AGENDA

- **Program Reminders and Updates**
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  - Closing Cases when Transitioning to DD Waiver Services
  - Adding Participant-Directed Personal Support Services (PSS)
  - Submitting Plan Modifications to End Personal Support Services (PSS)
  - Notifying Financial Management Service (FMS) of Plan Changes
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  - Mom's Meals Provider Documentation
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- **Training on the Participant-Directed Service Delivery Model**

TOPICS

Applications & Change of Agency Requests

When submitting initial CCW Applications or Change of Agency Requests to the Division for processing, please be sure all information is accurate, complete and legible.

Closing Cases when Transitioning to DD Waiver Services

When a CCW case closure is initiated due to an active CCW participant receiving and accepting a funding opportunity to transition to the DD Waiver, it is important for the CCW case manager to *notify all plan providers of the case closure and service end-date.* Initiating a case closure in EMWS will *eventually* end the service lines and automatically notify providers, but the process can be delayed.

Case closures do not complete immediately in EMWS due to software limitations and other factors involved in transition from one Waiver to another. Providers, such as those providing Meal Delivery, are not always notified by the system of the service line end-date until after the fact. Unfortunately, there have been instances where these providers have continued to provide non-billable services far after the service end-date.

When a participant transitions from the CCW to the DD Waiver (and vice versa), it is important for both case managers to work together to ensure a smooth transition and help coordinate and communicate with providers. The Long Term Care (LTC) Unit needs time to complete their review of the case, and the incoming case manager needs time to submit the new service plan within required timeframes. If you have questions or concerns during a transition, please reach out to the assigned BES for assistance.

Adding Personal Support Services (PSS) to Participant Directed Service Plans

Good-to-Go Letters from the Financial Management Service (FMS) Vendor (currently ACES$) must be uploaded to service plans when adding Participant-Directed Personal Support Services (PSS) to a plan. If the case manager does not have a copy of the original Good-to-Go Letter, they may email (ACES$) directly at supportwy@mycil.org to request a copy.

Terminating Participant-Directed (PD) Services

- **Submitting Plan Modifications to End Personal Support Services (PSS)**
  Plan modifications must be submitted to end Personal Support Services on Participant-Directed plans when closures are initiated. As mentioned earlier, it is critical for case managers to contact the Employer of Record and inform them of the PSS service end-date. All PSS providers must also be notified of the service end-date. The Division has received an increase in payment denials to CCW Participant-Directed PSS providers. Submitting plan modifications to end the PSS service line will help prevent further issues.

- **Notifying Financial Management Service (FMS) of Plan Changes**
  It is the case manager's responsibility to notify the FMS (ACES$) of any changes to Participant-Directed services for a participant as soon as possible. There have been occasions when the FMS vendor (ACES$) was not notified that a participant was no longer using the Participant-Directed Service Delivery Option. The case manager is required to complete the *CCW Financial Management Services (FMS) Change Notification Form* whenever the Case Manager or Case Management Agency changes, or whenever a service terminates. This should be completed and submitted prior to the change. If a participant passes away, this should be completed as soon as possible to ensure that services are not billed for beyond the participant's date of death. This is extremely important and is how ACES$ knows what action they need to take.

Chapter 34 Updates

With the roll out of Chapter 34, the HCBS Section has received many questions from case managers and providers on what will be expected of them in relation to the requirements for documentation standards, documentation review, and participant-specific training.

Chapter 34, Section 20(a) describes the information that each provider, including case managers, must document:

- The location of the service;
- The date of the service;
- The time the service begins and ends;
- An initial or signature of the staff member performing the service; and
- A detailed description of services provided.

This is the information that all providers must document every time a waiver service is provided. This information has always been required, but is now supported by Chapter 34.

Section 20(g) further states that providers must make service documentation available to the case manager each month by the 10th business day of the month following the date that the services were provided. The HCBS Section understands that, in the past, this resulted in the provider sending large volumes of information to the case manager, and since case managers are also required to review service utilization, this is causing a great deal of concern for everyone involved.

Providers do not need to send every page of documentation that is recorded in their individual documentation systems. The purpose of providing the documentation is to give case managers a way to review service utilization. A summary, which includes the date, time, name of the service provided (home health, skilled nursing, homemaker), and location if the service was provided outside of the participant's home, will suffice. Again, the HCBS Section does not have a full understanding of each

provider's documentation systems, but this is the same information that would be needed to submit a claim, so it is presumed that there is a mechanism for each provider to ensure that this information is available.

The case manager's review of this information is not intended to be an audit of the provider's records. Case managers are reviewing service utilization to ensure that services are occurring in accordance with the service referral. While we understand that, in the past, this was a question that was asked of participants, we also understand that a participant may not always be forthcoming if they have concerns or don't like or want a particular service. If a case manager identifies a discrepancy between the services a participant is supposed to receive and the services that the provider is documenting, the case manager must reach out to the provider to better understand the problem. Is it a provider staffing issue? Is the participant refusing services? Depending on the reason, the case manager, participant, and plan of care team may need to determine the best approach to address the issue.

Participant-specific training also seems to be of great concern. As established in Chapter 34, Section 11, case managers are responsible for training one staff member from each provider, and providers are then responsible for ensuring that each staff member who works with the participant receives that training. When we speak of participant-specific training, there are some things to keep in mind.

We are not asking case managers to provide skilled training, such as providing nursing training to a nurse. This thought is simply absurd. Home and community-based services focus on the wants, needs, and preferences of the people being served. A nurse coming into a participant's home to provide wound care may not have this information. Training on cultural considerations, WHY a participant wants help with showers only on Tuesday and Thursday afternoons, and any behavioral concerns that the provider might need to be aware of (Joe likes to give the pretty girls hugs), are all important things to know. This is the participant-specific training that we are speaking of. We are finalizing a resource that will give case managers some things to consider when they are developing this information.

The type of information needed will depend a great deal on the services the provider is delivering. For example, a PERS or frozen meal provider will probably not need any training. These are indirect services and the provider won't have any contact with the participant. However, not all indirect services are created equally. For example, homemaker is an indirect service, meaning that the participant doesn't need to be present for the provider to deliver the service. However, if a homemaker is going to clean a participant's house, it would be important for them to know if the participant is very particular about ensuring that everything is placed exactly where it was, or that floral smells are particularly off-putting to the participant. Case managers should talk to participants about what they want their providers to know, and ensure that this information is shared with the providers. We ask that common sense and reasonableness prevail.

Case managers can add the identified participant-specific training information to the service referral. When the provider accepts the service referral, that stands as an electronic signature that they have received the participant-specific information. Case managers will need to ensure that the information is shared with employers of participant-directed services.

Our intent is not to make things hard, but to make sure that providers have the information necessary to build relationships and support the full person...not just the wound or vital sign that the person represents. These are home based services, and the services should be provided in a way that promotes respect, caring, and person-centeredness.

The Provider Support Unit will hold its next CCW Provider Support Call on May 20, 2024. Providers will receive specific training on what they will need to do to demonstrate that the information from the service referral has been shared with the individuals who will be performing the service.

Mom's Meals Provider Documentation

You may already be aware, but we want to mention it again for those that did not see the email from earlier this week. The HCBS Section has been working with Mom's Meals to ensure that they are able to send case managers the required service documentation in accordance with Chapter 34. The Security Team at Mom's Meals has determined that they can only send the necessary reports, which contains personally identifiable information, to the case management agency (CMA) that has been selected by the participant. CMAs that work with participants who have Mom's Meals services on their person-centered service plan must contact **Katie Mednick at katie.mednick@momsmeals.com**, and provide the CMA contact email address to which Mom's Meals monthly reporting should be sent. Please include the following information in the email:

- Name of the CMA
- List of case managers affiliated with the CMA
- Primary email address to which all Mom's Meals monthly reporting should be sent
- Name of the individual who monitor's the email address.

If you have questions regarding this request, please reach out to Katie Mednick at Mom's Meals.

Tiered Email Communications

The total number of emails received can be overwhelming and lead to becoming desensitized to incoming information. Critical communications may get lost in the shuffle resulting in inaction, unresponsiveness and misunderstandings that can be especially detrimental to our stakeholder relations. To help our audience to identify the purpose and priority level of our email communications, a visual, tiered system is now being used. Please note the banner images and subject-line snippets.

- **Level one:** most frequent/please read or reference as needed.
- **Level two:** higher priority; be sure to open and read.
- **Level three:** least frequent but highest priority; response or action needed within 1-3 business days.

WRAP UP

Our next CCW Case Manager Support Call is scheduled for June 10, 2024.

Questions & Answers

What is 200% of the medium amount? Where would we find this information?

This is figured by the fee schedule. The wage paid to the employee cannot exceed 200% of the corresponding maximum rate for the service they are providing. Rates can be found in the current CCW Waiver Fee Schedule available on the HCBS website. To determine the maximum rate you would multiply the existing rate by 200%. It is important to remember that if a participant chooses to pay a

higher rate, their budget cannot exceed the maximum amount of units allowed and must last the entire plan year with the higher rate in place.

With regard to background checks for the employee, what sort of offenses disqualifies an employee? At what level and capacity of the offense? Is there a document that can be reviewed and provided to the employer for when they are looking for an employee?

Pursuant to Wyoming Medicaid Rules, an individual does not meet the background screening requirements:

- If listed on the DFS Central Registry;
- If listed on the Department of Health and Human Services Exclusions Database;
- If a criminal background screening reveals that the individual has been convicted, plead guilty, no contest, or is currently under investigation for an **Offense Against the Person** (Wyoming Statute Title 6, Chapter 2), or **an Offense Against Morals, Decency and Family** (Wyoming Statute Title 6, Chapter 4), or ***any similar law of any other state***. This includes but is not limited to:
    - Homicide (W.S. 6-2-101);
    - Kidnapping (W.S. 6-2-201);
    - Sexual assault (W.S. 6-2-301);
    - Robbery and Blackmail (W.S. 6-2-401);
    - Assault and Battery (W.S. 6-2-501);
    - Human trafficking (W.S. 6-2-701);
    - Bigamy (W.S. 6-4-401);
    - Incest (W.S. 6-4-402);
    - Abandoning or endangering children (W.S. 6-4-403);
    - Violation of an order of protection (W.S. 6-4-404);

Because criminal offense definitions vary by state and participant safety is paramount, providers should seek legal advice when interpreting background screening results.