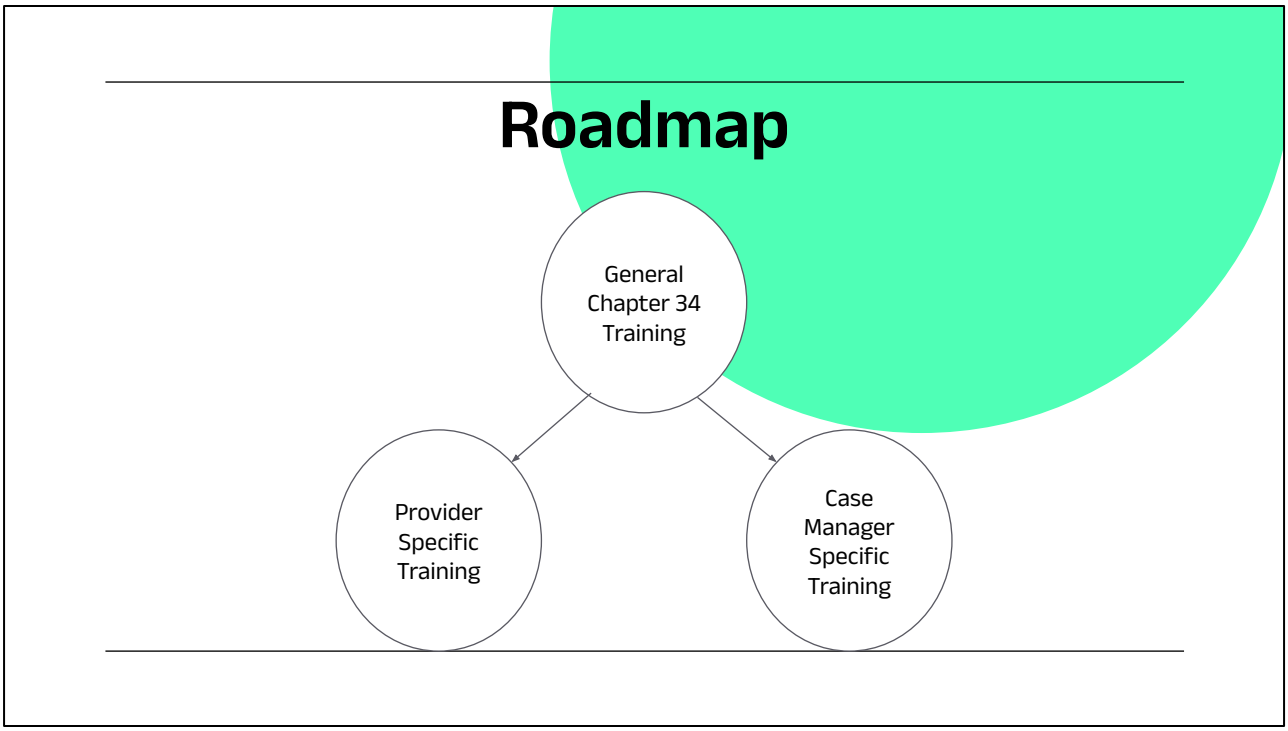
Chapter 34 CCW Provider Training

January 23, 2024

HOME AND COMMUNITY-BASED SERVICES

WYOMING MEDICAID
DIVISION OF HEALTHCARE FINANCING

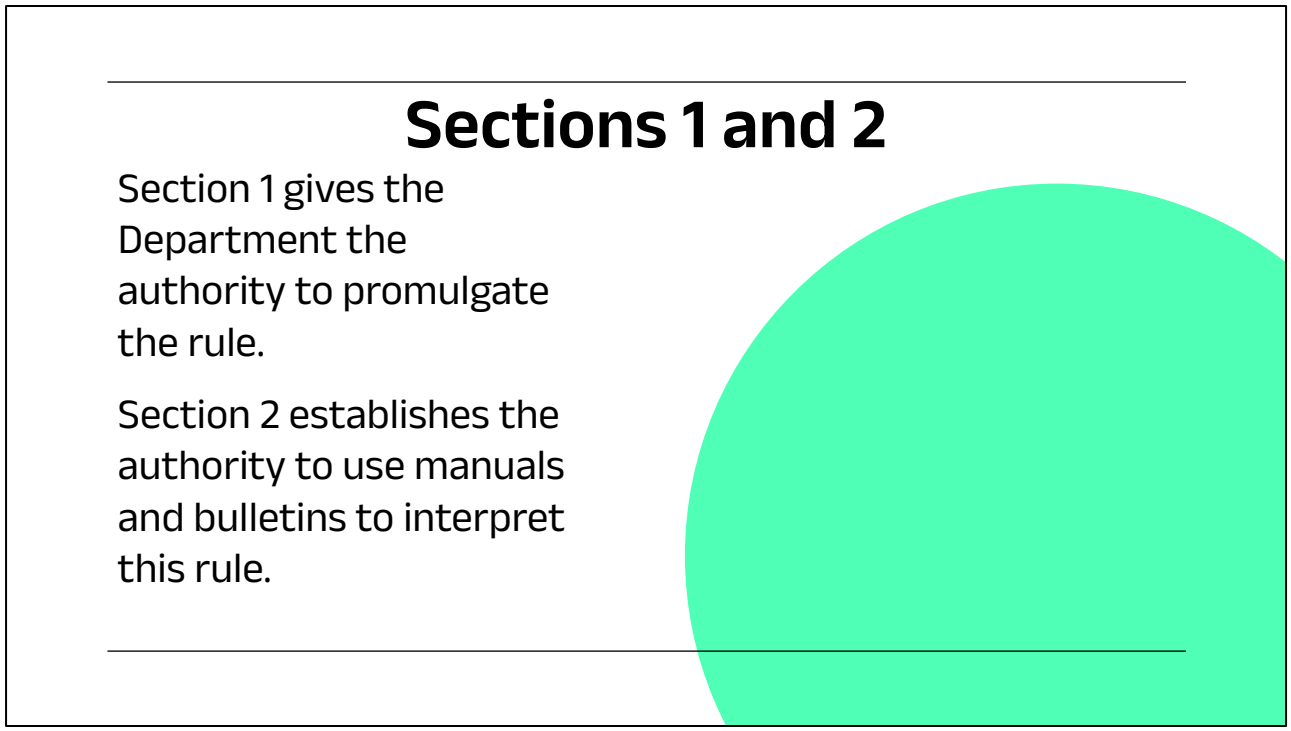
Wyoming Department of Health



Before we get into the details of Chapter 34 we want to review the goal of today's training and what to expect going forward. Today's goal is to give a general overview of Chapter 34 and to highlight important information in different Sections. After today, you can expect to receive further guidance from our Provider Support Unit and our Benefits and Eligibility Unit in the upcoming weeks during the normal scheduled support calls. Also please note that the rule is currently in effect so everyone is expected to be in compliance with this rule. However, we do understand with a situation like t

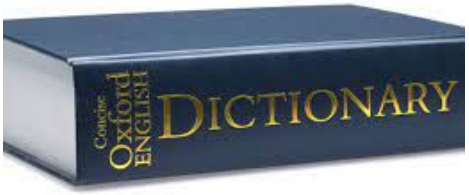
Why have Administrative Rules in the First Place?

- The purpose of Chapter 34 is to establish administrative rule for the Community Choices Waiver program. The rule itself hasn't been updated since before the year 2000 and a need was recognized for a document which aids in aligning all things waiver related from our waiver agreement to our day to day operations. But why have an administrative rule at all? Rules can feel cumbersome and it would seem obvious what the difference is between right and wrong. The reality is that most people want to do the right thing, but sometimes they don't have the knowledge or self-awareness to do so, until rules are established. Complying with rules creates an environment where people feel safe and comfortable. Rules set guidelines and boundaries for participants, providers, and the Department of Health. They provide the framework for the Community Choice Waiver program, and clearly state what is allowed and not allowed. Rules promote consistency. Everyone is expected to comply with the rules, regardless of who you work for or where you live, and apply to everyone equally every time. The HCBS Section cannot pick and choose the rules they will enforce, and cannot make exceptions, regardless of how compelling a particular situation may be.



Starting with a very short explanation is Section 1. Section 1 speaks to the authority the Department has in promulgating the rule. Then we have Section 2. Particularly we have Section 2, Subsection (c) which states that the Department may issue manuals and bulletins to interpret this Chapter. The rule provides the overall program expectation, but process, practices, and other program standards are further clarified in the manuals issued by the HCBS Section and hold the same level of enforceability as rule. The CCW program has a case manager manual and a provider manual, and these manuals are updated as necessary, based on the issues that arise and if there is any need further clarification. These manuals can be found on our website under the CCW Providers and Case Managers tab.

Section 3 - Definitions



Just briefly, Section 3 covers the definitions of a few words used in rule. Any word that is not defined in this section has the same meaning as outlined in Chapter 1 of Medicaid Rule.

Section 4 - App. Process

Section 4 establishes base processes and standards for individuals applying to be placed on the Community Choices Waiver. Also contains info related length of time for applications to be reviewed.

Section 5 - Eligibility

Section 5 establishes eligibility requirements for the Community Choices Waiver. This Section also states the time frames associated with the nursing facility level of care assessment.

Section 4 establishes the process and standards for people who are trying to apply to the Community Choices Waiver. This Section states the application must be signed, completed, and dated by either the applicant or the legal guardian assisting the applicant. This Section also allows for applicants to request a Case Manager to assist the applicant with the application. This means helping the participant collect the information, with filling out the appropriate fields, etc). Once the Division has received ALL required information for an application, the Division has 30 calendar days to determine if a participant is eligible for the waiver.

Section 5 covers eligibility. Section 5 names all factors an applicant has to have in order to be eligible for the Community Choices Waiver. The eligibility requirements listed in rule are a duplication of what is contained within our waiver agreement with the federal government. This Section does contain mention of ineligibility factors by stating a person may no longer be eligible for the waiver provided they no longer meet the Nursing Facility Level of Care requirements or if a participant goes to an institutional setting for longer than 30 days.

Section 6 - Reserved Capacity Waiting List

We Don't Have One, But We May One Day

The most important part of this Section is that the Community Choices Waiver DOES NOT currently have a waitlist. However, the Division maintains the right to implement one if there is ever a reason to implement one. In the case we do have a waitlist one day, this section explains the guidelines on how people will be added to and funded from the waitlist.

Section 7 - Loss of Eligibility

A participant loses eligibility for the following reasons:

- No longer meets eligibility requirements.
- Does not receive minimum services
- Living in an institutional setting
- Re-evaluation
- Living out of state
- On another waiver

Section 7 is mostly just Section 5 which covers eligibility but opposite. However there are two important parts of section 7 we need to highlight. First, is that a participant may be terminated from the waiver if the participant has been in an out of state placement or residence for 6 consecutive months. I want to highlight the Division deliberately used the wording “MAY BE TERMINATED” as there are times when participants are out of the state for longer than 6 months but the Division would still consider a participant eligible for the waiver.

Secondly, a person MAY be terminated from the waiver if they are enrolled in a different waiver. This is also a case by case basis as sometimes we have participants move from our Community Choices waiver to our Supports waiver. To ensure continuation of care, we may allow someone to continue receiving services on CCW until their services start on the Supports waiver even if they are technically considered enrolled on the Supports waiver.

Section 8 - Provider Certification and Recertification

- Section 8(a) - You cannot be paid to provide services unless Medicaid and CCW certified provider. 8(g) also states certification cannot occur retroactively.
- Section 8(b) - Authorizes the section to establish provider qualifications and standards
- Section 8(h) - Providers must adhere to the Chapter 3 Medicaid Rule conditions.

- Section 8 addresses provider certification and recertification Section 8(a) is critical, and establishes that, in order to be paid to provide services through the CCW, you must be enrolled as a Medicaid provider and certified as a CCW provider. Until you are established as a Medicaid provider and a CCW provider, you cannot be reimbursed for the services you provide. Subsection (g) further states that you cannot be certified retroactively. If you provide services before you are certified, or during a time when your certification has lapsed, we cannot backdate your certification to allow you to be paid.
- Section 8(b) authorizes the HCBS Section to establish provider qualifications and standards. These qualifications and standards are outlined in the agreement with CMS, and further clarified in the manuals issued by the Division. The HCBS Section is obligated to ensure that providers meet these standards and qualifications at all times, and must report to CMS any situation in which a provider fails to meet established qualifications. If a provider fails to meet the established standards and qualifications, the HCBS Section will try to work with them to bring them into compliance; however, if they continue to be out of compliance, the HCBS Section must act accordingly, which may include issuing the provider corrective or adverse action. This type of action is not intended to be malicious, but is necessary in order to ensure the integrity of the program.
- Section 8(h) states that all providers must adhere to the conditions for Medicaid provider participation contained in Chapter 3 of Wyoming Medicaid rules. Please remember that, as a CCW provider, you are also a Medicaid provider and must adhere to the requirements for all Medicaid providers, including those to which you agreed when you signed the Medicaid Provider Agreement.

Section 8 Continued

Section 8(i)-(l) addresses provider certification renewals:

- Providers will receive a task in WHP portal 120 days before expiration.
- Provider must verify they meet renewal requirements 45 days prior to expiration.
- If documentation is not submitted, a transition plan is due 20 calendar days prior to expiration.

- Section 8(i) - (l) address provider certification renewals. While we have had some really good experiences with getting CCW providers recertified, one of the ongoing concerns that the HCBS Section has had is the collective inaction of CCW providers to complete their CCW certification before it expires, which leaves them without certification for a period of time. Now that we have solid timelines established in rule, we hope that providers will better understand the steps they need to take to renew their provider certification.
    - As established in Section 8(i), providers will receive a task in the WHP portal at least 90 calendar days, but most likely 120 calendar days, prior to their certification expiration date. This gives the provider approximately 4 months to complete the recertification process. If the provider starts the process when they receive the first email, then they should have very few problems completing the process on time. However, providers often wait until the month their certification is due to expire and that, bluntly stated, is too late. A provider that waits that long risks their certification expiring and not being paid for services.
    - Section 8(j) states that providers must verify that they have met all applicable certification renewal requirements 45 days prior to their certification expiration. This means that they must have submitted all required documentation into the WHP portal, AND had that documentation reviewed and accepted by the HCBS Section. If the provider has not met this deadline, the HCBS Section will begin the process to decertify the provider, to be effective the date their certification expires.
    - As indicated in Section 8(j)(ii), if the provider does not submit this

- documentation, they are then required to submit transition plans that detail how they will ensure that participants are transitioned to different providers. These transition plans are due at least 20 calendar days prior to the provider's certification expiration date. These transition plans are not optional.
- Providers that fail to recertify within the required timeframe will be considered a voluntary decertification, and may reapply at any time. However, if they fail to submit the required transition plans, the HCBS Section may impose additional adverse action which could negatively affect the provider's application, should they choose to reapply.

Section 9 - Provider Participation Standards and Decertification

Providers must offer and render services without discrimination, and must identify any conflict of interest in accordance with Section 9(b).

Section 9 also requires providers to implement HCBS identified policies. Providers must provide services as outlined in the CCW Service Index and the participant's service plan.

Section 9 - Provider Participation Standards and Decertification

- Section 9 addresses, generally, the standards for provider participation and decertification. Providers must offer and render services without discrimination. Providers must also identify in writing any potential conflicts of interest that may exist with their employees, the participant, other service providers, or the participant's legal guardian, and explain how that conflict will be addressed in accordance with section 9(b). This information must be shared with the affected parties and the participant's case manager prior to accepting the participant into services, so that the participant is aware of the conflict and can make an informed choice regarding the services and providers they choose.
- Section 9 establishes that providers must institute the policies required by the HCBS Section, and must provide services that meet the definitions established in the CCW Service Index and are identified in the participant's service plan.

Section 9 Continued

Section 9(f) - Providers should only agree to provide services if they have the adequate resources and systems.

Section 9(k) - The HCBS section may try to resolve non-compliance through technical assistance or corrective action.

If a provider fails to meet standards and qualifications, the HCBS section may take adverse action up to and including decertification.

- Section 9(f) is particularly important, and establishes that providers should only agree to provide services if the provider has adequate resources and emergency backup systems necessary to provide the services. The provider should not agree to provide services if they are not equipped to do so.
    - If, for any reason, the provider needs to terminate services with the participant, they must notify the participant and the HCBS Section in writing at least 30 calendar days in advance. The provider must continue to provide services during the 30 days, or until the participant secures another provider…whichever occurs first.
- As indicated in Section 9(k), the HCBS Section may try to resolve suspected non-compliance through technical assistance or corrective action. Technical assistance is a more informal attempt to cooperatively bring a provider into compliance, while corrective action is a formal way to bring a provider into compliance. Neither of these actions is considered an adverse action, so the provider cannot seek reconsideration or a fair hearing.
    - If a provider is required to submit a corrective action plan, they must follow the process outlined in the provider manual to submit a plan that explains the actions they will take to address each area of non-compliance, the individual within their organization that is responsible for each action, and the anticipated due dates. Providers will also be required to identify the actions they will take to ensure that they remain in compliance.
- Finally, the HCBS Section wants providers to be successful. The CCW program doesn't exist unless we have qualified providers to offer the services that our participants need. However, if a provider fails to meet the established standards and

- qualifications, the HCBS Section may take adverse action, up to and including decertification.

Section 10 - Background Screening Requirements

All providers and associated staff members must successfully pass a full background screening when hired and every five years thereafter.

Important Note: A worker can provide unsupervised services at provider's discretion if the worker did not disclose a qualifying crime on their application.

Section 10 - Background Screening Requirements

- Section 10 addresses background screening requirements. These requirements have been in place for some time, but Chapter 34 now reflects what has been established in CCW agreement with CMS. As a reminder, all providers and associated staff members, including managers, supervisors, direct-care staff, and workers hired through participant-direction must successfully pass a full background screening that includes:
    - A DFS Central Registry screening;
    - An OIG Exclusions Database search; and
    - A name and social security based criminal history database screening.
- Backgrounds must be screened every five years.
- At the discretion of the provider, an individual worker can provide unsupervised services on a provision basis while the results of a submitted screening are pending, as long as the worker didn't disclose a disqualifying crime on their application.
- Providers must maintain background screening results in their employee files. Background screenings cannot be transferred from one employer to another.

Section 11 - Provider Training Standards
And
Section 12 - Covered Waiver Services

We aren't going to give these two Sections a lot of stage time as they are relatively short and they mostly explain themselves. Section 11 covers the training standards for all providers as required by the Division in order to be a Community Choices Waiver Provider. Section 11 covers required documentation of training, receiving training on the service plan, and highlights that training must occur before the service plan starts or any changes to the service plan come into effect.

Section 12 - covers the categories of services offered on the Community Choices Waiver. This is not a word for word list of all services offered, just that all services that we do offer fall into one of the service categories mentioned in this section.

Section 14 - Participant Rights And Safeguards

Section 14 - Participant Rights and Safeguards

- Section 14 addresses participant rights and safeguards. CCW participants have always had the same legal rights and responsibilities as guaranteed to other citizens under the US and Wyoming constitutions and state and federal laws, but this section also addresses how these rights may be restricted in limited circumstances. Rights restrictions are already established in the CCW agreement with CMS and the provider and case manager manuals, but Chapter 34 now reflects this issue as well.

Section 15 - Incident Reporting and Complaints

Critical Incidents

Must be reported immediately after assuring the participant's health and safety or immediately after being notified of the incident.

Non-critical Incidents

Must be reported within three business days after assuring the participant's safety or after being notified.

Section 15 - Incident Reporting and Complaints

- We have had several questions about the incident reporting requirements that went into effect on April 1, 2023. Section 15 now aligns with the requirements that are outlined in the CCW Provider Manual.
- Every provider is responsible for reporting incidents through the WHP portal. Providers cannot delegate incident reporting responsibilities to the case manager, or vice versa. A provider's failure to report incidents may result in corrective or adverse action.
- As established in Section 15(b), providers are responsible for ensuring the safety and well-being of the participants they support. Incident reports should be filed only after immediate medical, health, or law enforcement interventions have been addressed.
- Critical incidents include suspected abuse, neglect, exploitation, and unexpected death. Critical incidents must be reported immediately after assuring the participant's health and safety or, in the event of an unexpected death, immediately after being notified of the incident.
- Reportable non-critical incidents must be reported within three (3) business days after assuring the participant's health and safety or, in the event of death, within three (3) business days of being notified of the incident. Non-critical incidents include the use of restraint or unauthorized use of restrictive interventions; seclusion; serious injury; elopement; medical, behavioral, or emergency room admissions that are unexpected and occur while the participant is receiving services; and death that does not meet the definition of "unexpected."

Section 15 - Continued

Important Points of Emphasis for critical and non-critical incidents

- The scope and duration will vary.
- Providers must have a system in place for handling complaints.
- The HCBS Section provides a guidance manual.

- The HCBS Section will investigate incidents; the scope and duration of the investigation will vary based on the circumstances.
- Providers must have policies and procedures for handling complaints in accordance with the requirements of the Long Term Care Ombudsman. Providers will typically file incidents; however the HCBS Section also maintains an electronic complaint system. Complaints can also be filed through the WHP portal. This system is not intended for providers to report on situations with participants in their services; those concerns should be reported as incidents. However, if a provider has a complaint or concern regarding a participant that is outside of their services, or if a participant wants to file a complaint, the complaint process would be the appropriate filing mechanism.
- The HCBS Section has created guidance manuals for filing incidents and complaints. For more Information, please refer to the guidance documents on the HCBS Document Library.

Code of Federal Regulations Title 42 (CFR 42) establishes the rules for waiver programs. To implement waiver programs the DOH must have an agreement with CMS and service as a contract with the Federal Government. DOH must maintain compliance with these federal agreements in order to receive funding.

- This upcoming Section is the bread and butter of what we at the HCBS Section are responsible for. As I am sure we have covered ad nauseam, the Code of Federal Regulations Title 42, which is usually referred to as CFR 42, establishes the rules for waiver programs like the CCW.
    - In order to implement waiver programs throughout Wyoming, the Department of Health must have an agreement with the Centers for Medicare and Medicaid Services (CMS), the federal department with oversight authority for all state waiver programs.
    - These agreements are the Department's contract with the federal government, and establish details such as the services that will be offered, provider qualifications, costs limits, and health and welfare assurances.
    - The Department must maintain compliance with these federal agreements in order to receive funding from the federal government - funding that accounts for 50% of the money budgeted for waiver services throughout the state.

Section 16 - Home and Community-Based Settings Standard

This section was added to directly align with CFR 42.

Participants have the same rights and responsibilities that other community members have and must have a lease in provider controlled settings.

Section 16 - Home and Community-Based Settings Standards

- The regulations require providers of home and community-based services to ensure that participants have full access to their community, have the freedom to make their own choices, have interactions with whom they want, when they want, and experience privacy, dignity and respect in their life. Additionally, if a participant lives in a provider owned or controlled residential setting, the participant must have a lease that gives them the same responsibilities and protections that any Wyoming tenant has under state, county, city, or other laws…including protection from eviction.
- Providers that deliver services in settings that they control need to be held to a very high standard to ensure that the participants receiving those services continue to have the rights and responsibilities that other community members have.
- This section directly aligns with the federal regulation, but is also included in Chapter 34 to ensure that participants and providers are held accountable to these standards.

Section 17 - Case Management and Service Planning Requirements

Established to align with existing waiver documents regarding case management.

Outlines expectations of case management duties.

Defines Conflict Free Case management requirements.

Section 17 gives specific information regarding the case managers responsibility in development and oversight of the plan of care. This Section also outlines the specific requirements case managers must meet to become a conflict free case manager and remain free of conflict.

These requirements were developed to align with the current Community Choices Waiver agreement and provide an outline of the expectations a case manager should provide when agreeing to provide case management services to a participant on CCW. There will be a training on February 12th for CCW case managers to explain further the expectations in regard to these rules and to answer specific questions that case managers may have.

Section 18 - Participant Direction

Section 18 lists out all of the standards and responsibilities of anyone operating under the Participant Directed service delivery model.

Some important things to remember:

- Can be used in tandem with Agency Services.
- Highly dependent on participant's needs on if participant direction is an appropriate option.
- Can voluntary request to switch deliver models.

Section 18 - Participant Direction of CCW Services

- Participant Direction can be used in tandem with Agency services to account for gaps in service access (e.g.: no provider availability in the area, participant's service delivery schedule does not align with agency provider availability, etc.), for participant convenience, or to meet their specific preferences and goals.
- While there are benefits and risks associated with both PD and Agency service models, neither approach is necessarily better. (model neutrality) Whether PD is appropriate for a participant is highly dependent on the participant's needs, goals, preferences, the availability of service providers who can meet those, and the Case Manager's insight and input about the participant's (or delegate's) ability to manage the increased employer and budget activities in compliance with program expectations and rules.
- If a participant is receiving PD services, they can voluntarily request to move to agency services. In some cases the Program may determine that a PD Employer (either the participant or their delegated employer) is not in compliance with Program rules and expectation related to the employer or budget authority that has been granted to them. In this cases, the Program will work with the CM to determine if the PD Employer should be removed from that role and a new Employer put in place, or if the participant should move off of the PD service model and onto an Agency service model. In both cases, the CM will coordinate with the participant and, as necessary, their chosen agency providers to make the necessary plan changes.

Section 19 - Service Authorization and Reimbursement

Services must be authorized before they can be reimbursed. Service Authorization must meet the standards outlined in Chapter 3 of Medicaid Rule.

A provider has up to a year to bill for services. Billing information is made available to the case manager by the 10th business day of the following month once a provider submits a claim for payment.

Section 19 - CCW Service Authorization and Reimbursement

- CCW services must be authorized before they can be reimbursed. Service authorization and reimbursement must meet the standards outlined in Chapter 3 of Medicaid Rules. As a reminder, this chapter addresses provider enrollment and participation, pre-authorization, payment and submission of claims. Every CCW provider is required to meet the standards of this Chapter.
- A provider has up to a year to bill for services. Once the provider submits a claim for payment, they must make that billing information available to the case manager by the 10th business day of the following month.
- For participant direction, employees must submit their within two pay cycles from whatever date the service is provided.

Section 20 - Service Documentation Standards

- Documentation must include
  - Where services were provided
  - The date the services was provided
  - The time the service was provided
  - Initials or signature of individual who provides the services
  - Detailed description of the provided services
- Electronic Documentation is allowed

Section 20 - Service Documentation Standards

- The purpose of documentation is to support the claim that will ultimately be submitted to pay the provider for the service. Although documentation should include information on what the participant did, it is equally important for the documentation to clearly outline what the provider did to support the participant.
- Any time a provider delivers services, they must document where those services were provided, the date the service was provided, the time the service was provided, initials or a signature that identifies the person who provided the services, and a detailed description of the service that was provided.
- Electronic documentation is allowed, but must meet specific standards. Electronic entries must have automated tracking that shows when information was deleted or altered. Any service that requires electronic visit verification must meet all EVV standards established by the Department, which align with federal law.
- Many providers have documentation requirements that are in addition to the CCW requirements. Regardless of the documentation required by other licensing agencies, providers must meet the CCW documentation requirements, even if they have to maintain separate documentation.

Section 20 -Continued

Please remember that service delivery documentation must be completed in timely manner even though providers have up to a year to bill for services.

Case Managers are also waiver service providers and must also meet documentation timeline standards. Documentation must be entered into the Electronic Medicaid Waiver System (EMWS) within five business days of doing the work.

- Even though providers have up to a year to bill for the services they provide, they are still required to document the service provision in a timely manner. They must ensure that their documentation is made available to case managers by the 10th business day of the month following the month the services were provided. If the provider didn't provide services during the month, they must notify the case manager of that fact in writing.
- Case managers are also waiver service providers, and must also meet timely documentation standards. As established in the CCW agreement with CMS and the CCW Case Manager manual, case managers must enter documentation into the Electronic Medicaid Waiver System within five (5) business days of doing the work. Section 20(h) establishes that the documentation within EMWS must be submitted to the HCBS Section by the 10th business day of the month following the month that the case management services were delivered.

QUESTIONS?