ensure all enrollment activities have been completed adequately.
- The case manager is responsible for helping the EOR complete paperwork, and must be able to answer questions and address issues as they arise.
- The case manager needs to follow up with the EOR and ACES$ as necessary to ensure that the participant-directed services are in place in a timely manner, in accordance with Division policy, and as desired by the participant and EOR.
- The case manager must assure that the service being provided actually meets the service definition outlined in the Service Index.
- Finally, the case manager is responsible for reviewing timesheets and monitoring the participant-directed budget to ensure that services are being used and delivered in accordance with the participant's IPC.

19

Sharing Information with Providers

- Obtain signatures.
- Send team meeting notes.
- Send a copy of the plan, including protocols, positive behavior support plans, or other necessary documents.
- Conduct participant specific training.



Chapter 45, Section 9(e)(vii) states that the case manager must ensure all providers on the participant's IPC sign off on the plan, receive a copy of the plan, receive team meeting notes, and complete participant specific training.

Open communication, transparency, and information sharing is crucial to ensuring that the participant receives the best services possible, and this starts with the case manager. The case manager is responsible for making sure that the decisions agreed upon by the team are accurately reflected in the participant's IPC. They must send providers a copy of the IPC, as well as any documentation that is considered part of the IPC but may not print off as part of the IPC from EMWS. This includes any protocols the participant may have, and the positive behavior support plan, if applicable. This information should be re-sent each time a modification to one of the documents or the participant's IPC is made. This information does not need to be sent to providers of home modification, specialized equipment, or homemaker services.

It is also the responsibility of the case manager to ensure that each provider listed on the IPC receives participant specific training. There is a great deal of information contained in a participant's IPC, protocols, and positive behavior support plan, and it is important that this information is adequately explained to providers. The case manager should keep documentation of the participant specific training that occurred, and must make it available to Division personnel upon request.

20

Sharing Information with Participants

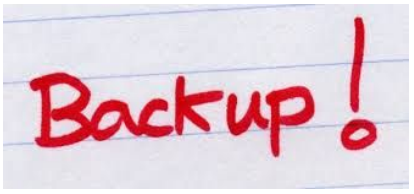
- Obtain signatures;
- Send team meeting notes;
- Send copy of the plan, including protocols, positive behavior support plans, or other necessary documents;
- Maintain releases of information.

Chapter 45, Section 9(e)(vii) establishes that the case manager must assure information is shared with the participant and appropriate parties involved in the participant's care or as authorized by a release of information that is signed by the participant or the participant's legally authorized representative.

The same documentation sent to providers should also be shared with the participant and legally authorized representative...after all, it is the participant's IPC, so they should certainly have a copy of it. If information is sent to anyone outside of the plan of care team, case managers should ensure they have a release of information on file that gives them the authority to share protected information.

24

Back-Up Case Managers



- Provide case management services in the event the primary case manager is unable to do so.
- Be prepared to provide all necessary services for all participants each month.
- Be knowledgeable of participant needs.

Module #6 of the Provider Training Series addresses provider qualifications. One of the qualifications of case management services is that every case manager is required to identify a back-up case manager from the list of case managers currently certified by the Division. The backup case manager is there to provide necessary case management services in the event that the selected case manager is unable to do so. If the primary case manager falls ill, or has to leave the state for a family emergency, the back-up case manager is there to take care of things in the primary case manager's absence.

It is important for the back-up case manager to reflect on what will be necessary to support all individuals on their caseload, including those for whom they provide back-up services. If a primary case manager has emergency surgery and is out for 6 weeks, the back-up case manager will now be responsible for home visits, service observations, and IPC renewals and modifications for each person on their caseload, as well as each person for whom they provide back-up services.

If the case manager has 20 people on their caseload, and is the only back-up case manager for the 20 people on the primary case manager's caseload, the back-up case manager is now responsible for ensuring all 40 people have the services and supports that they need during that 6 week period. Case managers should be prepared to provide all of the services for all of the participants on whose IPC they are named, and be careful not to over promise services they cannot reasonably provide.

It is important that back-up case managers know the participants and their needs so that they can step in during an emergency. Primary and back-up case managers are required to meet on a quarterly basis to review all participant cases.

22

Provider Monitoring and Evaluation

The case manager shall monitor and evaluate the implementation of the participant's IPC, as well as the participant's satisfaction with their supports and services.

Chapter 45, Section 9(e)(viii)

Chapter 45, Section 9(e)(viii) establishes that the case manager must monitor and evaluate the implementation of the participant's IPC, including a review of the type, scope, frequency, duration, and effectiveness of services, as well as the participant's satisfaction with the supports and services.

23

Monitoring Responsibilities

- Provider implementation of IPC.
- Utilization of the participant's individual budget amount.
- Participant health and welfare.
- Second-line monitoring of participant medications.

Monitoring service implementation and utilization is one of the most important tasks the case manager must complete. The case manager is responsible for ensuring that the services are being delivered in a manner that ensures participant choice, addresses participant specific needs, and is in alignment with what was agreed upon during the person-centered planning process and outlined in the participant's IPC.

The case manager must review service utilization to ensure that the number of units will span the plan year so that the participant does not run out of units for needed services. Services included in the IPC must be sufficient to last the entire plan...failure to plan for services that cover the plan year, or provider overutilization of services that results in an insufficient number of service units to cover a full plan year, does not meet the criteria to request additional funding through the Extraordinary Care Committee. The case manager is also responsible for monitoring the health and welfare of the participant. This is done through a timely review of incidents, as well as during home visits and service observations.

As established in Chapter 45 Section 9(f), the case manager is the second-line monitor for participants receiving medications. Second-line monitoring helps to ensure a participant's medical needs are addressed and medications are delivered in a manner that promotes the health, safety, and well-being of the participant. The case manager is responsible for reviewing trends regarding the usage of the participant's over-the-counter and prescription medications through a monthly review of medication assistance records and PRN medication usage records.

28

Reporting Requirements

Concerns with provider implementation of the IPC	Upon Identification
Concerns with participant health and safety	Upon Identification
Type, scope, frequency, duration, and effectiveness of services.	Quarterly
Participant satisfaction with the supports and services.	Quarterly

Chapter 45, Section 9(e)(ix) states that the case manager must report concerns with the provider's implementation of the IPC, or concerns with the participant's health and safety, directly to the provider. Rule violations must be reported to the Division through the incident reporting or complaint processes. The information should also be included in the case manager's monthly documentation, but if it is not reported to the Division as required, the case manager will be in violation of rules established in Chapter 45. The table in the slide outlines the timeframes case managers must meet when reporting concerns.

This is a good time to remind all providers and case managers that everyone works for the participant, and must work together. Providers are obligated to deliver services as outlined in each participants IPC, and in accordance with Division rules and policy. Case managers are obligated by rule to monitor the provider's implementation of services and, if they have concerns, report them to the Division. This is not meant to strain relationships between case managers and providers. This system is intended to ensure that participants get the services they want and need.

The Division expects all providers to behave professionally in all interactions with other team members. If a case manager or provider files a complaint or incident that involves a different case manager or provider, everyone is expected to behave in a professional manner regardless of the issue, and should understand that the submission of complaints and incidents is a responsibility of all waiver providers and case managers. In order to ensure the best possible

support for the participant, all team members must be professional and work together.

25

Provider Non-Compliance with Documentation

The case manager shall send the Division and the provider or employer of record written notification of noncompliance with these rules, the health, safety, or rights of the participant specified in the individualized plan of care, or when documentation is not received by the tenth (10th) business day of the following month after services were provided.

Chapter 45, Section 9(e)(x)

Chapter 45, Section 8 addresses documentation standards for all providers, and will be covered in a later module. Section 8(n) requires providers to make service documentation available to the case manager by the 10th business day of the month following the date that the services were rendered.

If the provider does not send documentation as required, the case manager is required to request the information from the provider and notify the Division of the provider's rule violation. Even if a provider sends the documentation at a later date, the case manager is required to complete the appropriate form and send it to the Division. The case manager must submit the form by the last business day of the month that the documentation is due.

Remember, providers and case managers must work together to ensure each participant's services are delivered in accordance with Medicaid Rules.

26

Maintaining Files and Service Documentation

The case manager shall maintain a participant's file and service documentation.

Chapter 45, Section 9(e)

Information is only useful if it is accurate. Case managers are responsible for ensuring that the file for each participant with whom they work is up-to-date, and that they complete service documentation in a timely fashion to ensure that participant information accurately reflects the participant's current needs, services, and health.

27

File Maintenance

- Information must be accurate and up-to-date.
  - Contact information
  - Guardianship paperwork
- Information must be stored securely.
- Information must be retained and destroyed appropriately.

Chapter 45, Section 9(d) establishes that the case manager must assure that all information, including but not limited to guardianship paperwork and contact information, is updated and accurate at all times.

The Division uses this information to notify participants and legally authorized representatives of important changes and updates that may affect the participant. Failure to keep this information updated could result in participants and legally authorized representatives missing important information.

Chapter 45, Section 9(e)(xi) requires the case manager to securely store and retain all confidential provider documentation for twelve months after the services were rendered. The documentation that case managers have contains confidential information, so it is necessary for them to follow safe destruction policies, which are established under Chapter 45, Section 7.

28

Service Documentation

The case manager shall document all monitoring and evaluation activities, follow-up on concerns and actions completed, and make appropriate changes to the individualized plan of care with team involvement, as needed.

Chapter 45, Section 9(e)(xii)

We've said it before, but it bears repeating...if it isn't written down, it didn't happen. Case managers must document all of their activities. They are also responsible for conducting follow up on any concerns, and making changes to the participant's IPC as needed. If a case manager is aware of a problem, they are obligated to contact the people that can address the problem. If a health trend or satisfaction issue is identified, the case manager is obligated to bring the team together to discuss solutions.

Monthly Documentation Requirements

- Case Management Monthly Review form in EMWS must be used for all case management service documentation.
  - Direct contact with the participant or legally authorized representative.
  - Review of goal progress.
  - Review of billing and service documentation.
  - Review of incident reports, including behavioral trends.
  - Review of PRN medication usage.
  - Home visit (monthly billing unit) and service observations.

Case managers must document their activities using the Case Management Monthly Review form found in EMWS. Documentation should include more than just dates and times. The case manager should provide a detailed accounting of the topics discussed, decisions made, and follow up that needs to occur. Activities that should be documented include:

- Contact with the participant or legally authorized representative, including telephone calls and email conversations.
- The review of goal progress, including potential changes to the participant's objectives.
- The review of billing and service documentation, including service under or over utilization.
- The review of incident reports, including behavioral trends and potential ongoing health or safety concerns.
- The review of PRN medication usage.
- A home visit, if the case manager is billing a monthly unit.
- Service observations, which should be conducted every three months for habilitation services and every six months for all other services.

There are a couple of important things to know when completing home visits and service observations. The intent of the home visit is to interact with the participant, and is different from a Community Living Services observation. The home visit should be used to learn about what is happening in the participant's life and discuss concerns, service satisfaction, and choice.

Service documentation must support the time that is billed for the home visit. Documenting one sentence for a home visit that lasted one hour does not support the hour of service being billed.

The case manager must document home visits and service observations in EMWS, and must also document and obtain appropriate signatures on the Home Visit and Service Observation Form, which can be found on the Forms and Document Library page of the Division website, under the *Forms* tab. Observations of habilitative services should include an observation of the participant working on their goal objectives. Observations of Community Living Services must be documented separately from the home visit.

30

Billing Requirements

The billing requirements for monthly and 15-minute case management units can be found in the Comprehensive and Supports Waiver Service Index.

Case managers can bill a monthly case management unit, or can bill 15-minute units, depending on the needs of the participant. The billing requirements for monthly and 15-minute case management units can be found in the Service Index. A monthly unit can only be billed for a participant once per month. Likewise, monthly and 15-minute units cannot be billed for the same participant in the same month. If a participant transitions from one case manager to another in the middle of the month, both case managers must bill 15-minute units for the work that they do.

Billable time may be cumulative during the time in which a case manager bills.

A billable case management activity is any task or function defined by the Division as an activity that only the case manager can provide to, or on behalf of, the participant or legally authorized representative. Services include:

- Plan development, monitoring, and follow-up;
- Medication monitoring;
- Home visits and service observations;
- Team meetings;
- Participant specific training;
- Face-to-face meetings and time spent facilitating choice and coordination of services and providers;
- Advocacy and referrals;
- Crisis intervention and management;
- Monthly responsibilities and required reporting; and
- Meetings with the back-up case manager.

These services cannot be performed by anyone but the case manager or the designated back-up case manager, if necessary. They cannot be provided by other employees of a case management agency. All services must be accurately documented before the case manager can bill for services. Service documentation must be submitted within 60 calendar days of the service being provided.

32

Non-Billable Activities

- Ancillary activities;
- Time spent with the participant or legally authorized representative for social reasons;
- Continuing education; and
- Travel time.

There are tasks that the case manager will complete that cannot be counted as billable time.

- Ancillary activities, such as mailing, copying, filing, faxing, or supervisory or administrative activities. The administrative costs of these activities, and other normal and customary business overhead costs, are already considered in the reimbursement rate for case management services.
- Social time spent with the participant or legally authorized representative, unless billable case management activities are also occurring. Incidental contact and social exchanges are part of conducting and building a business and offering customer service, and are not considered a case management service. This might include a case manager watching a participant in a school play, or attending a picnic or party hosted by the participant.
- Time spent acquiring continuing education units, including support calls offered by the Division.
- Travel time, which has already been included as part of the rate for case management services. Even if you have to travel longer distances...perhaps 50 miles...to see a participant, this time cannot be billed as part of case management services.

33

Monthly Unit Requirements

- Bill must be submitted on or after the last day of the month, and only if documentation is complete and uploaded in EMWS.
- A minimum of two hours of billable services must be documented.
- A monthly home visit must be conducted.
- At least one hour of person to person contact must be completed.

In order for a case manager to bill a monthly unit, they must complete a minimum of 2 hours of billable activities during the month, with at least one of these hours of service being used for person to person contact with the participant or legally authorized representative. Person to person contact can occur via telephone or video conferencing, and may occur over several shorter time frames (i.e., four 15-minute visits). Although only 2 hours of billable services are required, the case manager should still document ***all*** services provided during the month.

Billable activities must include a visit to the participant's residence, with the participant present, in order to monitor the participant's health and welfare, ascertain the participant's satisfaction with services, and discuss needed changes to the participant's IPC.

If the case manager bills a monthly unit, the bill must be submitted on or after the last day of the month during which the services were provided. A bill must not be submitted until all documentation that supports that claim is complete and uploaded in EMWS.

15-Minute Unit Requirements

- At least one unit must be provided each month.
- Units must be based on needs of the participant, not to exceed 224 units annually.
- A quarterly home visit must be conducted - monthly if the participant receives Community Living Services.

The 15-minute unit rate is based on the same methodology as the monthly unit. The number of 15-minute units on an IPC cannot exceed 224 units, which calculates to an average of 4.5 hours per month. The units should be used based on the needs of the participant or legally authorized representative. At least one unit of case management must be provided each month in order to discuss participant satisfaction and address any needs or concerns the participant may have.

A monthly visit to the participant's place of residence, with the participant present, is required if a participant receives community living services. A quarterly visit is required if a participant does not receive community living services. Case managers may complete additional visits to the participant's place of residence during times of crisis, or when requested by the participant or legally authorized representative.

35

Transitions

The case manager shall coordinate transition plans when the participant chooses to change, stop, or add providers to his or her IPC.

Chapter 45, Section 9(e)(iii)(B)

Participants or legally authorized representatives may choose to change providers at any time for any reason. Case managers are responsible for coordinating any transition that may be necessary for a participant's services.

Although the Division understands that there may be hard feelings involved when a participant selects a new provider, it is the expectation of the Division that all parties participate in the transition meeting and behave in a professional manner during the transition period.

36

Case Manager Transitions

- Must provide at least thirty (30) calendar days written notice.
- Must continue to provide services for 30 calendar days or until a new case manager is approved.
- Must collaborate with new case manager to ensure the transition of services is seamless for the participant.

Participants may elect to change their case manager, or a case manager may elect to end services with the participant. In either case, the case manager is responsible for ensuring that the transition from one case manager to another is as seamless as possible.

If the case manager chooses to discontinue providing services, the case manager must provide written notice of this decision to the participant, legally authorized representative, and Division at least 30 calendar days before the services are set to end. The case manager must continue to provide services for that 30 days. If it takes more than 30 days for the participant to secure a new case manager, the back-up case manager must provide the service until the participant selects a new case manager and they are added to the participant's plan. In most cases, it is best if the transition from one case manager to another occurs on the 1st of the month.

The current case manager must work together with the new case manager during the transition. The case manager is required to schedule and hold a transition meeting when a participant changes a case manager or provider. The exchange of information that occurs during this transition meeting is necessary in order for all team members and the new provider or case manager to have the information needed to deliver services to participants without an interruption. The case manager will need to complete a transition checklist for all transitions, and upload the completed form into the Document Library of EMWS at the time the new IPC is submitted. The transition checklist can be found on the Forms and Document Library page of the Division's website, under the Forms tab.

37

The Division may establish caseload limits to ensure the case manager effectively coordinates services with all participants on his or her caseload

Chapter 45, Section 9(g)

The DD Waivers do not have system wide limits on the number of participants a case manager may serve. However, the Division reserves the right to establish caseload limits in order to ensure that case managers are able to effectively coordinate services for all of the people they serve. Caseload limits may be imposed on a system wide level, or on a case by case basis. If a case manager demonstrates chronic non-compliance with Department of Health Medicaid Rules, the Division may impose a caseload limit on that case manager.

38

1. Case management services are mandatory, and key to ensuring participants receive quality services.
2. The case manager is the team facilitator, and responsible for ensuring the participant has an IPC that is developed through person-centered planning.
3. The case manager has responsibilities spanning eligibility, advocacy and choice, budgeting, and plan development.
4. The case manager is responsible for monitoring IPC implementation and utilization, and reporting provider noncompliance.

Before you complete this training, we'd like to review some of the key takeaways:

1. Case management services are mandatory. The case manager is the key to effectively delivering waiver services, and plays a critical role in ensuring that the participant receives quality services.
2. The case manager is the team facilitator, and is responsible for leading the team through a person-centered planning process that results in an IPC that comprehensively addresses the supports, activities, and skill development that the participant will need to live a full and meaningful life.
3. The case manager has a number of responsibilities. These responsibilities start as the case manager supports an applicant through the eligibility process, and continue on with advocating and offering choice, developing and modifying the plan of care, and ensuring the services fit within the participant's budget, just to name a few.
4. The case manager is responsible for monitoring the provider's implementation of the IPC to ensure that services are being delivered in a manner that facilitates participant choice, addresses participant specific needs, and is in alignment with what is outlined in the participant's IPC. The case manager is also responsible for monitoring service utilization to ensure that the participant does not run out of units for needed services. Provider noncompliance must be reported to the Division.

Thank you for participating in the training on case management services. If you have questions related to the information in this training, please contact your Provider Support or Benefits and Eligibility Specialist. Contact information can be found by clicking on the link provided in the slide.

Don't read this section as part of the live presentation
Please be sure to complete a summary of this training so that you can demonstrate that you received training on the rights of participants receiving services.