AGENDA

- **Program Updates**
  - Case Management Agency roles
  - Case manager timelines
  - Participant case closures during public health emergency
  - Partial month service referrals
  - Submitting incident reports and complaints
  - Benefit Management System concerns
  - Service observations flexibilities and requirements during public health emergency
  - Protected health information
  - Updating Participant Agreement forms
  - Billing units for case management services
  - Transportation services billing code
  - Reporting changes in circumstances to Medicaid Long Term Care Unit
  - Monitoring service plans
- **Monthly Training Session** - Technical Assistance - Slidedeck

TOPICS

Case Management Agency roles

The Case Management Agency, or CMA, has many obligations, most of which are outlined in the CCW Service Index. Among these responsibilities is the requirement that the delegated representative of the CMA assign a case manager to new participants. This information should be added in the Electronic Medicaid Waiver System so that the Division of Healthcare Financing (Division) has a record of the participant's case manager.

When a case manager leaves a CMA, the participants on that case manager's caseload must be offered a choice to transition to another case manager within the CMA, or to choose a new CMA. If the participant chooses a new CMA, the current CMA must work with the participant to complete a Change of Case Management Agency Form, which can be found on the *CCW Case Manager Forms* tab of the HCBS Document Library.

In accordance with the Community Choices Waiver agreement and the CCW Case Manager Manual, case managers must have an assigned backup. The CMA will need to determine if the associated case manager or the CMA will assign the backup case manager. The backup case manager should be able to step in when appropriate to ensure that service plans are completed and submitted on time, and ensure that participants do not have a gap in needed services or support if their primary case manager is not able to provide services. The case manager must identify each participant's backup case manager in the *Contact* section of the service plan. To make this identification, the case manager must use the drop down menu in the *Contact* section and select **Case Worker**. In the coming weeks, there will be an option for the case manager to select **Backup Case Manager**. The BES will roll back service plans and modifications if the backup case manager is not identified on the service plan.

Case manager training on how to complete the service plan, the team meeting process, and other service plan processes should be handled through the CMA. Questions related to entering information into the service plan, unit usage, formulating participant goals, services, or service plan content should not be directed to Benefits and Eligibility Specialists, or BES. These are questions that should be handled within the participant's team, or through training that is provided by the CMA. The BES is responsible for assisting case managers with submitting service plans that meet State and Federal requirements. The BES cannot provide recommendations or comments regarding the content of a service plan as they are not part of the person-centered plan of care team. The BES will only make recommendations when the service plan is out of compliance with the current CCW Service Index or waiver documents.

Case manager timelines

Case managers are still submitting service plans after the 15th of the month prior to the month the service plan starts. Additionally, case managers are not submitting initial service plans in a timely manner, which results in the start date being pushed to the first day of the next month. This means that the participant's services are delayed. As a reminder, case managers must submit all service plans by the 15th of the month prior to the month that the service plan starts. Case managers must develop and submit Initial service plans within 30 calendar days of being notified that the participant is eligible for CCW services.

The Division has also been receiving late submissions of case manager documentation and service plan modifications. When the case manager creates a service plan modification, they must allow for seven calendar days for Division review. The case manager needs to consider the time it takes for a provider to accept a referral when they indicate the effective date.

Case Management Monthly Review forms, or CMMRs, must be completed in EMWS within five (5) business days, and must be submitted in EMWS by the 5th business day of the following month. Case management services cannot be billed prior to the CMMR being submitted in EMWS. If case management services are billed before the CMMR is completed and submitted, the claim may be considered fraudulent, and could be subject to provider payback.

If the case manager is unable to make contact with the participant, the CMMR must still be completed and submitted in EMWS. Please remember that, if the case manager fails to make contact with the participant during the month, the case manager cannot bill for that month of case management services.

If the case manager continues to submit service plans, modifications, or other required documentation outside of established timelines, the case manager will be subject to formal technical assistance and possible corrective action if this becomes a chronic issue.

Participant case closures during public health emergency

During the COVID-19 public health emergency (PHE), the 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 or voluntarily disenrolling from services. 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 EMWS document library. The letter should state that the participant is moving out of Wyoming and understands that they will no longer receive Wyoming Medicaid State Plan or waiver services. This guidance was initially sent to case managers in an email dated November 9, 2021.

Partial month service referrals

When a case manager adds services that have a start date other than the first of the month, the case manager must indicate the number of units that will be needed for the partial month. If the case manager does not indicate the number of units in the box that populates in EMWS, the system will not allocate the service units for the partial month.

When the participant needs to have their services increased mid-month, the case manager should not use the same service line to indicate the needed change. The case manager must add a new service span to the existing referral and indicate the date that the service will change. Do not change the hours in the original service span. A new service span needs to be added for frequency changes.

The Division has seen this issue with participant-directed services on a regular basis. If the number of units isn't indicated in the referral box, the Division cannot backdate those services as there was no budget allocated for the partial month. The direct support worker will not get paid in these cases.

Submitting incident reports and complaints

In accordance with the CCW agreement approved by the Centers for Medicare and Medicaid Services (CMS), 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 service plan 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.

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Benefit Management Services 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.

Service observations flexibilities and requirements during public health emergency

The Division developed and published a document that outlines the flexibilities that have been approved by 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 service plan 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. 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.

Protected health information

Case managers must remember that information released to providers must be limited to what the provider needs to know to serve the participant. This includes information about the services that a participant needs and the basic information a provider would need to bill. It would not be appropriate to release medical records to a provider without a signed release. Furthermore, if a provider is requesting medical records prior to providing services to a participant, they should request this information from the participant or their legally authorized representative. The provider should obtain a signed release and get medical records from the participant's treating provider. The case manager should not be the go-between in obtaining such records, and any records they do release to the provider should be discussed with the participant prior to the release and should only be related to the services they will provide.

Updating Participant Agreement forms

When a case manager submits a modification to a participant's service plan, a new signed Participant Agreement must be uploaded into EMWS. The signed Participant Agreement demonstrates that the participant or their legally authorized representative is aware of and agrees to the changes being made to the service plan.

Billing units for case management services

When the new CCW agreement went into effect on July 1, 2021, the case manager unit changed to a monthly unit instead of a daily unit. If you have billed 31 units instead of the 1 monthly unit you will need to contact CNSI to get assistance on adjusting the claim.

Transportation services billing code

If a case manager submits a service plan modification to change the transportation service code, the old code will need to end on the last day of the month and the new code will need to have an effective date on the first of the next month. Hypothetically, all of the transportation could be used in a single day, so EMWS will not allow a change of the service code in the middle of the month.

Reporting changes in circumstances to the Long Term Care Unit

The case manager must report any change in circumstance to the Medicaid Long Term Care (LTC) Unit within 10 calendar days of the change occurring. This report can be made via email or phone call. For example, if a participant's spouse passes away, if the participant's income changes, or if the participant is

admitted to the hospital, the LTC Unit must be notified because these changes may impact the participant's eligibility.

Monitoring service plans

It is the case manager's responsibility to ensure that participant services are being delivered according to the CCW Service Index. If a BES identifies circumstances in which the CCW Service Index is not being followed, the BES will notify the case manager. The case manager will be required to make changes to the service plan as necessary.

WRAP UP

Next call is scheduled for April 14, 2022.