

## AGENDA

- **Program Updates**
  - Participant-directed service requirements
  - Documentation authorizing rights restrictions
  - Changes in participant living situations, and implications to the individual budget amount for Comprehensive Waiver services
  - Participant case closures
  - Guardianship of minors
  - Submitting incident reports and complaints
  - Benefit Management Service concerns
  - Provider certification renewals
  - Service observation requirements and flexibilities during public health emergency
  - Provider reimbursement rate changes effective February 1, 2022
  - Targeted Case Management unit cap
- **Monthly Training Session** - Targeted Case Management and the WaitList - [Slidedeck](#)

## TOPICS

### **Participant-directed service requirements**

Participant-directed services must meet the standards and requirements that are outlined in the Comprehensive and Supports Waiver Service Index (Service Index). Case managers are required to conduct regular follow-up with the employer of record to assure that services are being provided in accordance with the participant's individualized plan of care (IPC) and the Service Index, including adherence to established service caps. Case managers are required to report concerns to the area Benefits and Eligibility Specialist (BES).

### **Documentation authorizing rights restrictions**

In accordance with Chapter 45, Section 4 of Wyoming Medicaid Rules, a participant's rights cannot be restricted unless there is medical or legal authority authorizing the rights restriction, such as a medical note from a doctor, legal order, guardianship documents, or representative payee documentation. In the past, case managers have referenced the psychological or neuropsychological evaluation as the medical document that authorizes rights restrictions for many restrictions. These evaluations will not be accepted as medical authorization for any restriction other than those related privacy as a result of mobility concerns.

### **Changes in participant living situations, and implications to the individual budget amount for Comprehensive Waiver services**

A participant's individual budget amount (IBA) for the Comprehensive Waiver is calculated using three factors:

1. An assessed Level of Service score;
2. The participant's living situation; and
3. The participant's age.

If a participant who was previously receiving community living services no longer receives those services, the case manager must notify the area BES so the participant's IBA can be adjusted to reflect their current living situation.

In addition, any change in financial or marital status must be reported to the Medicaid long term care office within 10 days of the change.

### **Participant case closures**

During the COVID-19 public health emergency (PHE), the Division of Healthcare Financing (Division) is required to obtain confirmation from a participant when the closure of the waiver case is a result of the participant moving out of Wyoming. When a case manager initiates a waiver case closure for this reason, the case manager must upload a signed letter from the participant or legally authorized representative in the Electronic Medicaid Waiver System (EMWS) document library. The letter should state that the participant is moving out of Wyoming and understands that they will no longer receive Wyoming waiver services.

### **Guardianship of minors**

In accordance with Wyoming Statute §14-1-101(a) and Wyoming Statute §3-1-101, an individual reaches the age of majority and, as an adult, acquires all rights and responsibilities granted or imposed by statute or common law when they turn eighteen (18) years of age. The guardianship of a minor, whether parental or through the Department of Family Services or any entity that was granted the guardianship by a court of law, terminates on the day that the participant turns 18. The Division will consider a participant to be their own guardian unless an adult guardianship order is uploaded into EMWS, or the minor guardianship order specifically states that the order remains in effect after the participant turns 18.

### **Submitting incidents and complaints**

In accordance with Chapter 45, Section 20 of Wyoming Medicaid Rules, case managers and other providers are required to submit identified incidents within established timeframes. Incidents must be reported through the Division's [Provider Portal](#). The Division conducted training on how to register and use the Provider Portal on June 15, 2021. To view the recording of this training, please visit the [Training](#) page of the Division website, under the *Combined HCBS Program Trainings* section.

It is imperative that, once the provider starts an incident report in the portal, the report is either submitted or deleted. Unfinished incident reports should not linger on a provider's task list.

Providers are also required to submit complaints using the [on-line complaint form](#). Complaints should only be submitted for circumstances over which the Division has authority, such as participant health and safety concerns that don't fall within the scope of an incident report, rule violations, and violations of a participant's rights. The Division will not follow-up on complaints that are outside of Division authority or are unrelated to a rule violation, such as those related to personality issues within a plan of care team, or between providers, case managers, and other entities. The Division expects all parties to behave professionally, and will not serve as mediator when problems arise.

When a complaint or incident report is submitted, the Division will follow its internal processes for review and additional follow-up. The Division may or may not investigate a complaint or incident, depending on the initial review of the incident or complaint.

### **Benefit Management System (BMS) concerns**

The Division recognizes that there are ongoing concerns with the implementation of the new Benefit Management System, or BMS. If you have continued issues with this system, please contact CNSI directly at 1-888-996-6223. The Division is able to provide limited troubleshooting if the provider supplies the TCN number, but the provider should contact CNSI first for assistance.

### **Provider certification renewal**

In accordance with Chapter 45, Section 28, the Division is required to provide at least 90 days notice that a provider's waiver certification is expiring. Although the Division provides this advance notice, providers often wait until the 11th hour to submit their certification renewal documentation.

Providers must not procrastinate. They should start the renewal process as soon as they receive the notification that their certification is going to expire in order to avoid last minute delays or problems that may arise. It is important to note that decertification as a result of a provider's failure to meet the timeline requirements for certification renewal is not considered an adverse action, so the provider is not entitled to an administrative hearing. Once the provider is decertified, they must start the process for becoming a certified provider all over, and are not eligible to provide services or receive payment in the interim.

### **Service observation requirements and flexibilities during public health emergency**

The Division developed and published a document that outlines the flexibilities that have been approved by the Centers for Medicare and Medicaid Services (CMS) during the COVID PHE. This document can be found on the [COVID-19 Updates for Home and Community Based Services](#) page of the Division website.

Although the Division offers some flexibility in how case management services are offered, all case management activities are still required. Case managers may conduct IPC development and monitoring activities, including plan of care team meetings, home visits, and service observations, by telephone or video conference as an alternative to in-person case management visits. However, telephone or video conferencing is an option, but is not required by the Division. If the case manager, participant, family or provider agree that in person visits are safe, then visits should take place on-site.

If a home visit or service observation is conducted via telephone or video conferencing, documentation of the visit is still required. Please review the [additional guidance](#) on documentation expectations.

### **Provider reimbursement rate changes effective February 1, 2022**

Provider reimbursement rate changes for the Comprehensive and Supports Waivers will be effective February 1, 2022. This rate change is a result of a revised rate setting methodology that was developed as part of a required rate study and rebasing that was conducted in 2020 and 2021. Proposed rates, which will be in effect through March 31, 2024, have been updated in EMWS for plan renewals.

Provider payment rates beyond March 31, 2024 will be subject to budgetary appropriations as determined by the Wyoming State Legislature.

The Division will not decrease any provider rates with this implementation. The Division will not implement different rates for agency and independent providers with this implementation.

The Division will not adjust IBAs for a participant's active plans, so providers should continue to use their current active prior authorization (PA) numbers to bill at the higher rate. This process will simplify the process for the case manager. EMWS will not display two lines for every service, and new PAs will not be required for most services. Four services have new modifier codes, and will require new PAs.

- Adult Day Services - Intermediate (Daily) will change to S5102 **U2**
- Community Support Services - Intermediate (Daily) will change to T2020 **U3**
- Community Support Services - High (Daily) will change to T2020 **U4**
- Respite - Group of 2 (Daily) will change to S5151 **U8**

### **Targeted Case Management unit cap**

During the support call, the Division received several comments related to the 120 unit annual cap on targeted case management (TCM) services. The Division would like to clarify that this cap is established through the Medicaid State Plan. The case manager must use the units in a way that addresses the needs of the participant. The anticipated unit usage should be outlined in the *Case Manager Support* section of the TCM Plan of Care, and the case manager must ensure that there are enough units available each month to provide the TCM services as described in the plan. The Division recognizes that some months will be more involved than others. Case managers should plan on checking in with the individual at least once a month during the year, and shall not exceed 120 units annually.

## **WRAP UP**

***Next call is scheduled for March 14, 2022.***