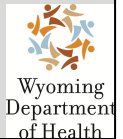


# Case Manager Support Call

## **Waiver Cost Limits and Individual Budget Amounts, Prohibited Uses of Waiver Funds, Denial of Funding for Waiver Services**

Wyoming Department of Health  
Division of Healthcare Financing  
Home and Community Based Services Section  
July 12, 2021



Good Afternoon. My name is Jessica Abbott, and I am a Benefits and Eligibility Unit Assistant Manager for the Home and Community-Based Services Section of the Division of Healthcare Financing (Division). Today we will be discussing waiver service requirements and restrictions.



The purpose of this training is to explain the determination and calculation of a participant's individual budget amount, and review situations in which waiver services will be prohibited or denied.

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# Training Agenda

- The purpose of the individual budget amount (IBA) and how it is calculated
- Prohibited uses of waiver funds
- Situations in which participants will be denied waiver funding

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

- We will review individual budget amount (IBA), its purpose, and how it is calculated for participants of the Supports and Comprehensive Waivers.
- We will outline situations in which waiver funding cannot be used.
- Finally, we will discuss situations in which participants will be denied waiver funding.



Case managers must ensure that the participant can spend their IBA to get the services and supports they need.

Choice is a basic tenet of home and community-based waiver services. Participants must have the freedom to choose the services they receive and 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.

As we discuss participant IBAs, it is important to remember that the participant has choice in how their IBA is spent, as long as the services they choose align with the service index and program regulations. A key component of person-centered planning is ensuring that a participant's services are selected based on their wants and needs. Plan of care teams should never make an assumption that specific services should be included on a participant's plan, or that the participant's IBA should be spent a certain way. Case managers should explain the different services that are available, and make sure that the participant understands that they can have multiple services and providers on their IPC. The participant's wants and needs should always be considered first.

# Authorities and Resources That Support Division Expectations

- Chapter 46 - Medicaid Supports and Comprehensive Waivers
- Supports and Comprehensive Waiver agreements
  - Appendix J - Cost Neutrality



Chapter 46, Section 11 of the Department of Health’s Medicaid Rules establishes rules related to waiver cost limits and IBAs, while Sections 16 and 17 address prohibited uses of waiver funding and situations in which funding for waiver services may be denied.

In the waiver application that is approved by the Centers for Medicare and Medicaid Services (CMS) and each year during the period that the waiver is in operation, the state must demonstrate that the waiver is cost neutral. This means that the state must demonstrate that the average per participant expenditures for waiver and non-waiver Medicaid services cost less than the average per person expenditures of institutional and other Medicaid State Plan services for individuals who require the same level of care. This cost neutrality demonstration is outlined in the agreements for the Comprehensive and Supports Waivers.

# Cost Neutrality

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	57387.49	5429.00	62816.49	226860.00	37571.00	264431.00	201614.51
2	59447.55	5565.00	65012.55	232557.00	38500.00	271057.00	206044.45
3	57341.14	5704.00	63045.14	238397.00	39453.00	277850.00	214804.86
4	58367.32	5846.00	64213.32	244385.00	40430.00	284815.00	220601.68
5	59497.93	5993.00	65490.93	250523.00	41432.00	291955.00	226464.07

Total average waiver costs

Total average institutional costs

The image in the slide shows the current average waiver cost for the Comprehensive Waiver compared to Wyoming’s institutional costs. Factor D (Column 2) shows the average waiver services cost that has been calculated for waiver year 2, which started on April 1, 2021. Factor D prime (D’), which is found in column 3 is the projected cost of non-waiver Medicaid medical services. The projected average of the per participant cost for waiver year 2 is \$65,012.55 (Column 4). The total projected cost for institutional care (Factor G, column 5) and additional Medicaid costs for people who reside in institutions (Factor G’, Column 6) totals \$271,057 which is noted in Column 7. The difference of \$206,044.45 shows that waiver services are, on average, less expensive than institutional services.

In addition to the cost neutrality demonstration, the State has an individual cost limit of \$264,430 for the Comprehensive Waiver, which is based on a weighted average of the cost of the Wyoming Life Resource Center and state funded nursing homes. This cap will be discussed again a little later in the training

# Individual Budget Amount



So, what is an individual budget amount, or IBA? The IBA is the budget that the participant has to purchase services. The IBA will vary from participant to participant, depending on the waiver from which the participant receives funding, and the participant's assessed needs. Section 11 establishes that funds available to participants shall be based on the participant's assessed needs and the approved IBA methodology.

## Supports Waiver IBA Determination

Participants enrolled on the Supports Waiver shall be assigned a designated budget amount outlined in the most current Supports Waiver application.

- Children - \$18,457
- Adults - \$21,444

Participants who are enrolled on the Supports Waiver are assigned a designated budget amount, based on what is outlined in the current Supports Waiver agreement. Children currently receive \$18,457, while adults receive \$21,444. The IBA assigned to children accounts for services that are provided through the Department of Education, the Individuals with Disabilities Education Act (IDEA), or other entities required to provide services to children with disabilities. Since other entities are required to fund children's services, the child's IBA is lower.



# Comprehensive Waiver IBA Determination

Participants enrolled on the Comprehensive Waiver shall be assigned a Level of Service score and an individual budget amount based on the following:

- ICAP assessment scores;
- The participant's age group and living situation;
- Medical or behavioral conditions; and
- Temporary IBA changes determined by the ECC.

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Participants enrolled on the Comprehensive Waiver are assigned an IBA, based on several factors. First, they are assigned a Level of Service score, which is based on their Inventory for Client and Agency Planning (ICAP) assessment scores. This Level of Service score translates to an IBA, based on the participant's age and living situation. Once the base IBA is determined, add-ons are included for behavioral or medical conditions that were not captured through other functional or medical assessments. Finally, temporary IBA increases or decreases approved by the Extraordinary Care Committee (ECC) are applied.

Chapter 46, Section 11 states that a participant's IBA on the Comprehensive Waiver shall not exceed the institutional cost limit specified by the most current Comprehensive Waiver application approved by CMS. This means that, while on average the waivers cannot be more expensive than institutions, there is also an overall cap for the IBA that any one participant can receive. As mentioned earlier, the cap for the Comprehensive Waiver is \$264,430.

# Medical or Behavioral Conditions

- Flags may be applied as a result of an ECC request.
- Conditions are flagged in EMWS, which increases the IBA.
- Flags may be temporary or permanent.

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If a plan of care team agrees that there is a situation in the participant's life that meets the standards to submit an ECC request, the case manager must gather necessary medical and behavioral documentation that will support the request. If the ECC determines that the participant's situation has been adequately demonstrated, then they may approve an increase in the IBA. The Division will mark the participant's IBA with a medical or behavioral flag in the Electronic Medicaid Waiver System (EMWS), which will increase the participant's Level of Service score. The participant's IBA will then be adjusted accordingly.

This increase may be temporary or permanent. For example, if the participant is demonstrating challenging behaviors, there is an understanding that the situation will stabilize with appropriate treatment. In this case, the increase in the IBA would be temporary, typically no longer than 12 months. At the end of the 12 months, the participant's team will let the temporary increase expire, or will need to return to the ECC with an additional request.

A permanent increase may also be approved. As an example, if the participant has a chronic health condition that will be ongoing for their lifetime, this may warrant a permanent IBA increase to be applied.

# IBA Methodology and Matrix

IBA Amounts as of 2/1/21			
Living Situation	Age	LOS 1	LOS 1.1
Living with family	Age 0-21	\$17,860.58	\$18,005.33
Living with family	Age 21+	\$17,315.66	\$17,455.97
Living independently (CLS 1-2)	Age 18+	\$20,972.32	\$21,148.19
Living independently (CLS 1-2)	Age 21+	\$41,706.88	\$42,090.09
Living in a Group home or with roommates	Age 18+	\$33,492.99	\$33,794.06
Living in a Group home or with roommates	Age 21+	\$41,706.88	\$42,090.09

Living Situation	Age	LOS 2.1	LOS 2.2
Living with family	Age 0-21	\$22,879.00	\$23,072.00
Living with family	Age 21+	\$22,800.88	\$22,993.11
Living independently (CLS 1-2)	Age 18+	\$27,824.21	\$28,066.17
Living independently (CLS 1-2)	Age 21+	\$48,184.17	\$48,627.71
Living in a Group home or with roommates	Age 18+	\$37,814.14	\$38,155.02
Living in a Group home or with roommates	Age 21+	\$48,184.17	\$48,627.71

Living Situation	Age	LOS 3.1	LOS 3.2
Living with family	Age 0-21	\$27,752.68	\$27,993.93
Living with family	Age 21+	\$27,387.54	\$27,625.18
Living independently (CLS 1-2)	Age 18+	\$35,151.46	\$35,465.97
Living independently (CLS 1-2)	Age 21+	\$65,210.25	\$65,822.37
Living in a Group home or with roommates	Age 18+	\$49,485.60	\$49,942.04
Living in a Group home or with roommates	Age 21+	\$65,210.25	\$65,822.37

- Available for reference.
- Review before submitting ECC requests.

The methodology that is used to calculate a participant’s IBA for the Comprehensive Waiver, as well as the matrix that shows a participant’s IBA, based on the determining factors, is available on the [Public Notices, Regulatory Documents, and Reports](#) page of the Division website, under the Statistics and Reports section.

We know that many participants who have been receiving Comprehensive Waiver services for more than ten years have IBAs that are higher than the IBAs established by the methodology. The ECC will use the IBA matrix when considering funding requests, and if the matrix indicates that the participant should be receiving an IBA that is lower than what the participant currently receives, the participant may end up with a lower IBA as a result of an ECC request. Teams are strongly encouraged to review the IBA Matrix prior to submitting an ECC request.

# Aging Up

- Aging up occurs the month after participant's 21st birthday.
- The IBA is prorated based on number of months the participant receives services as a child.
- The IBA is level-set to align with the IBA Matrix.

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Children who receive services on the Comprehensive or Supports Waivers must have a new individualized plan of care (IPC) developed when they turn 21. This process, referred to as aging up, occurs the month after the participant turns 21. The IBA that is associated with the closing plan will be prorated for the number of months that the participant is receiving services as a child.

For example, Huey is receiving services on the Supports Waiver. His IPC started in January. He turns 21 on May 14th. Since he will be receiving services as a child for the months of January through May, his IBA will be revised to account for five months. For the ease of this example, Huey has an IBA of \$12,000. That number is divided by 12 to determine the monthly IBA, which calculates to \$1000. Huey is then allotted 5 months to cover January through May, which calculates to a \$5000 IBA. His adult IPC will begin on June 1st.

Children who receive services on the Comprehensive Waiver may have IBAs that don't align with their current level of need. This sometimes occurs when the child's ICAP assessment is older, and is based on a time when they needed more support as they were developing skills. When the child turns 21, their Level of Service score will be recalculated. If the participant's ICAP is close to five years old, the Division may request a new ICAP assessment. This recalculation may result in a decrease to their IBA.

The aging up process in EMWS starts 90 days prior to the participant turning 21 years old and includes the eligibility process of going from the child to the adult waiver.

# Prohibited Uses of Funding



There are many situations and circumstances that are not covered through Waiver services. Section 16 outlines prohibited uses of Waiver funding.

# Services Provided by a Legally Authorized Representative

Legally authorized representatives (LARs) cannot be paid for waiver services if:

- The participant is the LAR's spouse;
- The participant is over the age of 18; or
- The LAR is the owner or operator of an organization from which the participant is receiving services.

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Generally, legally authorized representatives are not allowed to receive payment for waiver services. Section 16 specifically states that services provided by the following will not be reimbursed:

- A spouse of the participant, if the spouse is also the participant's legally authorized representative;
- A legally authorized representative of a participant who is eighteen years of age or older; or
- Any owner or officer of a provider organization if the organization is serving a participant for whom they are the legally authorized representative.

This rule is further defined in Chapter 45, Section 31 of the Department of Health's Rules, which addresses relative providers. This section states that a participant's legally authorized representative shall not directly or indirectly receive reimbursement for providing waiver services for their ward, except as indicated in the Comprehensive and Supports Waiver Service Index. Direct or indirect reimbursement includes, but is not limited to, providing direct services for, or serving as the owner or officer of, a provider organization. Indirect reimbursement also includes payments made to a spouse of a legally authorized representative.

The Service Index allows a legally authorized representative to be paid for limited personal care services for children under the age of 18 if specific requirements are met. Case managers should be aware of the requirements outlined in the personal care service definition before adding a legally authorized representative to the a participant's IPC.

A spouse can be paid for some waiver services, but not if they are the participant's legally authorized representative. Under no circumstances shall a legally authorized representative be reimbursed for participant-directed services.

## Other Prohibited Uses of Funding

- Institutional care;
- Room and board;
- Services that exceed the institutional cost limit;
- Hours when a child is attending school or a vocational program; and
- Services covered by the Medicaid State Plan or other state agency.

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There are other services that are prohibited as well.

- Institutional services are not covered by the Waivers. Institutions include, but are not limited to, nursing facilities, intermediate care facilities for individuals with intellectual and developmental disabilities, such as the Wyoming Life Resource Center, and other institutional placements such as the Wyoming State Hospital, psychiatric residential treatment facilities, and Boards of Cooperative Educational Services (BOCES). Institutional care is all-inclusive, so even when a case manager is supporting an individual in transitioning out of an institution, they cannot bill waiver case management services for the work that they do. They must bill Targeted Case Management for these services.
- Room and board cannot be paid with waiver funding, unless it is part of a respite service that is provided in a facility and approved by Medicaid.
- As mentioned earlier, services that exceed the institutional cost limit cannot be reimbursed with waiver services.
- The Individuals with Disabilities Education Act (IDEA) was established to provide a free appropriate public education to children with disabilities. It is the responsibility of the Department of Education and local school district to provide school services for children and as such, waiver funding cannot be used to fund services that are delivered during hours when the child is attending school or is in a vocational program.
- Finally, Medicaid is the payer of last resort, meaning that if a similar service is available through another funding source, that funding source must be exhausted before Medicaid funding is available. For example, John is a participant who is interested in finding a job. Supported employment is a Waiver service, but the



Division of Vocational Rehabilitation (DVR) also offers services that John could use to find and learn a job. John must seek, exhaust, and provide proof that the DVR services are no longer available to him before he could receive waiver supported employment services.

# Denial of Waiver Funding



Section 17 establishes situations that may cause a participant or applicant of waiver services to be denied funding. The Division may deny or revoke authorization for waiver services for many reasons.

# Eligibility



- Participant fails to meet eligibility criteria.
- Participant fails to meet emergency criteria, and no other waiver funding opportunities are available.

Individuals must meet eligibility criteria in order to receive funding for waiver services. If a participant or applicant fails to meet financial, clinical, or residency requirements, they will be denied funding. The Division reserves capacity for individuals who are in an emergency situation, as defined by Chapter 46, Section 14. If an eligible individual does not meet the emergency criteria established in Section 14, they may be placed on a waiting list and denied immediate funding if a funding opportunity is not available.

## Participation and Cooperation

- Does not consent to waiver services.
- Chooses institutional care.
- Does not supply needed information.
- Fails to apply for and accept other state and federal benefits.
- Does not sign required documentation.
- Fails to cooperate or refuses services.

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Waiver services are voluntary, meaning that individuals are not entitled to services even if they meet eligibility requirements. Participation and cooperation are key to obtaining and retaining waiver services. Applicants, participants, or their legally authorized representative play a key role in the eligibility and planning processes. They must consent to services, supply necessary medical, behavioral, and financial information within the established timeframes, and sign required documents. If they fail to conduct these necessary tasks, they may be denied funding. As we mentioned earlier, institutional care cannot be paid through the waiver, so if a participant chooses institutional services, they will be denied waiver funding.

Participants must have their rights respected while receiving waiver services, but they must also meet certain criteria. Participants, or their legally authorized representative, must participate in the person-centered planning process. The participant must also participate in their services. A participant has the right to refuse services; however, case management is a mandatory service so they must agree to case management services, including required home visits, in order to receive waiver services. If the participant refuses services for three consecutive months, they will lose their waiver funding as it is then presumed that they no longer want or need waiver services.

# Needs

- Needs are not being met through waiver services.
- The IPC has not been implemented.



The Comprehensive and Supports Waivers are intended to provide services that allow a participant to receive services in their community rather than an institutional setting. However, there are times when a participant's health and safety needs are not adequately covered with home and community-based services. If a participant's needs exceed what home and community-based services offer, such as 24-hour nursing care, the participant may be denied waiver funding to cover the additional supports that exceed what the waiver would typically cover. On occasion a participant may make decisions that result in incarceration. While it is always unfortunate when an individual ends up in jail, which is also an institution, waiver services cannot be used to substitute incarceration.

Conversely, a participant may be leading a very independent life, receiving very few waiver services, and consistently refusing waiver services because they are not interested or do not feel they are needed. While waiver services do cover the lifespan if the participant is eligible, that does not mean that the participant must be on waiver services for their entire life. If a participant is able to gain the skills and knowledge necessary to live without the paid support that the waiver provides and is able to get their needs met through community and natural supports, then waiver funding may not be necessary any longer.

## Funding Availability

- The Legislature has not appropriated sufficient fiscal resources.
- Funding for requested service is available through another source.
- Educational services are available.

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As mentioned earlier, waiver services are not entitlements, so funding is not automatically available to every person who is eligible for services. The Wyoming Legislature appropriates a budget for waiver services, and the Division is obligated to work within the budget. If the Legislature has not appropriated enough money to fund everyone who is eligible for services, then the Division must institute a wait list. The Division currently places newly eligible individuals on a wait list, which is funded on a first come, first served basis.

Since Medicaid is the payer of last resort, funding for services that could be covered through other sources such as the DVR, the Department of Education or the Department of Family Services, or third party insurance carriers, will be denied.

As a reminder, participants are eligible to receive educational services through the school year in which they turn 21 years old. If a participant is eligible for school services, they may be denied waiver funding for services that are typically covered through the school system.

# Supporting Participants Who Lose Waiver Funding

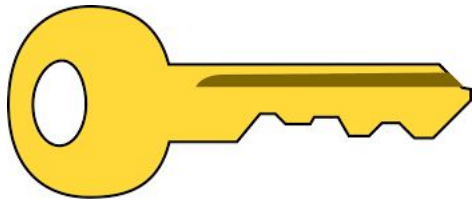


- File a reconsideration or fair hearing request.
- Link to other federal, state, or local programs.

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In some situations, a participant may be entitled to a reconsideration or fair hearing to dispute the Division's decision to deny or revoke waiver funding. If requested by the participant, applicant, or legally authorized representative, case managers must support them in submitting that request. It is extremely important that case managers understand when a reconsideration or fair hearing is appropriate. Not all funding decisions that adversely affect a participant are subject to the fair hearing process. More information on reconsiderations and fair hearings can be found in Chapter 4 of the Department of Health's Medicaid Rules.

When a participant is denied waiver funding, the case manager must support the participant in finding other federal, state, or local services, including services offered through DVR, religious and charitable organizations, and public housing and financial assistance. Case managers must be knowledgeable of the programs and services offered in the communities they serve.



# TAKEAWAYS

1. A participant's IBA is assigned based on the waiver and approved methodology.
2. A participant's IBA will change only if specific situations occur.
3. Case managers must be knowledgeable of the prohibited uses of waiver funding and reasons why waiver funding may be denied.

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

1. A participant's IBA is assigned based on the waiver in which they are enrolled. The IBA assigned to participants enrolled on the Supports Waiver is outlined in the Supports Waiver Agreement. If a participant is receiving Comprehensive Waiver services, their IBA is calculated using a methodology approved by CMS.
2. A participant's IBA will change only if specific situations occur, such as a participant aging up or having a change in their life that meets the criteria for an ECC request. Case managers must use the tools provided by the Division to understand how an ECC request may affect the participant's IBA.
3. Chapter 46, Sections 16 and 17 clearly outline the prohibited uses of waiver funding and reasons why waiver funding may be denied. Case managers must be knowledgeable of these provisions and ensure that participant IPCs do not violate these rules.



# 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 waiver cost limits and IBAs, prohibited uses of waiver funds, and denials of funding for waiver 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.