



AGENDA

- **Program Updates**
 - Monitoring Services in Accordance with the Comprehensive and Supports Waiver Service Index
 - Submitting Current Eligibility Assessments
 - Supporting Documentation for Restrictions on a Participant's Right to Privacy
 - Uploading Documents in EMWS
 - Attestation Reminder
 - Issues with Plan Modifications
- **Monthly Training Session** - Participant-Direction - [Slidedeck](#)

TOPICS

Monitoring Services in Accordance with the Comprehensive and Supports Waiver Service Index

In accordance with Chapter 45, Section 8 of Wyoming Medicaid Rule, services delivered by Comprehensive and Supports Waiver (DD Waiver) providers must meet the service definitions outlined in the Comprehensive and Supports Waiver Service Index (Service Index) and be provided pursuant to the participant's individualized plan of care (IPC).

Chapter 45, Section 9 requires case managers to 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 their supports and services. This monitoring includes ensuring that the services the participant is receiving align with the service definition in the Service Index. If the case manager identifies that services do not conform with the service definition, they must document the concern and notify the provider. If the provider does not make necessary adjustments, the case manager must file a complaint using the Division complaint process.

If Division of Healthcare Financing (Division) staff members identify that services are not being provided in accordance with the Service Index, they will notify the case manager and have the case manager contact the provider and make necessary adjustments to the participant's IPC.

Submitting Current Eligibility Assessments

It is the responsibility of the case manager to ensure that all required eligibility assessments are current when submitting an initial or renewal IPC. If you are not sure if an assessment is considered current, please contact the assigned Benefits and Eligibility Specialist (BES) for assistance. As a reminder, when a participant with an intellectual or developmental disability begins waiver services, an LT104 assessment must be completed before the initial IPC is submitted, and annually thereafter. A participant with an acquired brain injury (ABI) must have an LT101 assessment initially and annually thereafter. The Inventory for Client and Agency Planning (ICAP) assessment, which is required for participants on the Comprehensive Waiver, must be completed every five years. Participants with an ABI are required to have a neuropsychological evaluation every five years. Children with a development or intellectual disability are required to have a new psychological evaluation every five years. Finally, adults with an IQ of 60 or higher are required to have a psychological evaluation every five years, and all other participants are required to undergo subsequent psychological evaluations as determined necessary by the Division. These timelines are established in Chapter 46 of Wyoming Medicaid Rule.

Supporting Documentation for Restrictions on a Participant's Right to Privacy

As a reminder, 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 many rights restrictions. These evaluations will not be accepted as medical authorization for any restriction other than those related to privacy as a result of mobility concerns.

Uploading Documents in the Electronic Medicaid Waiver System

When uploading multiple page documents such as psychological evaluations, guardianship orders, Positive Behavioral Support Plans, or medical records, case managers must ensure that all pages are legible and submitted in a way that is easy to read and review. This includes assuring that all items are oriented top to bottom. It is the responsibility of the case manager to review all documentation after it is uploaded and before it is submitted. If submitted documentation does not meet these minimum standards, the Division will consider the documentation unacceptable and the case manager will be required to resubmit within the required timeframes.

Attestation Reminder

On February 1, 2022, the Division implemented revised provider reimbursement rates for providers of DD Waiver services. In accordance with guidance from the Centers for Medicare and Medicaid Services (CMS), and in response to widespread staffing shortages throughout Wyoming, the Division expects all providers to apply the entirety of increased funding received through the rate increases to the compensation of direct support professionals. Direct support professionals are defined as those individuals who were hired with the intent to provide direct services to DD Waiver participants. This includes case managers.

In order to demonstrate compliance with this expectation, the Division is requiring all providers, including case management agencies, to complete and submit an initial HCBS DD Provider Rate Increase Attestation Form no later than March 31, 2022. This attestation identifies the methods by which the entirety of the rate increase will be directed to direct support professionals and case managers on staff. Providers should have received a task in the Wyoming Health Portal (WHP) entitled License/Document Renewal - Rate Increase Attestation Document. They must complete the Attestation Form, and upload it into WHP. All DD Waiver providers are required to complete and submit this form. If a provider does not pay employees, or does not provide services that received an increased rate, the provider must indicate that on the Attestation Form and submit the form as required.

Additionally, providers will be required to submit an annual reporting for each year in which they receive the increased rates. The HCBS DD Provider Rate Increase Annual Reporting Form includes the following information:

- The reporting period, which will typically cover the provider's fiscal year;
- The total dollar amount of the increase to the provider's income that is attributable to the rate increase; and
- The methods by which the entirety of the rate increase will be directed to direct support professionals.

The Annual Reporting Form covers July 1 - June 30th of each year the increased funding is available. On July 1st of each affected year, the provider will receive a task in the WHP to complete and submit the Annual Reporting Form. The provider must complete and submit the Annual Reporting Form by July 31st of each year.

A provider's failure to complete and submit the Attestation Form and subsequent Annual Reporting Forms may result in a recovery of payment for the rate increase, as well as corrective or adverse action.

The Division has issued a formal bulletin related to the attestation and reporting requirements, which is located on the DD Providers and Case Managers page of the Division website, under the DD Program Bulletins toggle. The Attestation Form and Annual Reporting Form are available on the HCBS Document Library of the Division website, under the DD Certification Forms tab. The Division also conducted a question and answer session related to the attestation process on February 9, 2022. A recording of the session, as well as the presentation slidedeck, can be found with the Attestation and Annual Reporting Forms.

Issues with Plan Modifications

The Division has received several phone calls and emails from case managers who are having difficulty adding services to IPC modifications. As a reminder, before a modification can be developed, the case manager must first enter the modification effective date and save it in EMWS. Once this has been completed, the case manager can go into the Service Authorization screen and add the necessary information. If the provider still isn't showing up in the drop down menu, the provider's certification renewal is likely due. The provider should ensure that they submit their certification renewal documents timely. The provider cannot be added to plans until their certification renewal is complete.

WRAP UP

Next call is scheduled for May 9, 2022.