

Case Manager Support Call

The Eligibility Process and Case Manager Responsibilities

Wyoming Department of Health
Division of Healthcare Financing
Home and Community Based Services Section

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Good Afternoon. My name is Dennis Yost and I am a Benefits and Eligibility Specialist for the Home and Community-Based Services Section of the Division of Healthcare Financing (Division). Today we will be discussing the eligibility process for the Comprehensive and Supports Waivers (DD Waivers) and the case manager's role in that process.



The purpose of this training is to discuss the eligibility criteria and eligibility process for participants on the DD Waivers.

This training will also explain the case manager's role in supporting participants through this process.

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Training Agenda

- Discuss the eligibility criteria for participants on the DD Waivers.
- Explain the eligibility process and the case manager's role in that process.
- Review eligibility determination options.

At the end of this training, the following topics will have been introduced and explained:

- We will discuss the eligibility criteria for participants on the DD Waivers and where the criteria can be found in Department of Health Medicaid Rules.
- We will explain the eligibility process, and the case manager's responsibilities in supporting the participant through this process. The process includes the sequential steps and timelines that are necessary to determine level of care, financial eligibility, and clinical eligibility.
- Finally, we will outline eligibility determination, and the role the case manager plays when an individual is determined eligible and placed on the waitlist, or determined ineligible.



Throughout the eligibility process, while the individual is on the waitlist, and when they receive services, case managers have an obligation to offer each individual choice, document the choices that the individual makes, and ensure that the individual's choice is respected.

Choice is a basic tenet of home and community-based waiver services. Waiver participants must have the freedom to exercise choice in who provides their services, where they live, with whom they spend time, and what they want for their future. Having choice is paramount to human dignity.

Even before receiving home and community-based services, individuals have choice regarding these programs. First and foremost, individuals can choose between institutional services and services that are provided in their home or community. If they choose waiver services, they immediately have choice in who their case manager will be. Once they are determined eligible and have received funding, they have ultimate choice in the services they receive, who provides those services, and how their services will be delivered.

Throughout the eligibility process, while the individual is on the waitlist, and when they receive services, case managers have an obligation to offer each individual choice, document the choices that the individual makes, and ensure that the individual's choice is respected.

Authorities and Resources That Support Division Expectations

■ Chapter 46

- Section 4 - eligibility requirements
- Section 6 - institutional level of care
- Section 7 - clinical eligibility criteria
- Section 8 - ICAP criteria

■ DD Waiver agreements

■ Application Guide for the Supports Waiver

■ IPC Guide



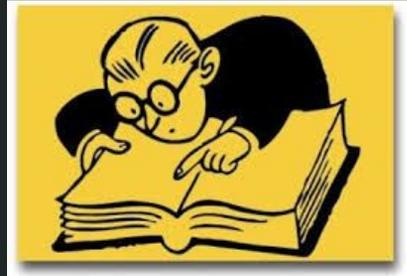
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Chapter 46 of the Department of Health’s Medicaid Rules provide authority for the Division’s participant eligibility process. Section 4 establishes the overall eligibility requirements for DD Waiver participants. Sections 6, 7, and 8 go into further detail on the specific criteria for institutional level of care, clinical eligibility criteria, and the Inventory for Client and Agency Planning assessment, or ICAP. These requirements are mirrored in the DD Waiver agreements, which are approved by the Centers for Medicare and Medicaid Services (CMS).

Additionally, the Division offers applicant and case manager resources that explain the eligibility process. The Application Guide for the Supports Waiver is located on the [DD Participant Services and Eligibility](#) page of the Division website. This document walks the applicant through the eligibility process, provides pages for the participant to document important numbers and information, and gives a detailed description of their rights and responsibilities, as well as the responsibilities of the case manager and service providers.

The IPC Guide can be found on the [DD Providers and Case Managers](#) page of the Division website, under the *Reference Materials* toggle. The IPC Guide is intended to provide instructions and references on the forms, documents, and processes necessary to meet the Individualized Plan of Care (IPC) review requirements, but includes specific information on the eligibility process and the case manager’s obligations related to opening the case and documenting the eligibility process.

Eligibility Criteria



The eligibility criteria for the Supports and Comprehensive Waiver are similar, but there are a couple of distinct differences. Applicants who are determined eligible are placed on a waitlist and ultimately offered funding on the Supports Waiver. However, individuals who meet very specific criteria may qualify for Comprehensive Waiver services

Supports Waiver Eligibility Criteria

- Meets citizenship, residency, and financial eligibility requirements
- Qualifies for relevant institutional level of care
- Meets clinical eligibility requirements

In order for an applicant to be eligible for the Supports Waiver, they must meet citizenship, residency, and financial eligibility requirements that are established in Chapter 18 of Wyoming Medicaid Rules. Case managers should be aware of these requirements and be able to discuss them with individuals who contact them to discuss DD Waiver services.

Applicants must also qualify for the relevant institutional level of care, which is assessed by the LT101 or LT104. These assessments will be described in greater detail later.

Finally, applicants must meet clinical eligibility, which is determined through a psychological or neuropsychological evaluation.

Comprehensive Waiver Eligibility Criteria

- Meets initial Supports Waiver eligibility **AND**
- Has assessed needs that exceed the established limit on the Supports Waiver **AND**
- Meets emergency criteria or criteria for reserved capacity

In order for an applicant to qualify for the Comprehensive Waiver, they must meet the eligibility criteria established for the Supports Waiver. *Additionally*, they must have assessed needs that exceed the capitated budget amount for the Supports Waiver. Finally, they must meet one of the emergency criteria that is established in Chapter 46, Section 14 or meet the criteria for reserved capacity, which is limited to individuals who are transitioning from a Wyoming institution into the community.

Case managers should be well versed in Chapter 46, Section 14, which covers emergency services, and submit a request to the Extraordinary Care Committee for Comprehensive Waiver Services **only** if the applicant meets the criteria established in Section 14.

The Eligibility Process



The eligibility process can be daunting for a participant or legally authorized representative who is new to waiver services. The case manager is responsible for helping the participant through the process. Remember, the case manager is the professional, and should have the knowledge and expertise to support the participant, answer questions, and provide guidance as necessary.

It is important to note that the eligibility process is sequential and the steps must be followed in order. If steps of the process are missed, or if an applicant is determined to be ineligible at any point in the process, the process will end.

As a reminder, in accordance with Chapter 45, Section 9(b) of the Department of Health's Medicaid Rules, case managers must submit all eligibility paperwork within 30 calendar days of being selected as the case manager.

Individual Applies for the Waiver

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Before an applicant can be determined eligible for waiver services, they must first complete an application.

Waiver Application

- Applicant should contact the Benefits and Eligibility Specialist (BES) with questions.
 - Applicant may contact case manager.



The information on the Division's DD Participant Services and Eligibility webpage directs interested parties and applicants to contact the Benefits and Eligibility Specialist, or BES, if they have questions or concerns, or need help with the initial application process. However, case managers may also get calls asking for help. Case managers should be prepared to answer questions and provide the Supports Waiver Application Guide upon request. Case managers should refer interested parties and applicants to the area BES for questions related to subjects other than the application process.

Case Management Selection Form

- Applicant chooses a case manager
- Applicant and case manager sign the Case Management Selection Form
- Case manager requests guardianship paperwork
- Case manager notifies the participant that, if determined eligible, they will be placed on the waitlist

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Applicants for the waiver must choose a case manager. Applicants are encouraged to take the time to interview case managers and ask questions about the case manager's caseload, experience, and communication strategies. Case managers should make themselves available to meet with applicants if they are accepting new participants to their caseload.

Once the applicant chooses a case manager, the applicant must complete a Case Management Selection Form and both the applicant and the case manager must sign and date the form. If the applicant has a legally authorized representative, the case manager should request a copy of the guardianship order at this time to ensure that the individual has the authority to act as the legally authorized representative. This document will be required, so it makes sense to obtain it early in the process.

The Division currently maintains a waitlist for the Supports Waiver, which means that even though an applicant may ultimately be determined eligible for DD Waiver services, they will have to wait for a funding opportunity to become available. Case managers should be up front with applicants about this situation.

Submitting the Application



The case manager is responsible for submitting the participant's complete application and Case Management Selection Form.

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The case manager is responsible for submitting the participant's application for services and the Case Management Selection Form to the Division. Applications may be submitted to the area BES in a variety of ways, including mail, email, and fax. Before the case manager submits the forms, they should review the forms to ensure that the applicant has completed all sections of the form and signed as indicated. An incomplete form will cause a lag in the process. It is the case manager's responsibility to ensure that the applicant is able to navigate the process as smoothly as possible, and reviewing forms for accuracy is a simple step the case manager can take to support this outcome.

Best Practice!



Case managers should ensure their contact information is updated with the Division at all times. If not accepting new participants, case managers should notify the Division immediately via the credentialing email address at wdh-hcbs-credentialing@wyo.gov.

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Participants often use the searchable provider list to find case managers in their area. The Division has often heard that applicants get frustrated when they try to contact a case manager, only to find that the contact information is incorrect, or the case manager isn't accepting new participants. Case managers should ensure their contact information, such as their phone and email address, are updated with the Division at all times. They can request changes to this information by submitting a Name and Address Change Form to the provider credentialing email address at wdh-hcbs-credentialing@wyo.gov. If the case manager isn't accepting new participants, they should notify the Division immediately via the credentialing email address so they can be removed from the searchable provider list.

Targeted Case Management

- Case managers can be paid before the participant has waiver funding.
- A targeted case management (TCM) case must be established if an applicant is not a current Medicaid recipient.
- Case managers must help applicants connect with non-waiver services during the eligibility process.

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Once a case manager is selected, they can be paid for the support they provide to the applicant throughout the eligibility process, and for ongoing support once an applicant is placed on the waitlist. Targeted case management, or TCM is a Medicaid State Plan service. Additional information on TCM can be found in the Comprehensive and Supports Waiver Service Index, under the Case Management Services definition.

Some case managers don't bill for TCM, and that is certainly their choice. However, even if a case manager chooses not to bill for the TCM service, they are still required to provide support and assistance to the participant throughout the eligibility process and while the participant is on the waitlist. A TCM case must be established if the applicant is not a current Medicaid recipient in order for required psychological assessments to be paid.

It is important for case managers to understand their obligations in supporting applicants during the eligibility process and once they are placed on the waitlist. This obligation includes linking people with non-waiver supports and services, conducting regular monitoring and follow-up, and providing crisis intervention and stabilization in situations requiring immediate attention or resolution.

To open a TCM case, open the Targeted Case Management screen in the Electronic Medicaid Waiver System (EMWS), which can be found under Waiver Links. The start date for a TCM case will be the first day of the month in which the case manager was selected.

Level of Care Assessment

A critical federal requirement of home and community-based waiver programs is that participants of these programs must meet the same level of care as someone who needs institutional care, such as a skilled nursing facility or an intermediate care facility like the Wyoming Life Resource Center. Requirements for institutional level of care are established in Chapter 46, Section 6.

In order to demonstrate institutional level of care, applicants and participants with a developmental or intellectual disability are assessed using the LT104 assessment and applicants and participants with an acquired brain injury are assessed using the LT101 assessment.

For initial applicants, institutional level of care must be established before the next step in the eligibility process can occur. For current waiver participants, institutional level of care must be established annually.

LT104 Assessment

- The LT104 assessment must be completed for individuals with an intellectual or developmental disability.
- Case managers must submit the initial LT104 within thirty (30) calendar days of being selected and annually thereafter once the participant is receiving services.
- The LT104 form will be reviewed by the Division.

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If the applicant has a diagnosis of an intellectual or developmental disability, the case manager must complete and submit the LT104 assessment through EMWS within thirty (30) calendar days of being selected, and annually thereafter. Once the LT104 form is submitted in EMWS, a BES will review the assessment to determine if the participant meets the prescreening criteria for the waiver. For initial applicants, this assessment demonstrates presumed eligibility. When the case manager and plan of care team develop the IPC, the IPC must support the responses submitted in the LT104. In subsequent LT104 submissions, the case manager must be sure that their responses are supported by information included in the participant's IPC.

LT101 Assessment

- The LT101 assessment must be completed for an applicant with an acquired brain injury.
- For applicants, the LT101 must be completed by the Public Health Nurse within seven (7) calendar days of the participant being determined financially eligible.

If an applicant has a diagnosis of an acquired brain injury, a public health nurse (PHN) will administer an LT101 assessment. Case managers should remind the participant that a PHN will be contacting them to complete an assessment so the participant isn't surprised or confused when they are contacted.

For applicants, the case manager must ensure that the PHN has contacted the applicant and completed the LT101 form within 7 calendar days after the PHN has received the referral, which takes place after financial eligibility has been determined.

Reassessment is required every year once the participant is receiving services. The PHN has thirty calendar days to complete the reassessment once they receive notification that the reassessment is required.

Financial Eligibility

Financial eligibility is determined by the Long Term Care (LTC) Eligibility Unit as part of the initial eligibility process, and annually thereafter. Although this step in the process is not handled by the Division, the case manager still plays an important role in ensuring that the participant submits the required paperwork within the established timelines.

Financial Eligibility



- Once selected, case managers should support the applicant in submitting required financial eligibility paperwork to the LTC Eligibility Unit.
- Applicants have 30 calendar days after the financial task populates in EMWS to submit financial eligibility paperwork.

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Case managers are responsible for supporting the applicant or participant in completing financial eligibility paperwork and gathering necessary supporting documentation and verifications. Although the case manager may not actually collect documentation or complete the application, the case manager should be available to answer questions and troubleshoot any areas of confusion or concern. When requested, the case manager should help the participant to submit the required financial eligibility paperwork to the LTC Eligibility Unit.

The financial task in EMWS populates in a different order for applicants who are assessed with the LT101 and LT104. For applicants who are assessed with the LT104, the financial task will populate after the LT104 is completed. For applicants who are assessed with the LT101, the financial task populates after the case manager is selected. The applicant has 30 calendar days after the financial task populates to complete and submit their paperwork, or the LTC Eligibility Unit will initiate closure of the case. The case manager must ensure that the applicant is aware of the timeline.

Subsequent determination of financial eligibility will occur annually.



Best Practice!

Case managers should contact the Long Term Care Eligibility Unit to ensure a financial eligibility packet is sent to the applicant or participant.

During the initial eligibility process, applicants have a lot of information coming at them from all directions. Case managers should ensure that the applicant has contacted the LTC Eligibility Unit to request their financial eligibility packet. Once a participant is receiving waiver services, case managers should receive notification in EMWS that the participant is due for redetermination of financial eligibility. Case managers should remind the participant or legally authorized representative of the importance of completing and submitting financial paperwork, and provide support when needed. If the applicant or participant hasn't received a financial eligibility packet, or isn't sure if they have, case managers should contact the LTC Eligibility Unit to ensure a packet has been sent.

Clinical Eligibility

In order for an applicant to be determined eligible for waiver services, they must meet specific clinical criteria. Requirements for clinical eligibility are established in Chapter 46, Section 7. The applicant cannot pursue clinical eligibility determination until they have been determined financially eligible for waiver services.

Clinical Eligibility Criteria

- The psychological evaluation or neuropsychological evaluation must demonstrate that one (1) of the diagnoses are met:
 - An intellectual disability;
 - A developmental disability or a related condition;
or
 - An acquired brain injury (ABI).

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In order to be determined clinically eligible for waiver services, an applicant must have a diagnosis of an intellectual disability, a developmental disability, or an acquired brain injury (ABI). A psychological evaluation will be used to demonstrate the developmental or intellectual disability diagnosis. A neuropsychological evaluation will be used to demonstrate an ABI diagnosis, which must meet the definition of an ABI established in Chapter 1 of the Department of Health's Medicaid Rules.

Case Manager Responsibilities

- Schedule psychological and neuropsychological evaluation with Medicaid enrolled clinicians who are conflict-free.
- Submit signed evaluations to the Division.
- Schedule subsequent psychological and neuropsychological evaluations as required.

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Case managers are responsible for scheduling the appropriate clinical evaluation based on the participant's diagnosis. Case managers must ensure that the evaluation is scheduled with a Medicaid enrolled psychiatrist, neurologist, or clinical psychologist who is licensed in Wyoming and free of conflicts with other providers chosen by the participant. Additionally, case managers should remind the clinician that all required assessment scores must be included in the evaluation. Required scores are outlined in guidance documents that provide more information on the specific criteria that the evaluations must demonstrate. These documents are available on the [DD Providers and Case Managers](#) page of the Division website, under the *DD Case Manager and Provider Reference Materials* toggle.

Once the evaluation is complete, the case manager must upload the evaluation report into EMWS. The case manager must ensure that the report is signed and contains the required information that is outlined in the guidance documents provided by the Division.

Psychological evaluations do not need to be repeated unless there is a significant change in the participant's condition or the Division requests an update to the evaluation. A subsequent psychological evaluation must be approved by the Division before it is scheduled. A neuropsychological evaluation is required every five years and must also be approved by the Division before it is scheduled.

The Division may request another psychological or neuropsychological evaluation at any time.

Billing for Psych Services

- The case manager uploads the assessment report and the invoice.
- The BES creates the billing span.
- The case manager notifies the clinician of the date they can bill, using billing code T2024.

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Once a case manager uploads the signed psychological or neuropsychological evaluation into EMWS, the system will prompt the case manager to upload the invoice for the assessment. Once the invoice is uploaded, the BES will create a billing span for the clinician to use, and send a task back to the case manager via EMWS. When the case manager receives the task that includes the billing span, the case manager must notify the clinician that they may now bill for the evaluation, using the date of the evaluation and the the T2024 billing code.

If the case manager doesn't notify the clinician that the billing date has been created, the clinician will not know that they are cleared to bill for the assessment.

Inventory for Client and Agency Planning (ICAP)

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The Inventory for Client and Agency Planning (ICAP) is a nationally standardized assessment tool that estimates an individual's adaptive functioning and the extent to which behavior challenges may limit their inclusion in various settings. ICAP scores are used by the Division to determine eligibility and funding for Comprehensive Waiver services. The Division contracts with the University of Wyoming Institute for Disabilities (WIND) to conduct ICAP interviews for initial, emergency, and continuing eligibility. The ICAP is the final step in the eligibility process. The assessment must be completed every five years, or more frequently at the option of the Division. ICAP requirements are established in Chapter 46, Section 8.

ICAP

- The case manager will complete the ICAP Authorization form, including signature and date.
- Respondents can be chosen by the legally authorized representative, applicant or participant, and the case manager.
- Case managers may be respondents **only** as a last resort and as approved by the Division.

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The case manager must complete the ICAP Authorization and Information form, which includes the identification of at least two respondents who have had contact with the applicant or participant during the past three (3) months and who know their support needs. Respondents should reflect as many environments as possible.

Respondents can be chosen by the legally authorized representative, applicant or participant, and the case manager. Parents and legally authorized representatives can be respondents, but case managers may be respondents **only** as a last resort and as approved by the Division.

The form must be signed and dated by the case manager and the applicant or participant, or their legally authorized representative. The case manager must upload the form in EMWS, at which point WIND will be notified that an ICAP assessment needs to be conducted.

Eligibility Determination



Once the eligibility process is completed, the Division will make a final determination on the participant's eligibility for waiver services.

Eligibility Determination

- Applicant may be determined ineligible
 - Case manager may assist the applicant to request a reconsideration or fair hearing
- Applicant may be determined eligible
 - Applicant will receive a letter notifying them that they have been placed on the waiting list

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If an applicant does not meet eligibility criteria outlined in Chapter 46, Section 4, they may be determined ineligible. If an applicant is determined to be clinically or financially ineligible for Supports Waiver services, they will receive a denial of eligibility letter from the Division. If the applicant disagrees with the decision, they may request a reconsideration. Although the case manager can support the applicant in writing a request for reconsideration, the request must come from the applicant. A request for reconsideration must include documentation that supports at least one (1) of the following conditions:

- Information presented was misrepresented;
- Information was not represented to the fullest extent needed;
- There was a misapplication of standards or policy; or
- The criteria was misunderstood.

A request for reconsideration must be submitted within thirty (30) calendar days of the date of the applicant's denial letter. An applicant may also request a fair hearing. Information on how to request a fair hearing will be included in the participant's denial letter.

As established in Chapter 46, Section 5 a **participant** may be determined ineligible if they do not continue to meet clinical or financial eligibility, or if they move to a different state. If an applicant or participant is determined ineligible, the Division will notify them of their right to an administrative hearing. The case manager is responsible for answering questions related to the reconsideration and administrative hearing

process, and must submit the participant's request within thirty calendar days of the notification of ineligibility.

If an applicant is determined eligible, they will receive notification that they have been placed on the waitlist. Being placed on the waitlist means that the applicant is eligible, but they need to wait until there is funding available to begin receiving services.

Individuals on the Waitlist



- Case managers continue to assist individuals in the following ways:
 - Obtaining other non-waiver resources ;
 - Checking on the individual;
 - Providing crisis intervention and stabilization;
and
 - Updating contact information in EMWS.

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An individual who is placed on the waitlist may be waiting for services for several years. Case managers must continue to assist and support them by helping them access non-waiver resources, such as services through the Division of Vocational Rehabilitation and local service organizations. Case managers must check in on the individual on a regular basis to ensure they are still interested in waiver services. Case managers must be able to provide crisis intervention and stabilization should a situation requiring immediate attention or resolution arise. Remember, the case manager can bill TCM for services provided while the individual is on the waitlist.

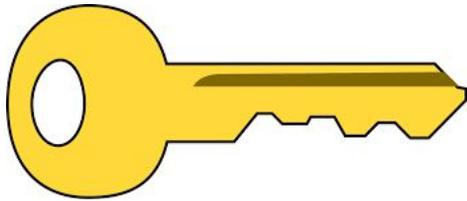
As established in Chapter 45, Section 9(d) of the Department of Health's Medicaid Rules, case managers must keep each individual's contact information accurate and updated in EMWS, even if they are on the waitlist. The Division uses the contact information in EMWS to send important communications to individuals.

Once Funding is Available



- Case managers help participants re-establish eligibility, if necessary.
- Case managers assist the participant's plan of care team to develop the IPC based on the participant's individual budget amount (IBA).

Once funding is available, the participant will receive a letter from the Division that includes their individual budget amount (IBA) and the date they will be able to begin services. Before services can begin, the participant may need to reestablish financial or clinical eligibility, and the case manager or PHN may need to re-administer the appropriate LT assessment. Once continued eligibility has been established, the case manager is expected to work with the participant and plan of care team to develop the IPC. This may include locating and interviewing potential providers, or discussing the participant's rights and responsibilities related to participant-directed services.



TAKEAWAYS

1. Case managers must know the rules that govern eligibility criteria and the eligibility process.
2. Case managers must know and follow the eligibility process.
3. All eligibility steps must be completed sequentially.
4. Case managers must provide ongoing support for individuals on the waitlist.
5. Case managers are responsible for assisting participants with continued eligibility.

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Before we end today, we'd like to remind case managers of the key takeaways of today's training.

1. Chapter 46, Sections 4 - 8 of the Department of Health's Medicaid Rules establish eligibility criteria and the eligibility process. Case managers are expected to know and follow these rules.
2. Case managers must know and follow the eligibility process. The Application Guide for the Supports Waiver is a good resource that is available to case managers.
3. All steps in the eligibility process must be completed sequentially. Failure to follow the steps may result in an applicant's eligibility determination being delayed.
4. Once eligibility is determined and an individual is placed on the waitlist, case managers have an ongoing responsibility to support individuals as needed.
5. Once a participant is receiving waiver services, case managers are responsible for supporting participants through the eligibility process so they can maintain continued eligibility.

Questions???

Contact your Provider Support or Benefits and Eligibility Specialist

<https://health.wyo.gov/healthcarefin/hcbs/contacts-and-important-links/>

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Thank you for taking time to participate in today's training on the eligibility process. 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.