AGENDA

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- **Monthly Training Session** - Community Choices Waiver (CCW) Changes - Slidedeck

TOPICS

Community Choices Waiver Case Management and Provider Manuals

The Division of Healthcare Financing, Home and Community-Based Services (HCBS) Section has updated the Community Choices Waiver (CCW) Case Management Manual. This update, which was published on January 3, 2023, is a result of the HCBS Section's efforts to implement CCW program changes and ensure that case manager's have the necessary resources to conduct their jobs in a professional manner. The updated manual includes more detail on the specific role and responsibilities of the case manager, and is presented in a user-friendly format. This manual explains timelines and expectations so that the case manager is aware of the standards and requirements of their jobs. Various desk references, guidance documents, and steps for using EMWS have also been incorporated. The CCW Case Management Manual can be found on the CCW Providers and Case Managers page of the HCBS Website, under the *CCW Case Manager Resources* toggle.

The CCW Provider Manual has also been finalized and published, and went into effect on January 13, 2023. The HCBS Section released a draft of this manual for stakeholder feedback from June 2 - June 30, 2022. Suggestions received, as well as the HCBS Section's response to these suggestions, have also been published for review. The CCW Provider Manual and stakeholder suggestions can be found on the CCW Providers and Case Managers page of the HCBS Website, under the *CCW Provider Resources* toggle.

The HCBS Section will discuss the Case Management Manual during this afternoon's training session. Updates to the CCW Provider Manual will be discussed in further detail during the CCW Provider Support Call scheduled for March 27, 2023.

ACES$ Notification of Participant Medicaid Eligibility

ACES$ now receives updates about a participant's Medicaid eligibility if the participant has participant-directed services on their IPC. This notification allows ACES$ to verify a participant's Medicaid eligibility and place a hold on employee payments if the participant was ineligible during the service period.

If a participant's eligibility ends but is later reinstated with no gap between the termination and reinstatement dates, the payment for the services rendered during that time frame will move out of a hold status and be processed for payment. If a participant's eligibility is reinstated but does not cover the full date range between the termination and reinstatement timeframe, ACES$ will not process payment for any services rendered while the participant was ineligible.

Reviewing Service Plan Rollbacks

If the area Benefits and Eligibility Specialist (BES) rolls a service plan back to you, it is imperative that you review the reason for the rollback using the *Show Comment History* option in the service plan checklist. Service plans should not be submitted until the requested changes have been made.

On Hold Service Plans

A service plan cannot be put on hold if the plan is actively being modified; the case manager must complete the modification prior to putting a case on hold. If a case is in on-hold status, a modification cannot be created until the hold has been removed. Please keep in mind that the start date of the on-hold status should not be added on a day that the participant received services. For example, if the individual was admitted to the hospital late in the evening, but had received services earlier that day, the hold date should not start until the following day. Case managers should carefully coordinate hold dates with participants.

Case Management Transition Form

The outgoing case manager must complete the Case Manager Transition Form whether the participant is transitioning to a new case manager within the current case management agency, or transitioning to another agency altogether. The purpose of the form is to ensure that case managers are sharing information, and to establish Division guidelines that must be followed when a transition to a new case manager occurs. The participant's choice in a new case manager must be honored to the extent possible, which makes it important for case managers to ensure that all steps on the form have been completed. If the case management change occurs within the same case management agency, some of the steps will be not applicable and can be marked as such. The form should be uploaded in the Electronic Medicaid Waiver System (EMWS) when the modification to change the case manager is submitted, or prior to assigning the new case manager within the same case management agency.

Financial Management Services (FMS) Change Notification Form

When a participant-directed service delivery closure is initiated in EMWS, ACES$ still requires the case manager to send a Financial Management Services (FMS) Change Notification Form in order to close the participant in their system. When ACES$ acknowledges the closure task in EMWS, they will add a note stating: *Acknowledgment of this task is to acknowledge receipt of notification of changes. Please note this task does not terminate self-direction services within the ACES$ systems. Please submit an FMS Change Notification form if self-direction services are terminating and need to be processed within ACES$ systems.*

Although ACES$ sends this note every time they acknowledge these tasks, they still are not receiving the required form. Please ensure the form is sent to ACES$ at supportwy@mycil.org.

Provider Changes in Wyoming Health Provider (WHP) Portal

On December 21, 2022, the HCBS Section notified all providers and case managers via our GovDelivery system that we have started processing provider-requested changes to the provider file through the Wyoming Health Provider (WHP) Portal. This process allows providers to request the following updates to their provider file:

- Contact name(s);
- Organization addresses and phone numbers;
- Service locations;
- Case management staff; and
- Service changes

This process is conducted through a request initiated by the provider, and includes work on the provider's task list, similar to the certification renewal, licensure updates, and other WHP Portal tasks.

To support providers with this new process, the HCBS Section published a Provider Change Guidance Manual (Guidance Manual), which can be found on the HCBS Document Library, under the *Technical Guidance* tab. The Guidance Manual provides step by step instructions on how to request changes.

As indicated in the Guidance Manual, when a provider selects the Provider Change Request option and begins the change request, they will be directed to a screen that displays five tabs at the top of the screen. If a provider makes a change on a screen that is associated with one of the displayed tabs, they must select "Save and Continue" at the bottom of that screen. The last tab is associated with a confirmation screen. In order for the change request to be submitted, the provider must select the Confirmation tab, add any relevant notes, and complete the following steps:

- Check the disclaimer box;
- Select "Submit for Review" from the dropdown menu; and
- Click "Submit".

If the provider has not completed all of the steps in the change request process, the status of the task in the WHP Portal will say "Pending Provider Entry". If a provider has a task with this status, they must complete the steps outlined in the Guidance Manual and upload any required documents in order for the request to be submitted to the HCBS Section.

Service Lines and Referrals

Provider agencies have been reminded of their obligation to review service requests in the Wyoming Health Provider (WHP) Portal often and purposefully in order to avoid errors or unnecessary service plan modifications. Furthermore, providers were reminded that service lines should be reviewed carefully and accepted only if the provider can commit to the service as it is presented. They were encouraged to work with the participant's plan of care team and case manager to ensure appropriate service lines are submitted.

Case managers must ensure that changes to services are handled within the existing service line. A new line should not be added to change the frequency of the service.

Participant Medication Lists

Case managers are required to upload a list of each participant's medications as part of the service plan. At a minimum, this list must contain the name and dosage of each medication.

Changes in Provider Ownership or Leadership

As established in Section 4, Paragraph O of the Medicaid Provider Agreement, which is signed by every CCW provider, providers are obligated to provide the Medicaid program with advance notice of any change or proposed change in the provider's name; ownership; licensure; certification or registration status; type of service or area of specialty; additions, deletions or replacement in group membership; mailing addresses; and participation in the Medicaid program. A change in the provider's ownership or organization does not relieve the provider of its obligations under the Medicaid Provider Agreement, and all terms and conditions of the Agreement apply to the new ownership or organization.

If there is a change in provider ownership, the new owner is required to sign a new Medicaid Provider Agreement. For example, if the owner of a case management agency retires, and sells the organization to a long time employee, the new owner is required to re-enroll with Medicaid as a new owner, and sign a new Medicaid Provider Agreement. Failure to re-enroll with Medicaid may result in adverse action against the new owner, including recovery of payments that have been made to the new provider.

If a case management agency owner is planning to sell their organization, or buy a new one, they must make sure to notify the Provider Credentialing Team of the HCBS Section in advance of the ownership change.

Service Plan Submission Timelines

Case managers must meet service plan submission timelines. The HCBS Section will roll a plan back if a required deadline is not met, even if it is missed by one day. If the case manager misses established deadlines frequently, the HCBS Section may issue corrective action. As a reminder, all service plan modifications must be submitted at least seven calendar days, and renewals must be submitted at least thirty (30) calendar days, before the service plan's effective date.

Updating Participant Addresses in the Electronic Medicaid Waiver System (EMWS)

The Division of Healthcare Financing, Long Term Care Unit is preparing to send financial eligibility packets to all applicable Medicaid recipients, including participants of the CCW. It is imperative that every participant's contact information and mailing address is correct in EMWS. Furthermore, case managers are strongly encouraged to work with the participants on their caseloads to ensure that the participant's contact information and mailing address is correct in the Wyoming Eligibility System (WES).

If a participant moves out of state and the case closure is being initiated, the case manager must add a forwarding address to the case. In addition, if a participant chooses to have their case closed, the participant must submit the request in writing. The case manager must upload the request, which has been signed and dated by the participant, into EMWS.

HCBS Technology Innovation Grants

The Division is implementing a Technology Innovation Grant program for all providers of Comprehensive, Supports, and Community Choices Waiver programs. This program is an initiative identified as part of the enhanced funding made available to the State of Wyoming through Section 9817 of the American Rescue Plan Act of 2021 (ARPA).

A Funding Opportunity Announcement (FOA) was recently published, and invites interested Comprehensive, Supports, and Community Choices Waiver providers to apply for grants to implement innovative programs that use technology to enhance, expand, or strengthen their HCBS programs. A total of $3,000,000 has been earmarked for this activity, with grants of up to $100,000 being awarded.

Applications will be reviewed and scored by an evaluation panel. Award recipients will be selected based on the applicant's success with demonstrating how the proposed project meets the goals and purpose of the grant. Final award amounts and the number of awards granted will be subject to the HCBS Section Administrator's discretion.

The Division will administer grants on a semi-annual cycle, until such time as all funding for this activity has been awarded. The first grant cycle runs from April 1, 2023 – June 30, 2023; applications for this cycle are due by 5:00 PM on April 30, 2023.

Unwinding Background Screening Flexibilities

On January 24, 2023, the Division sent a communication notifying all Community Choices Waiver (CCW) providers that effective February 1, 2023, the Division will discontinue background screening flexibilities offered during the height of the COVID public health emergency.

The Division is currently working with the Centers of Medicare and Medicaid Services to obtain approval on an amendment to the CCW. This amendment contains new background screening standards, which include a name and social security number based criminal background screening rather than a fingerprint based background screening. With this anticipated change expected to be effective on April 1, 2023, the HCBS Section has determined that it is more efficient to allow background screening flexibilities to continue until the new amendment is in effect.

CCW providers will have until May 1, 2023 to conduct a name and social security based criminal background screening for each staff member that has not undergone a background screening. Results that demonstrate that the staff member has passed this screening must be retained in each provider's staff records. CCW providers are required to retain documentation that demonstrates that their staff members have a name and social security based screening on file for all employees at least every five years. The HCBS Section may request this documentation during certification renewal, review of incidents and complaints, and during the course of other work.

ACES$ is updating their systems and will work directly with employers of record to ensure that participant-directed employees meet background screening requirements.

Ending Home Delivered Meal Services

Before ending a hot or frozen meals service line, the case manager must ensure that the meal provider hasn't already shipped or delivered meals. The case manager must coordinate with the provider to ensure the provider is aware that the service is ending so they stop the delivery. As a reminder, the service plan modification date and effective date must allow for seven calendar days for HCBS Section review.

WRAP UP

Next call is scheduled for April 13, 2023.