Participant Direction 101

Good afternoon. I am Julie Lacey, Operations Manager for the HCBS section.

This presentation is meant to provide a basic understanding of the Participant Directed Model of service delivery and how it fits into the HCBS Waiver processes. The information provided will give you a foundation for understanding some of the more complex pieces of the Participant Directed Service Model, and will help answer some of the basic questions that most stakeholders have as it relates to this service model.

The slides and information included in this presentation will be forwarded to attendees after the call.

What is Participant Direction?

- Optional Service Delivery Model
- Increased Responsibility for the Participant
- Risks and Benefits
- Traditional (Agency) Vs. Participant Directed

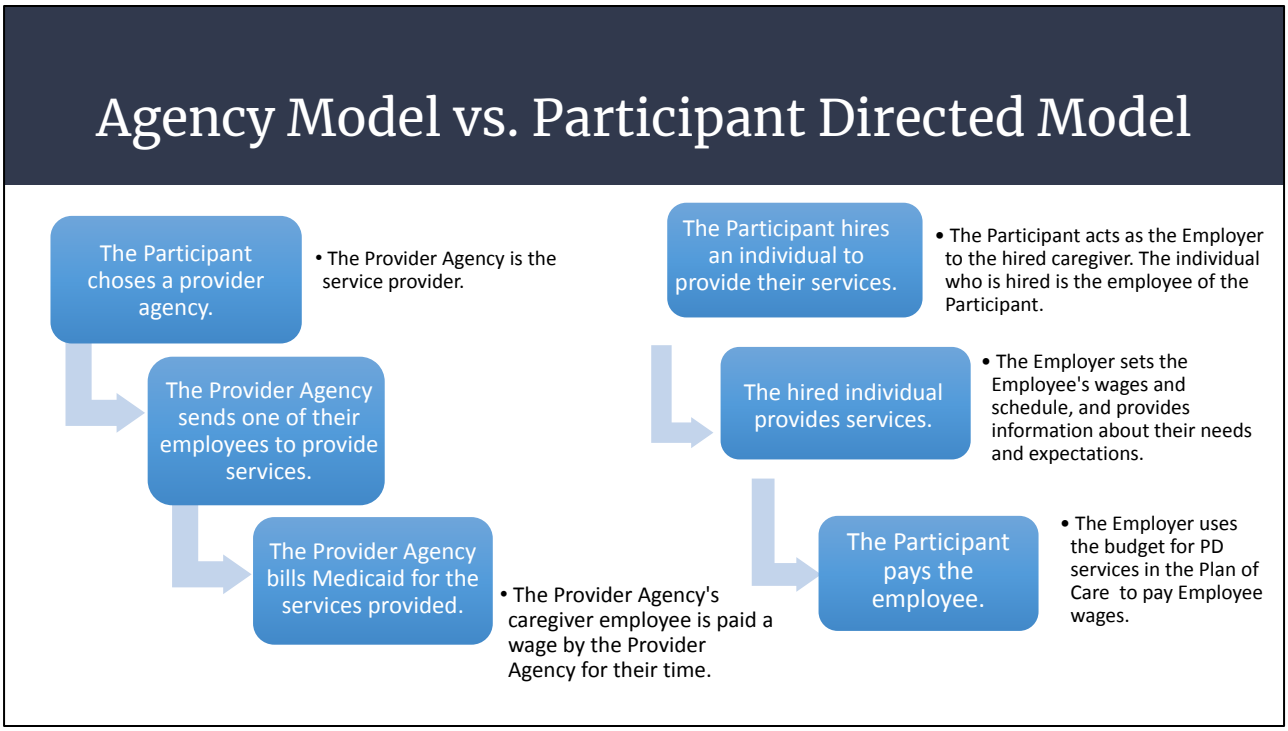
Participant Direction is an optional service delivery model that allows enrolled participants to receive their HCBS services, while taking a more active role in the process. This model is sometimes referred to as “self-direction” or “consumer direction” and can be used by both DD and CCW waiver participants, either independently or in combination with the agency based model services, depending on the participant’s specific needs and preferences, Participant Directed model services do come with the increased responsibility for participants to manage their own caregiver staff and the portion of the plan of care budget that is allocated for participant-directed services.

Because of the increased responsibilities, this service model is made available to participants based on their situation and their ability to manage these responsibilities. If an individual is interested in participant-direction, the Case Manager, participant, and planning team should talk about these responsibilities and the participant’s or their authorized representative’s feeling about them to make sure that this model is a good fit for them.

Participant Direction is not for everyone.The Case Manager should work to determine if a participant who wishes to use this model will be able to manage the increased responsibilities and to discuss other approaches if they feel that it is not a good fit. Both the traditional agency-based and participant directed service models have risks and benefits that are specific to that model of service delivery.

That being said, both can work equally well in supporting the delivery and receipt of

services as outlined in the Plan of Care when used appropriately. We'll talk more about these points throughout the training.



In order to talk about participant direction, it is easiest to first understand the primary differences between the traditional agency based service delivery model and the participant directed service delivery model. Both models get a participant from being enrolled, to receiving services but take different routes to get them there.

Both models begin with a planning process where the Case Manager works with the participant and their planning team to identify the participant's needs, preferences, and goals. Once the CM has created the Plan of Care, these two models begin to veer in different directions, as shown on this slide

For Agency model services, the Participant will chose a provider agency who they want to have provide the service or services that are on their plan of care. The Case Manager communicates with the Provider Agency to make the referral and give the Provider Agency the opportunity to confirm that they are able to meet the service needs of the participant. Once the Provider Agency has accepted the referral, they will schedule and send a caregiver staff member to provide the specified services to the participant. The Provider Agency then bills the State for payment of the services that have been provided, and pays their caregiver staff, as an employee of the Provider Agency. In this model, the Provider Agency is the service provider, meaning that they are responsible for making sure services are delivered as specified in the Plan of Care, that their staff deliver services as expected and are paid. In addition, the Provider Agency is responsible for hiring personal care staff who meet the requirements of the HCBS Section's statutes, rules, policies, and CMS waiver agreements, which includes guidance related to background screening, training,

oversight, and disciplinary actions as necessary to ensure the participant's safety and well-being, and for staying within the budget that is outlined in the plan of care for the specific services they deliver.

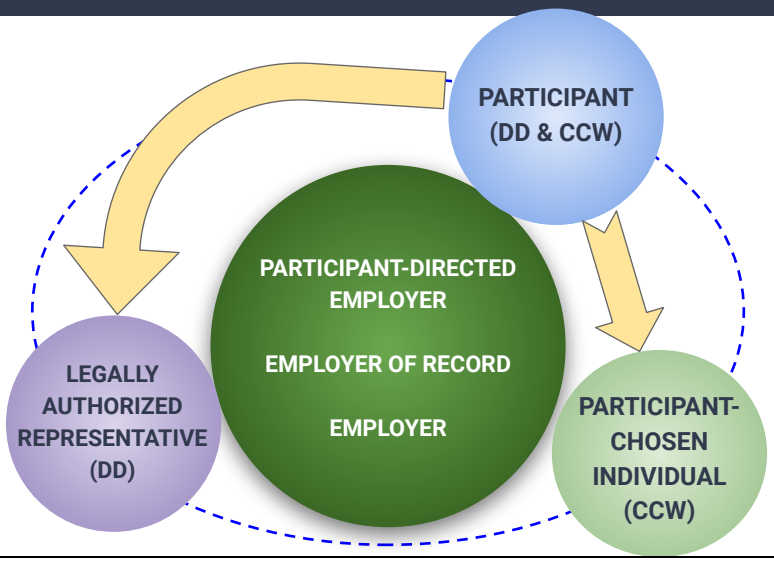
Risks related to using this service model could be that a participant is not able to find a provider or caregiver in their area who is able to provide services or accommodate their needs and preferences (such as receiving a service early in the morning, or late at night). It is also possible that the provider agency have a number of caregivers who they rely on to provide the service or services to the participant at any given time, rather than just one caregiver with whom the participant is comfortable and familiar. Low provider capacity in the participant's location is also a risk. In other words, providers are located and provide services in the participant's area but don't have sufficient staff or resources to be able to take on the additional workload. A benefit of this model is that the participant only needs to choose which provider agency they'd prefer to have delivering the services - They don't need to concern themselves with managing a budget or overseeing staff.

With the participant directed model, the case manager add's participant directed services to the participant's plan of care and makes a referral for the participant to the State's contracted Financial Management Services (FMS) vendor - we will talk more about what that is in just a minute. The participant, or their authorized delegate, will hire someone to provide the plan of care services to them and will act as the official Employer of that person.

While this model comes with a significant increase in the participant's responsibilities, it also allows the participant to be more actively involved in the management of their HCBS services and desired outcomes. They can hire people who can accommodate their preferences and are available at times of day when a traditional provider may not be, or hire family members who they are already comfortable having provide the necessary services.

Individuals who utilize the Participant Directed model are responsible to ensure that both they and their employee maintain compliance with the program rules and expectations for individuals who employ service providers and oversee a budget. This means that if an individual in the Employer role abuses or misuses their authorized budget or their employer authority, those privileges can be removed from the Employer. Examples of this could include signing off on service visits that didn't actually take place, allowing a Participant Directed employee to have their FMS password, or not checking shift entries before they are processed for payroll to make sure they are all recognized visits. Not taking action when a Participant Directed employee has been submitting "fraudulent" or inaccurate shifts, authorizing to many shifts or paying a wage that is too high that results in over-expenditure of the Participant Directed budget before the end of the plan period.

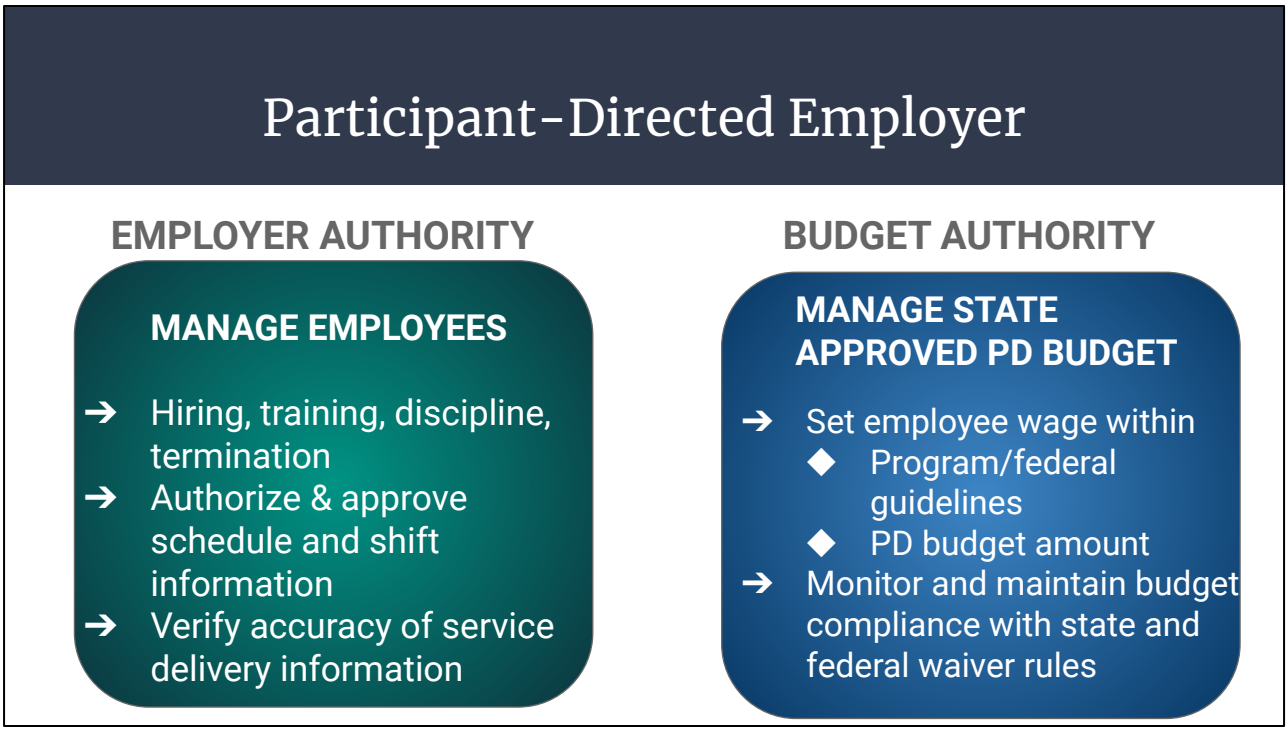
Participant-Directed Employer



When we talk about Participant-Direction, we often talk about the Participant-Directed Employer, Active Employer, or simply the Employer. This has been referred to in the past as the Employer of Record. When a participant, or their authorized decision maker (guardian, parent, power of attorney, etc) choses the participant-directed model, there are specific responsibilities and authorities that are granted to the participant by the Program, sometimes referred to as Employer and Budget Authority.

If the Participant does not feel comfortable or able to take on the increased responsibilities of being a participant-directed employer, they can delegate someone to act on their behalf, in accordance with the DD or CCW requirements . For DD, the Participant can elect to have their authorized representative (parent, guardian, PoA) act in that role.

The Employer becomes the person who is authorized by the Program to manage the hired care providers (Participant Directed employees) and the approved participant direction budget as specified by the State authorities and guidances. Individuals who act in the role of Employer or Employee within the Participant Directed Model are not required to go through the same HCBS Provider enrollment processes as traditional Agency Model Providers, however there are requirements and restrictions that apply to them.



The designated Employer oversees their hired caregivers and manages how the participant-direction portion of the authorized budget is used. It can help to think of the Employer as being similar to a Service Provider Entity within the Agency Model. They are granted Employer and Budget authority by the State and it is their responsibility to make sure that they maintain compliance with the waiver rules and guidelines related to employing caregivers and managing the authorized budget, as well as ensuring that their employee(s) (personal care providers) are compliant and meet the requirements of the HCBS Section's authorities, and are compensated for their tie and the services they provide, just as a traditional Agency Model provider agency would do for their hired caregiver staff.

The Employer is tasked with hiring, training, and providing direction and oversight to their caregiver employee(s); verifying shift and service delivery information; deciding on and paying their employee(s) a wage out of the authorized participant direction budget; performance oversight and reviews, or which may include taking disciplinary action or terminating employment when necessary.

As mentioned, the program grants authority to the Participant Employer or their Delegated Employer to oversee and manage the employer and budget responsibilities (you can think of these as responsibilities that are generally associated with the service provider entity in the Agency Service Model). If these authorities are mishandled or are not managed in alignment with program rules and expectations, or if the participant's health or welfare are not being adequately provided for, the program may recommend re-education, technical guidance, or in some cases the

individual may be removed from the employer role. In these cases, the participant would continue to receive the same or similar services, but the program-granted authorities would be re-called and someone else, either a delegate employer (if available/appropriate) or a traditional provider, would take on those responsibilities.

Role Responsibilities

Within the Participant Directed service model, it is important to understand the specific responsibilities that fall to each of the parties involved. These parties include the HCBS Waiver Section, often referred to as the State or the Program; the participant's Case Manager, the State-contracted Financial Management Services vendor or FMS (currently ACES$); the Participant-Directed Employer, and the Participant-Directed Employee.

Program Administration & Management

HCBS Waiver Section

- Administration and operational processes
  - CMS and waiver compliance
  - Budget creation and communication processes
  - PD Service descriptions and limits
- Provide and manage supports and resources
- Guidance and information
- Make employer determinations

The State HCBS Waiver Section is responsible to create and manage operational processes and program expectations for the participant direction service model. This includes accurately communicating to the federal government (CMS) what the State's participant-directed approach is, overseeing and administering the model, and ensuring that there are processes in place to support budget creation, service authorization, internal and external (Program, Case Manager, FMS) communications, and appropriate service delivery.

The State is responsible to ensure that any program required verifications, screenings, qualifications and trainings are taking place as communicated to CMS. Administration of many of these processes is delegated to the FMS as part of the contracted responsibilities, However it is still the State's responsibility to ensure that the FMS has adequate processes and guidance in place to gather and maintain the information as expected.

The State is also tasked with providing guidance and information to Case Managers in the administration of Participant Directed processes and services to ensure that these services are delivered and received in alignment with the program's rules and authorities.

The State is the final decision maker, in situations where there are noted concerns related to a participant-directed employer's management of their responsibilities (e.g.: fraudulent shift information, overspending of budget, inadequate or unauthorized services during authorized shifts). When necessary, the Case Manager and the State

will work together to determine if action is warranted, and whether an individual may need to be removed from the Employer role, even if it means that the participant (as the Employer) must delegate someone else to act in that role or move to traditional Agency services.

In these instance, the Case Manager should work with the State to determine the most appropriate action, based on if there is a history of these kind of issues and the employer's responsiveness to technical assistance.

Participant Support & Communication

- Participant support and assistance
- Inform and Educate about Participant Direction
- Plan of care, budget, and authorization
- Referral to FMS
- Communication and coordination
  - plan changes
  - compliance concerns
  - program guidance

The Case Manager's role is primarily participant centered. They are tasked with providing support and assistance to the participants in determining if this model is right for their unique situation and needs. They should review the employer responsibilities, program rules and expectations with the participant or their authorized representative, and their chosen employer (when applicable), and provide any program forms and documentation for them to review and complete. Once the participant or delegate employer has completed the necessary program forms and reviewed any guidance resources (online training, employer manual, etc.) the Case Manager makes the referral to the FMS, who will make sure the employer is enrolled in FMS support and ready to go when the plan of care and services have been authorized by the State.

Case Managers are the key communicators within the participant directed model. It is important for them to maintain open lines of communication with the participants, Employers, the FMS and the State. If a Case Manager is notified or uncovers potential compliance or safety issue, it is their responsibility to make sure the Employer is notified and reminded of their responsibility to oversee and manage their employees and budget. In some cases, the issue is resolved with some re-direction and education. However, if the employer does not take action to resolve the situation once they have been made aware of the concerns, the Case Manager's should contact and coordinate with the State to identify what next steps will be taken.

It is important for Case Managers to make sure that any plan or service modifications that decrease or terminate Participant Directed services are communicated to the

FMS timely to ensure there are no unauthorized Participant Directed payroll payments processed.

If the Case Manager is unsure how to approach or resolve a situation, they can reach out to the State program staff for input or guidance as needed, or review available participant direction resources on the website for additional support.

Financial Management

- Budget and Payroll support
- Screenings and Verifications
- Tax and budget information
  - W-2
  - W-4
  - Payroll Advice
  - Expenditure Information
- Electronically verify shift/visit information
- Comply with Contract and Program
  - Waiver, rules, statutes, service index

In order to support the Employer role, the State HCBS Program contracts with a financial management services provider (FMS) to assist with some of the more complex tasks that an Employer must manage. The FMS provides budget, employment, and payroll support to the Employers. This includes enrollment processes for hiring employees, assisting in gathering and providing tax and budget information so they are be able to manage their financial responsibilities. The FMS assists the Employer with IRS, tax and budget related processes, such as processing Employee Identification Number (EIN) applications, gathering and providing tax and budget related forms such as W-2, W-4s, payroll, and budget expenditure information.

While the FMS is responsible for assisting with gathering and providing employment and IRS information on behalf of the Employer, it is important to understand that the FMS entity does not employ the individuals who are providing care to the participant. All documents (W-2s, pay advice, etc.) and employment/IRS information that is gathered, maintained or provided by ACES$ to the employee is on behalf of the Employer as an administrative service being provided by a 3rd party (the FMS) who is authorized and contracted by the HCBS Program to provide this support.

The FMS facilitates the employer and employee screening and verification processes for the State, such as background screenings*, citizenship checks, waiver-specific certification/training requirements, to ensure that the individual meets the State program requirements. They also maintain the Electronic Visit Verification (EVV) solution for participant-direction enrolled services, which captures shift, service and visit information as Federally required in order to validate the information and process

payroll to the Participant Directed employees.

EVV is a federal requirement for all personal care services delivered to participants enrolled in an HCBS Waiver, whether services are delivered through the participant-directed or agency model. It is intended to verify that services are provided as outlined in the program service definition and as stated in a participant's plan of care in accordance with State and federal expectations. EVV captures clock in and clock out times and locations, service or services provided during that time frame, verification (via employer and employee signature) that the service was received by the participant as indicated, and that the visit clock in/out time is correct.

For Participant Directed model services, this information is received by the FMS once it has been approved by the Participant Directed Employee and Employer, and is compiled to support accurate and timely payroll processes. EVV shift information that is incomplete, or conflicts with program guidances such as overlapping services, specified service limits, +40 hours in a work-week per employee, or over-budget submissions, cannot be processed for payroll by the fMS until the issue is resolved. In most cases, these situations can be resolved through review and correction of the submitted shift. In some cases, the Employer may be directed to work with their Case Manager if the issue is related to over-expenditure of the Participant Directed budget, Plan of Care modifications, or other waiver-specific items.

Participant directed Employers and Employees take EVV system training during the FMS enrollment process, which is when they receive their login information. However, any EVV shift information that is submitted by an employee for a service provided before the plan of care, budget, or prior authorization start date, or before the FMS "good to go" date cannot be paid for by the FMS through the program. This is highlighted within the FMS enrollment packet information provided to employers and employees.

As a contracted entity, the FMS (currently ACES$) is required to maintain compliance with their responsibilities as outlined in the contract, to know the responsibilities outlined in the HCBS Waiver, to be familiar with State and federal rules, statutes, and guidances related to financial management of the participant-directed model and home-based employment, and to work with the State to update processes when necessary to align with State or federal changes.

The FMS does not have the authority to address or provide information related to Program administration, such as approved budget amounts, service limits and definitions, prior authorizations, plans of care, employer/employee screening requirements, service delivery expectations, employer and budget responsibilities. These questions should be directed to the HCBS Benefits & Eligibility team for triage, review, and guidance.

Employee & Budget Oversight

- Employee requirements
  - 18 years old
  - Follow Program guidances
  - Employer/Budget Management
- Delegate
  - Background screenings*
  - Prioritize participant
- Restrictions
  - Compensation
  - Delegation
  - Conflict of interest

Individuals acting in the role of Employer, whether they are the participant or a delegated employer must be at least 18 years old, and must demonstrate that they are able to understand and agree to manage the associated activities and responsibilities. This includes effectively managing their hired employees and Participant Directed budget, all aspects of the employment process, verifying and assessing services provided by the employee(s), and following applicable program requirements, rules, and regulations.

In addition to these basics, an individual who accepts the role of Employer on behalf of the participant (delegate employer) must be willing to submit to any background screenings* required by the program, and should ensure that the participant's safety and wellbeing is top priority in the execution of their role. This means that the individual should be someone who is familiar with the participant's medical and functional needs, goals and preferences. A delegated employer should expect to be physically present at the participant's home, both during and outside of service visits, regularly to ensure effective supervision of their employee and evaluation of their performance. It is also important for a delegated employer to maintain ongoing communication with the employee, participant, and the participant's case manager to ensure that waiver services are being provided appropriately and in line with the program rules and participant's plan of care.

A participant-direction employer cannot: be compensated for acting in that role or be reimbursed to provide waiver services to the participant for whom they act as

employer. Individuals for whom acting as a participant's employer may create a conflict of interest, such as the participant's Case Manager for example, are also prohibited from acting in that role for a participant.

Once an individual has accepted the Employer role they cannot assign or delegate those responsibilities to someone else, even temporarily. If an individual needs or wishes to move out of the Employer role, whether that person is the Participant or a delegated employer, they must work with the Case Manager and the FMS vendor to coordinate the process.

*These may vary between waivers, and may change over time.

Employee & Budget Oversight

- Manage employees
  - Provide access to training and instruction
  - Communicate responsibilities and expectations
  - Set work schedule
  - Performance review, discipline, termination
- Manage budget
  - Set wages and work schedules
  - Do not exceed budget amount

As mentioned earlier, the individual who is acting as the participant-directed Employer is responsible for management of the hired employee caregivers. This includes recruitment and hiring activities; guidance, training, and instruction; performance review, disciplinary action, and if necessary termination.

The Employer must also ensure that the employees are given adequate information and training to effectively perform their assigned duties; provide the services as outlined in the participant's plan of care and as defined in the waiver service index, and understand their responsibilities as it relates to the program guidances, participant preferences, needs and goals.

The Employer supports potential employee candidates in completing enrollment processes with the FMS provider and, once hired, sets the employee wages and work schedule to ensure the authorized PD budget is not exceeded. Because the Employer has been granted budget authority over the PD portion of their plan of care budget, they must ensure that the wages set for their employee(s) and the expected work schedule will not go over the allotted participant-direction budget as authorized in their annual Plan of Care.

While it is important that the Employer be the one who decides on their employee's wages, there are a few guidelines set in place by the program to ensure appropriate utilization of the authorized budgets. The wage set by the employer must be less than 200% of the national median for similar/same service employees and must be at or more than the federal and state minimum wage limits. If a wage document is received

from an employer that has a wage request that is more than 200% of the median, it will be sent to the program for review and approval or denial. In these situations, the program may ask for additional information or justification as to why they wish to set such a high wage.

The FMS entity provides support in budget management by providing information about wage setting, as well as providing access to the budget and expenditure information, to allow employers to monitor and manage their budget throughout the plan of care term.

Employee & Budget Oversight

PD Employer

- Manage employees
  - Provide access to training and instruction
  - Communicate responsibilities and expectations
  - Set work schedule
  - Performance review, discipline, termination
- Manage budget
  - Set wages and work schedules
  - Do not exceed budget amount

The Employer is responsible to ensure that their Employees are compliant with program requirements, which means it is very important that they are reviewing EVV shift and service information regularly. Shifts must be signed by the Employer (either within ACES$ Online or the CareAttend application), approving them for submission and payroll processes. Employers should also be encouraged to review submitted shifts prior to the end of each paycycle (the 15th and last day of the month) to verify that all submitted shifts are accurate and recognized as service delivery episodes prior to them being processed for payment.

In instances where it is identified that an employee is submitting inaccurate or potentially fraudulent shift information or is not providing the services as outlined in the plan of care in accordance with the waiver program, it is the employer's responsibility to take whatever action is appropriate and necessary to come into compliance with the program rules, which can include re-training, disciplinary action, or in some cases termination of employment.

If the Employer does not take action to resolve this type of situation, the Case Manager may recommend to the HCBS Program that the person in the Employer role be removed from the position and either replaced with an alternate Employer, if one is available, or that the participant receive the same or similar services through the Agency service model.

Provide Services as Outlined

- Provide authorized services
- Maintain program compliance
  - Training and certification requirements
  - Service delivery expectations
  - Participant preferences and needs are met
- Meet employer expectations
  - Work schedule
  - Shift submission
  - Communication

Participant directed employees must be 18 years of age and meet certain program and waiver-specific requirements in order to provide PD services. Based on the participant's particular waiver, these include specific certification and training requirements, background screening qualification, relative provider restrictions, and any others that may be implemented or specified by the DD or CCW waiver guidances. Because these vary by waiver type and can change over time, it is important for the Employer to know what these are for their particular situation before moving forward with hiring an employee candidate.

For DD, the current requirements for the employee is that they must have current CPR and First aid certification, with hands on skills demonstration and must pass program-required backgrounds screenings. A participant's legally authorized representative (parent, step-parent, guardian, POA) cannot be paid as a participant-directed employee except in circumstances that have been reviewed and approved by the HCBS program through the ECC process

Depending on the participant's identified needs and preferences, the employer should make sure they are clearly communicating their expectations to the employee as it relates to their specific responsibilities and the services they will be providing.

It is the employees responsibility to communicate with the employer and the participant if they are going to be late or miss a scheduled visit, and to work with the employer to decide if a shift needs to be rescheduled. Both the employer and the employee are responsible to sign off on shift/timesheet information before it can be

submitted to the FMS for payroll purposes, The employee should be ensuring that, as often as possible, both they and the employer are signing off on the shift (service visit information) at the time it is finished, and that they are reviewing their submitted shifts before the end of a paycycle to verify that they are all accurate and complete. This ensures that there are fewer surprises when payroll is received.

Extra! Extra!

Some “bonus” information and “tips” that you may find useful.

A “Work Week” for participant-directed employees runs Sunday through Saturday each week. It is important to know this since, an employee can only submit 40 hours a week (Sun - Sat) per employer for payment of services.

It is also important to note, that the FMS pay cycles are the 1st of each month to the 15th, and from the 16th of each month to the last day of that month.

These two points of reference are mutually exclusive and are not impacted by one another, meaning that If the end of a paycycle happens in the middle of a work week, the work week hours do not start over - they continue to accrue for that week through Saturday at 11:59 PM.

Before employees can begin to provide services the employer must have both the email from ACES$ that contains a "good to go" date and an approved, authorized budget from the program. The FMS “Good to Go” date indicates that the FMS has received all completed FMS information required for the participant or their delegate, to be fully enrolled with the FMS as a participant-directed employer, and that the chosen employee has completed enrollment documentation, screenings, trainings etc. and meets all program requirements. The FMS must also have received the authorized participant-directed budget from the program before services can be processed for payment. For DD participants, this is done through a report that is sent

to ACES$ every Tuesday and Friday by the Program, that includes all PA approved participant-directed budget information . It usually takes between 24-48 business hours for those budgets to be updated within the FMS system for those employer. Any participant-directed model services provided during a period outside of the plan of care start or end dates, after a plan has been terminated, before medicaid eligibility is in place or after it has expired, or prior to receiving the FMS “good to go” date, are not able to be processed for payment.

The program does not have fixed limits regarding participant-directed model services and how much can be added to a participant’s plan of care. This should be based on the Case Manager's observation and determination of services needed, discussion with the planning team to understand the participant’s preferences, goals and desired outcomes. The addition of participant-directed services in a plan of care and how much can depend on provider availability and capacity in the participant's location, as well as the participant’s unique situation and their ability, or their delegated representatives, to manage the responsibilities that come with being a participant directed employer. The program does maintain the option to review plans of care that appear to be over reliant on or over utilizing the participant-directed service model. Because of this, it is important for Case Managers to include information in the Case Management notes to support the addition of higher than usual participant-directed budget or services.

As noted earlier, there is a limit for how many hours one employee can work per week for an employer. This is important for Case Manager’s to note, as in some cases, a participant-directed employer may be acting in that role for multiple participants. Each PD employee can work up to 40 hours per week for each individual employer. This means that If one employer is acting on behalf of multiple participants but only hires one caregiver employee, the employer would need to make sure that the employee’s schedule could be split sufficiently between the participants to meet each of their individual needs within that 40 hour limit.

* When helping an employer understand the impact of wage setting on their participant-direction budget, a Case Manager may want to make sure to clarify with them that if the employee wage is set higher than the median wage used to calculate the participant’s service needs, the result will be that the participant would be able to receive fewer service hours than intended. One benefit of setting a higher wage may be to help keep employees on staff or to add employee satisfaction. Conversely, if an employer opts to pay the employee a wage that is lower than the national median but above the federal and state minimum wage, the participant may be able to receive

more service time, but it could result in a higher possibility of employee turnover.

The purpose of PD is to ensure that individuals throughout the State have access to necessary services that meet their support needs, while considering their personal preferences and goals as it relates to remaining in their home and community. This is particularly important in parts of the State where the service provider capacity is not sufficient to meet the needs of the participants in that area.

Q&A

A few common questions:

Can an Employee start submitting timesheets immediately after the Self Direction has been added to the plan? PD Services cannot be processed for payroll for any dates prior to the start date of an approved and prior authorized budget and full completion of the FMS enrollment process for both the employer and the employee, which is confirmed through the “good to go” email. Once the employer and employee have completed and submitted all FMS enrollment documents, background screening results have been received, and the budget PA and monthly breakdown or budget email is received, timesheets for services provided within the budget/plan dates can be processed.

Who does the Case Manager or Employer contact if there are problems with the enrollment process? This depends on what the problem is and how it was communicated to them. When a Case Manager or employer is notified of a problem with enrollment, they should make sure to understand what the problem is and whether it is related to waiver enrollment, medicaid enrollment, or with FMS enrollment. If the problem is related to an authorized budget or a delay in the budget being provided to the FMS, plan of care, medicaid or waiver eligibility, or related to a program specific requirement or limitation, the Case Manager should be working with the participant and State program staff to identify the source of the problem so that it

can be resolved.

If the enrollment problem is related to background screening delays the Case Manager or employer can work with the FMS initially to determine if there is an identified reason for the delay, but ultimately will have to work with the screening entity or the entity tasked with administering the screening (State of Wy HR, DFS) to discover what is causing the delay. If the problem is related to medicaid enrollment or eligibility, the Case Manager may need to refer the employer to have the participant contact their Medicaid Eligibility worker to identify the issue and work toward resolution.

If the problem is related to FMS enrollment specifically, it is important for the CM and the Employer to be able to clearly understand and communicate what the problem is. This may require that the Case Manager reaches out to the FMS to understand an issue that was communicated to the Employer as sometimes the employer's interpretation of the enrollment problem as it was communicated is more easily understood by a Case Manager who know some of the complexities and nuances of the participant directed model.

If after discussing the problem with the FMS, Case Managers and participants need additional support or clarification about the specific issue, they can reach out to their BES, and the HCBS team will work to identify what the root of the problem is so that it can be resolved.