HOME AND COMMUNITY-BASED SERVICES

WYOMING MEDICAID
DIVISION OF HEALTHCARE FINANCING

Community Choices Waiver Case Management Manual

May 2024

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Summary of Changes

The following changes have been made to this, April 2024, version of the CCW Case Management Manual:

1. For consistency and ease of understanding, some language and organizational features were updated. For example, EMWS process steps reflect updated functionality and terms like 'Person-Centered Service Plan' and 'Assigned Credentialing Specialist' were applied.
2. Chapter 34 of Wyoming Medicaid Rules was added as a reference in Section 1: Introduction and Purpose and throughout the manual.
3. Rights Restrictions and Restraints information was added to the Risk Mitigation section to highlight restraints as a rights restriction.
4. Referring Participants to Non-Waiver Services information was revised to include long-term care programs and service options.
5. The Operating Free of Conflict section was renamed and revised to define targeted case management limitations.
6. The Participant-Directed Service Delivery section was revised to clarify roles and responsibilities of case managers, participants, and designated employers of record.
7. The Participant-Specific Training section was added to define these important training concepts and to clarify case manager requirements.
8. The Case Management Documentation section was renamed and updated to include Documentation of Case Management Services, Review of Provider Documentation, and Participant Files subsections. Information was added to align with Chapter 34 of the Wyoming Medicaid rules.
9. The Closing a Participant's Case section and other areas referencing PCSP closures were updated to include the importance of timeliness and provider communication during person-centered service plan closure processes.
10. An EMWS Task Timeline for case managers has been added as Appendix A.

PLEASE NOTE: As stated in the Section 1, it is recommended that case managers also review the revised CCW *Provider* Manual released in conjunction with this manual. The CCW *Provider* Manual includes important information pertinent to all providers - including case managers. Updates on Certification Renewal, Documentation of Services, Required Written Procedures, Case Manager Training, PCSP Plan Development among others are included.

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Section 1. Introduction and Purpose

The purpose of the Community Choices Waiver (CCW) Case Management Manual is to provide the instructions and references that case managers need to meet with CCW applicants and participants, conduct person-centered service planning meetings, complete necessary paperwork, and develop and submit a comprehensive person-centered service plan (PCSP). This manual is written primarily for case managers, but can be used as a resource for participants, families, and teams.

Case managers are considered **providers** of CCW services. In addition to the requirements outlined in the CCW Case Management Manual, case managers must adhere to all provider standards and requirements outlined in the Community Choices Waiver Agreement that is approved by the Centers for Medicare and Medicaid Services (CMS), Chapter 34 of the Wyoming Medicaid Rules, the Wyoming Medicaid Provider Agreement, and the CCW *Provider* Manual. The CCW *Provider* Manual addresses overall provider requirements such as general responsibilities, filing incidents and complaints, and preventing and reporting waste, fraud, and abuse.

References to the Home and Community-Based Services (HCBS) Section website will be made throughout this manual. The homepage of the HCBS Section website can be found at https://health.wyo.gov/healthcarefin/hcbs/. Other pages of the website can be found by selecting the desired page listed on the navigation bar on the left hand side of the screen; however, most pages will typically be linked in this manual as well.

Case managers are encouraged to contact their area Benefits and Eligibility Specialist (BES) with questions related to the expectations and standards that case managers are required to meet, or questions regarding program rules or policies.

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Section 2. Overview of Case Management Services

Case management is the only required CCW service, which means that every participant must have a case manager of their choosing. The case manager is the key to effectively delivering waiver services. From developing a person-centered service plan (PCSP) that clearly addresses the participant's preferences, to assessing participant satisfaction, the case manager plays a critical role in assuring that the participant receives quality services. The person-centered service plan that the case manager develops will impact the success or failure of the participant's CCW services, and the excellence or mediocrity of their quality of life.

The Case Management Service definition can be found in the CCW Service Index, which is located on the Service Definitions and Rates page of the HCBS Section website. Case managers must adhere to the requirements outlined in the CCW Service Index and meet all applicable state and federal rules. Case manager monitoring is a monthly service.

In a nutshell, the case manager is responsible for developing a participant's person-centered service plan, and coordinating and monitoring the implementation of that plan. The key components of case management services are:

- Using person-centered planning strategies to develop the service plan;
- Evaluating participants using established assessment process;
- Referring participants for non-waiver services and related activities;
- Monitoring the PCSP; and
- Operating free of conflict of interest.

The case manager is responsible for providing education and information to applicants and participants in order to support them throughout the service plan development process and while they are receiving CCW services. Case managers must provide and explain participant materials, including the Participant Handbook, which can be found on the CCW Participant Services and Eligibility page of the HCBS Section website. In order to offer this education and explanation, case managers must be knowledgeable about CCW program requirements, rules, services, and participant rights and responsibilities, as well as the information contained in the Participant Handbook.

Person-Centered Planning

Case managers must use a person-centered approach that complies with 42 CFR §441.301(c)(1) when developing a participant's service plan. At a minimum, case managers must:

- Ensure that the participant chooses who is included and excluded from the service plan development process. This might include friends and family members, natural supports, and others who support the participant throughout the day, such as therapists or clergy. Case managers should offer suggestions, but the participant must ultimately decide who is and is not invited into the process.

- Ensure that the participant or their legally authorized representative leads the service planning process. This will require the case manager to ask questions, support the participant in articulating their preferences, and engage them in the planning process.
- Ensure that participants have the information necessary to make an informed choice of the services and providers that they add to their service plan, including the choice between community providers of their choosing and institutional settings. Case managers must not suggest a specific provider or choose a provider for the participant.
- Ensure that information is provided in plain language and in a manner that the participant understands, including those who have limited English proficiency.
- Ensure that planning meetings occur at times and locations that are convenient for participants.
- Ensure that strategies for solving conflict or disagreements are used throughout the process, and that clear conflict-of-interest guidelines are in place for all planning participants.
- Ensure that an explanation of the participant's specific needs, preferences, and overall goals, as well as a brief description of the specific tasks that the provider will be expected to perform in order to address the participant's needs, preferences, and goals, is included in the service referral.
- Ensure that the completed person-centered service plan complies with 42 CFR §441.301(c)(2). The PCSP must be comprehensive and reasonably assure the health and welfare of the participant, acknowledge the participant's strengths, promote the participant's self-determined goals, address all of the participant's assessed needs, include a plan to mitigate all identified risks, and accommodate participant preferences to the extent possible within the established service limitations and the availability of local resources.
- Ensure that the completed PCSP reflects the participant's preferences, specific needs, and cultural considerations.

More information on developing a person-centered service plan can be found in the person-centered service plan section.

Using Person-Centered Language

Person-centered language demonstrates respect for the participant and puts the person first. Service plans should be written from the perspective of the participant. Case managers should refrain from using emotionally charged language, which is defined as language that elicits an emotional response and is used to project the author's emotions onto the reader, in service plans or other documentation. For example, stating that a participant is cranky when they are asked to complete their exercises is an emotionally charged statement. In this example, the word cranky implies a negative emotion, and describes the participant as uncooperative or unpleasant. It is more appropriate to state that the participant's exercises cause them pain or are physically challenging, which can result in the participant's frustration.

Evaluating Participants Using Established Assessment Process

An evaluation of the participant, using the Participant Profile assessment required as part of the CCW service planning and development process, serves as the foundation of the person-centered service plan. A comprehensive evaluation process is crucial to identifying the participant's strengths, goals, preferences, needs, risks, and desires. In order to develop a service plan that meets the participant's needs, case managers must complete the Participant Profile assessment, which will help the case manager and participant identify any medical, educational, social, or other service needs that should be addressed in the PCSP.

More information on the assessment process can be found in the Completing the Participant Profile Assessment section.

Referring Participants to Non-Waiver Services

Services on a participant's PCSP must not be limited to the services available through the CCW. Medicaid and the CCW program are always the payer of last resort. Wyoming Medicaid Rules require case managers to provide education and information on the long-term care programs and service options available to the participant. Case managers must support the participant in identifying, considering, and when applicable, accessing services and supports outside of the CCW program and Medicaid State Plan, such as other community and local resources (community senior centers, faith-based programs), the participant's family and natural support system, and other relevant resources, prior to considering CCW services. CCW services cannot duplicate or supplant the services available through other funding sources.

While these alternative support options may be discussed during the assessment process, it is also important to discuss them during the service plan development process in order for the case manager to provide more detailed information about each option so the participant is able to make choices that best address the participant's needs.

Monitoring the PCSP

Service plan monitoring and follow-up activities are necessary to ensure that the PCSP is effectively implemented and adequately addresses the needs of the participant. At minimum, monitoring must occur monthly; however, monitoring activities and contacts may occur with the participant, family members, service providers, or other entities or individuals as frequently as necessary.

More information on service plan monitoring can be found in the Service Plan Monitoring section.

Conflict of Interest

The case management agency and case manager responsible for developing the participant's person-centered service plan must meet the following conflict of interest standards:

- The case manager must not be related by blood or marriage to the participant, or to any person paid to provide CCW services to the participant;
- The case manager must not share a residence with the participant or with any person paid to provide CCW services to the participant;
- The case manager or case management agency must not be financially responsible for the participant;
- The case manager or case management agency must not be empowered to make financial or health-related decisions on behalf of the participant; and
- The case manager or case management agency must not own, operate, be employed by, or have a financial interest in any entity that is paid to provide CCW services to the participant. Financial interest includes a direct or indirect ownership or investment interest or any direct or indirect compensation arrangement.
- A CCW case manager may not provide DD (or other) Waiver targeted case management services for the same participants on their CCW caseload.

Backup Case Managers

Every participant must have a specific backup case manager assigned to their case. The backup case manager must be able to step in when appropriate to ensure that service plans are completed and submitted on time, and ensure that participants do not have a gap in needed services or support if their primary case manager is not able to provide services. The case manager must meet with the backup case manager on a routine basis to ensure the backup case manager is familiar with the participant's case.

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Section 3. Participants of the Community Choices Waiver

Eligibility

To be eligible for the CCW, individuals must meet the following criteria:

- Medicaid recipient
  - Determined by the Division of Healthcare Financing's Long Term Care Unit
  - Certain residency and financial restrictions apply
- Target Group
  - Be aged 65 years or older, or
  - Be an adult between 19 and 64 years old with a disability
    - Determined by Social Security Administration (SSA), or
    - Determined by the Division of Healthcare Financing using SSA guidelines
- Nursing facility level of care
  - Determined by the LT-101 assessment conducted by a Public Health Nurse (PHN)

Individuals who are interested in applying for the CCW should visit the CCW Participant Services and Eligibility page of the HCBS Section website.

Choice in Providers and Services

As part of the application process, all applicants must select a case management agency from a list of case management agencies serving the applicant's county of residence, unless provider availability is limited. A searchable list of case management agencies and other certified providers is available on the HCBS Section Homepage, using the *CCW Provider and Case Manager Search* button. Once the participant selects a case management agency, the agency will assign one person as the participant's primary case manager, based on the participant's preferences. Case managers must be conflict-free.

As established in the requirements for person-centered planning, case managers must ensure that participants have the information necessary to make an informed choice of the services and providers that they add to their person-centered service plan, including the choice between community and institutional settings. This will require the case manager to thoroughly explain the differences between various settings and services, and review the providers that are available. The full list of CCW services, as well as a description of each service, is available in the CCW Service Index, located on the Service Definitions and Rates page of the HCBS Section website.

The case manager must also explain participant-directed service options for services that have this option available. If a participant chooses the participant-directed service delivery model, the case manager must help them complete the referral form for the Fiscal Management Services provider. Information on how to access this form can be found on the HCBS Document Library page of the HCBS Section website, under the *CCW Case Manager Forms* tab.

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Section 4. Completing the Participant Profile Assessment

The Participant Profile Assessment must be completed as the first step in the service planning process. Although the completion of the assessment and service planning process can occur during the same meeting, the assessment must be completed before the person-centered service plan can be developed.

The Participant Profile must be completed with the participant present, unless the participant has an appointed legally authorized representative to attend in their stead. Although the case manager can update and add additional information after the initial meeting, the participant or their legal representative must be available at the initial meeting to answer questions.

An annual reassessment must be conducted no sooner than sixty (60) calendar days and no later than thirty (30) calendar days prior to the service plan end date. The case manager must schedule a time and location that is convenient for the participant to complete the assessment, and the meeting should include individuals the participant wishes to have present.

Although the assessment has specific questions that must be addressed, case managers should conduct the assessment as a conversation rather than a series of questions and answers. As often as possible, case managers should ask open ended questions to promote a conversation. When applicable, case managers should ask questions that provide information related to the scope, frequency, and duration of support the participant currently receives, or additional services the participant needs in order to complete tasks or achieve goals. The case manager should consider participant needs identified in the LT101 assessment, and use the Participant Profile meeting as a time to gather more information on those identified needs as well. Case managers should always consider the participant when asking questions, and should reframe questions so that the participant is comfortable responding.

For example, if the Participant Profile or level of care assessment indicates a participant needs assistance with bathing, the case manager should ask questions such as:

- Do you prefer to have a male or female help you with bathing?
- Do you prefer showers or baths?
- How often do you need to bathe? How long does it usually take for you to bathe?
- What type of support do you need? Help washing your hair? Help getting into and out of the tub? Help with all bathing activities?
- What will you do if support is not available?

Case managers should encourage participants to answer questions that will paint a comprehensive picture of how the participant accomplishes a task, their support needs, and their preferences. Answers to these types of questions will help the case manager and participant develop a more comprehensive person-centered service plan that addresses the

participant's needs and preferences. In addition, answers to these questions will help the case manager determine the number of service units to add to the participant's PCSP.

A template of the Participant Profile questions is available for case managers to use in the event they are not able to use a computer to document responses at the time they meet with the participant. This template is available on the HCBS Document Library page of the HCBS Section website, under the *CCW Case Manager Forms* tab. Case managers must enter assessment responses into the Electronic Medicaid Waiver System (EMWS) within five (5) business days of the date the assessment is completed.

Establishing Participant Goals

As part of the overall participant evaluation, case managers should ask the participant what they are looking forward to, what they want to accomplish, and what they need help with in the coming year in order to identify and establish the participant's goals. A goal can be as simple as "I want to stay in my home as long as possible," or may be more involved such as "I want to visit my kids in Florida" or "I want to volunteer to read with school-aged children."

While some goals may seem unattainable, the case manager's role is to help the participant identify steps that can be taken to achieve the goal. It is important to note that a participant's goals may not be directly tied to their waiver services. For example, if the participant wants to read with school-aged children, the case manager may need to help them reach out to the local school district for more information on volunteering. If the participant says they want to work a couple of days a week, the case manager may need to refer the participant to the Wyoming Department of Workforce Services to explore employment opportunities and supports.

Assessment Summary

An assessment summary is available for the case manager to print once the Participant Profile is completed in EMWS. Before a case manager discusses the potential waiver services that a participant can choose, the case manager should review the information from the assessment summary with the participant and the service planning team to confirm that it accurately reflects the participant's goals, strengths, preferences, needs, and risks. Confirmation of this information is critical to developing a comprehensive person-centered service plan.

The participant and case manager should discuss the needs that have been identified to determine if the participant would like to explore services to address them. If a participant chooses not to address a specific need, it becomes a potential risk. The case manager must keep a record of these risks, and review the risks and the consequences associated with accepting these risks on a regular basis. This discussion should be documented in the risk mitigation section of the plan.

More information on risk mitigation can be found in the Risk Mitigation section.

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Section 5. Person-Centered Service Plans (PCSPs)

Case managers must use the Electronic Medicaid Waiver System (EMWS) to create a participant's person-centered service plan (PCSP). Instructions on the technical aspects of developing and submitting a service plan in EMWS can be found in the Navigating the Electronic Medicaid Waiver System (EMWS) section.

Case managers are responsible for developing a comprehensive and accurate person-centered service plan that helps assure the health and welfare of participants. The PCSP must be based on the information included in the Participant Profile Assessment, address their needs and preferences, and identify when and how services will be delivered to the participant. A well-executed and person-centered planning process is a crucial first step to service plan development. Please refer to the Person-Centered Planning section of this manual for more information on the person-centered planning process.

The case manager must contact the participant and legally authorized representative, as appropriate, within five (5) business days of the participant's enrollment approval to schedule the Participant Profile Assessment and person-centered service planning meeting. The Participant Profile may be scheduled for the same day as the service planning meeting, but must be completed in its entirety before the planning meeting can begin. The service planning meeting must be conducted within five (5) business days of the Participant Profile Assessment being completed.

For initial applicants, the service planning process, in its entirety, must be completed within thirty (30) calendar days of the participant's enrollment approval.

Selecting Services

Once the case manager has reviewed the assessment summary and discussed needs, risks and preferences with the participant, they may begin adding services to the service plan. The case manager must know the services offered through the CCW program, and be able to explain the scope and limitations of each service to the participant in order for the participant to make an informed choice. Therefore, it is strongly recommended that the case manager print, or otherwise have access to, the CCW Service Index in order to refer to it frequently. The CCW Service Index can be found on the HCBS Section Website.

Participants should be the primary decision maker in regards to what services they need for their person-centered service plan. The case manager should never make assumptions regarding which services should be included on a participant's PCSP, and then try to meet the participant's needs within the services. The participant's preferences should *always* be considered first.

Non-Waiver Supports

The case manager must work with the participant and service planning team to identify, confirm availability, and coordinate the delivery of non-waiver services and supports. Case managers must provide information and additional referral assistance in order to facilitate the participant's access to non-waiver community supports such as Medicaid State Plan benefits, the Supplemental Nutrition Assistance Program (SNAP), the Low-Income Energy Assistance Program (LIEAP), or the local food bank, senior center, or housing authority.

Referral assistance could consist of providing the participant with the appropriate contact information, or contacting the entity on behalf of the participant if the participant requires or requests that level of assistance. The case manager must document all non-waiver services in the PCSP, including the specific service and support to be provided and a brief description of the tasks to be performed; however, they may not be able to determine the scope, frequency, or duration of non-waiver services that are available to the participant.

Backup Plan for Critical Waiver Services

Case managers must develop and document a backup plan for services that the participant regularly uses in order to ensure the ongoing stability, health, and safety of the participant in which a temporary disruption of service delivery would jeopardize the participant's health or welfare. The arrangements and strategies used for backup services must be tailored to the participant's needs, preferences, and available resources. Backup plans may include, but are not limited to:

- Seeking temporary assistance from a member of the participant's natural support network as documented in the participant's PCSP;
- Contacting the provider agency for assignment of an on-call or alternate caregiver;
- Contacting the case manager to coordinate delivery of an alternate service or support; or
- Employing an on-call or alternate employee under the participant-directed service delivery option.

A backup plan should never consist of the participant calling 911, as emergency response services cannot provide waiver services. Case managers and participants should discuss the importance of having more than one person or option for a backup plan to assure the participant has the most options available to receive services and supports.

Case managers must review the backup plan with the participant no less than annually, but as often as necessary to respond to changes in the participant's needs or circumstances. Case managers must update backup plans as they change.

Estimating Frequency and Duration of Services

The frequency and duration of the services authorized on a participant's person-centered service plan must correspond with their needs. **Frequency** refers to the number of days and number of times per day a service or support is provided to a participant (e.g. 3 days each week,

1 visit each day). **Duration** refers to how long that service or support is provided at each frequency (e.g. 2 hours each visit).

For example, a participant states that they bathe three times a week (frequency) and, with the support of a family member, it takes them one hour each time (duration). If the family member is able and willing to support the participant with bathing once a week, then the participant will still need assistance with bathing two times a week (frequency) for 1 hour each time (duration). If the participant experiences changes in their condition, such as increased incontinence, the participant may need to increase the number of times they bathe. The case manager may need to change the frequency of that service if the family member is not able to provide the additional assistance.

It is the case manager's responsibility to ensure that waiver services are authorized in accordance with the service definition established in the CCW Service Index. Case managers must also ensure that services authorized do not exceed service caps or limitations for the specific service, and that services are authorized within the scope of the service. CCW services are an alternative to nursing facility care, but are not intended to replace a nursing facility. If a participant's needs require services that are outside the scope of the service definition, such as 24-hour nursing, then the participant will need to consider transitioning to a more intensive support option, such as a nursing facility.

Once the participant agrees to the frequency and duration of each service, it is recommended for the case manager to document a draft schedule that demonstrates when services will be provided. The case manager should integrate the participant's preferences into the schedule, such as the specific days of the week that they will receive support with bathing.

Selecting Waiver Providers

A key component of person-centered planning is ensuring that the participant has a choice in who provides their services. After the case manager has drafted a schedule of the services the participant has selected, the participant must select the provider that they wish to deliver the services. The case manager must not suggest a specific provider, nor should they just assign a provider to deliver a service. Chapter 34 of Wyoming Medicaid Rules requires case managers to disclose any ownership of, affiliation with, or financial interest in any potential service providers.

Additionally, the case manager must ensure that the participant has access to a list of all providers that offer the participant's selected services in the participant's county of residence, and should encourage the participant to interview providers to determine if they are a good fit. A searchable database of certified providers is available on the HCBS Section Homepage, using the *CCW Provider and Case Manager Search* button.

Agency-Based Service Delivery

Most CCW services are provided by qualified agency-based service providers. When a participant selects an agency-based service provider, the agency is responsible for hiring,

training, and evaluating the staff members who provide the participant's services The agency is responsible for ensuring that the participant's services are delivered in accordance with their service plan.

Participant-Directed Service Delivery

The participant-directed service option affords the participant decision making authority over select waiver services, and requires the participant to take a direct role in managing them. Case managers must inform participants about the participant-directed opportunities available under the CCW when they are developing the service plan, at the annual service plan review, and any time the service plan is updated due to significant change in the participant's condition. The case manager must inform participants who express an interest in participant direction of the potential benefits, liabilities, risks, and responsibilities associated with that service delivery option.

If a participant expresses interest in the participant-directed service delivery model, the case manager must ensure the participant-directed questions in the Participant Profile have been completed. The case manager must ensure that the participant has access to the Participant-Direction Employer Manual and encourage them to read the manual so the participant has a full understanding of the potential benefits, liabilities, risks, and responsibilities associated with the participant- directed service delivery option. Case managers must also be familiar with the Participant-Direction Employer Manual as it provides detailed information on the role and responsibilities of the employer, including required forms and the Participant Direction Service Plan. The Participant-Direction Employer Manual and other required forms can be found on the HCBS Document Library, under the *CCW Participant/EOR Required Documents* tab.

The participant may choose to direct their own services, or may appoint another individual to serve as the designated employer and direct services on behalf of the participant. The participant or designated employer or record must be able to:

- Understand and monitor conditions of basic health, and recognize how, when, and where to seek appropriate medical assistance;
- Direct the participant's care, which includes training employees to meet the participant's specific needs;
- Interview, select, discipline, terminate, and otherwise manage employees;
- Understand and implement electronic visit verification (EVV) requirements; and
- Develop and maintain a budget and establish employee wages and schedules.

The Division of Healthcare Financing contracts with a private corporation to act as its Financial Management Services (FMS) agency. The FMS supports the participant or designated employer of record by performing financial administrative activities such as processing payroll and withholding payroll taxes. The case manager must help the participant enroll with the FMS. The enrollment form and other FMS documents can be found at https://login.mycil.org/DocumentCenter.

When participants choose the participant-direction service delivery option, the case manager is responsible for providing information and assistance. This consists of, but is not limited to:

- Assisting the participant in obtaining and completing the required documents for participant direction;
- Providing education on EVV requirements;
- Determining the participant-directed budget amount;
- Coordinating with the FMS agency;
- Monitoring participant-directed service effectiveness, quality, and expenditures;
- Reviewing and updating the participant-directed budget as required by the Department;
- Facilitating the transition of a participant to a different service delivery option when the participant voluntarily terminates, or is involuntarily terminated from, the participant-direction program.

The participant or designated employer of record must be able to manage participant-direction responsibilities and activities independently. Case managers may assist with obtaining and completing enrollment paperwork but are prohibited from participating in employment decisions or conducting the employer activities on behalf of the participant. Case managers who engage in employment decisions or conduct these activities on behalf of the participant can be considered a co-employer and be held legally responsible for the employees.

If the participant is not capable of managing the responsibilities associated with participant-directed care, the participant must designate another individual to act as the employer of record or receive services through the agency-based services option. If the case manager identifies violations of participant-directed requirements, they must re-educate the employer of record on their responsibilities. If the case manager identifies ongoing or chronic concerns, they must file a complaint with the HCBS Section, using the online complaint process. The case manager is also responsible for reporting over- and under-utilization of the participant-directed budget, and potential instances of fraud or misuse of participant-directed funds.

Changing Providers

Participants can change providers at any time during the service plan year. Although it is best practice for participants to notify their current provider in advance, they are not required to do so. However, modifications to a participant's PCSP must be submitted into EMWS at least seven (7) calendar days prior to the date that the modification is to take effect.

If a participant chooses to change case management agencies, or case managers within an agency, the outgoing case manager must complete a Change of Case Management Agency form and CCW Transition Checklist, which can be found on the HCBS Document Library page of the HCBS Section website, under the *CCW Case Managers Forms* tab. The outgoing case manager is responsible for notifying the assigned Benefits and Eligibility Specialist (BES) and completing the necessary modification to the PCSP.

The modification, as well as the completed Transition Checklist and Change of Change of Agency form, should be submitted to allow the new case manager to start as quickly as possible, but at the beginning of a month. The outgoing case manager must also ensure that they complete and submit any outstanding documentation, including documentation for the final month of service, before the transition to the new case manager occurs. After that time, the outgoing case manager will not have access to the case in EMWS and will not be able to complete the monthly review, which must be completed in order for the outgoing case manager to bill for case management services.

The incoming case manager cannot begin delivering services until the beginning of the month following the transition in order to ensure that both case managers are able to bill for the services they provide. The incoming and outgoing case managers must work together to coordinate the transition and ensure that the participant's case management services are not disrupted.

Sending Referrals to Providers

While it is important for the participant to choose the provider they want to deliver their services, the provider must ultimately decide if they will or will not provide the services.

Once the participant chooses their services, agrees to the frequency and duration of the services, and chooses the provider they would like to deliver the services, the case manager must send a referral to the selected provider. When sending the referral, case managers must ensure they accurately reflect the frequency and duration of the services, and provide detailed notes of the services needed so the provider can understand exactly what they will need to do to support the participant. Additionally, case managers are encouraged to include participant-specific training information, which is further discussed in the Participant-Specific Training section. Inaccurate referral information may result in the participant's services being delayed. Please note that case managers may need to discuss the referral with providers to clarify information and answer questions.

Once the case manager sends the referral to the provider through EMWS, the provider has two (2) business days to respond to the referral request through the Wyoming Health Provider (WHP) portal by either accepting, denying, or requesting a modification to the referral. When the case manager receives the response from the provider, the case manager must review the outcome (accepted, denied, request for modifications) and follow-up with the participant. If a provider suggests a modification to the referral, such as providing the services on a different day, the case manager must discuss those options with the participant and get their approval before making changes to the referral. If the provider and participant cannot come to an agreement on how and when services will be delivered, or if the provider denies the referral, the case manager must facilitate the participants's selection of a different provider.

If the participant wishes to change providers, the case manager must modify the plan to add the new provider and end the service line for the old provider. The provider being removed

from the plan must acknowledge the service termination date, which ends the service for that participant. For instances in which there is a new skilled nursing provider selected, the new skilled nursing provider must submit a request for prior authorization and approval. A new approval must be obtained at least annually or whenever there is a change in provider or change from LPN to RN or vice versa. Each approval is specific to the provider; therefore, the approval letter for the old provider may not be used when adding a new skilled nursing provider.

Risk Mitigation

When a need is not addressed on a participant's service plan, it is identified as a risk. The case manager is responsible for working with the participant and service planning team to identify services or other community resources to address the risk, or develop effective strategies to mitigate that risk. The case manager must document the steps that will be taken to address or mitigate those risks in order to reasonably assure the health and welfare of the participant.

Refusal of Services

A participant can choose to refuse services and support for an identified risk. This is known as dignity of risk, which is the belief that self-determination and the right to take reasonable risks are essential for dignity and self esteem and therefore should not be impeded or restricted simply because someone is living with some level of disability.

When a participant decides to refuse services or support for an identified risk, or services are not available, the case manager must ensure the participant understands the potential consequences associated with that decision. The case manager must document in EMWS that the participant or legally authorized representative, as appropriate, has chosen not to address an identified risk, that they understand the potential consequences, and are choosing to accept those consequences. Although it is the participant's choice to accept risk, the case manager must keep in touch with the participant in case the participant's situation changes. There is a fine line between a participant accepting risk and neglecting their basic health and safety needs. If the case manager feels a participant is self-neglecting, they must report the situation as self-neglect.

The participant has the right to address the unmet need at a later time. If this occurs, the case manager must work with the participant to modify the person-centered service plan. The case manager should revisit the identified risks frequently throughout the service plan year to determine if risk mitigation is possible.

Rights Restrictions & Restraints

A participant's rights shall not be restricted except in accordance with state or federal law and Department requirements. This includes written authorization by the participant or the participant's legal guardian. Restraints, which are rights restrictions, can only be used if the participant receives services in an assisted living or skilled nursing facility and must not be for

the convenience of service providers. The need for any restraints must be supported by a specific assessed need and documented in the PCSP.

Emergency Restraints

In emergency circumstances, restraints may be used only to ensure the immediate physical safety of the participant or provider when the risk of injury outweighs the risk associated with the restraint. Any emergency use of restraint shall be reported to the Department within three (3) business days.

Prior Authorization of Services

All CCW services require a prior authorization (PA) and approval before the provider can deliver or be reimbursed for delivering services. Providers are notified through the WHP portal that services have been authorized. Once the PA has been issued, it can be found on the Service Authorization page of EMWS. If a provider requests a PA number associated with their service delivery, the case manager must provide this information.

Backdating of waiver services is not permitted. Providers cannot be reimbursed for services that were delivered prior to the date of the PA.

Finalizing the PCSP

Prior to finalizing the person-centered service plan, the case manager must ensure that they have reviewed the participant's rights and responsibilities with the participant, and that all service units and dollar amounts are appropriate and accurate. Once all assessment, service plan development, referral, and prior authorization activities are completed, the case manager can finalize the service plan. The person-centered service plan cannot be finalized if a service line on the plan is backdated.

The case manager must ensure that they and the participant sign and date the PCSP; providers sign electronically by accepting the PCSP in WHP. Additional signatures from a legally authorized representative or anyone else involved in implementing the PCSP must be obtained, as appropriate.

The completed PCSP must be submitted through EMWS. **Initial plans must be submitted no later than the 15th of the month prior to the month of the initial plan start date.** Person-centered service plans are screened through a system review process and may be subject to a manual review by HCBS Section staff. The HCBS Section staff member may request additional information from the case manager as a result of this review. If additional information is requested, the case manager has two (2) business days to respond and enter the additional information into the PCSP. Once finalized, the case manager must provide a copy of the person-centered service plan to the participant and providers listed in the service plan. In order to assure the confidentiality of participant information, providers should only receive PCSP components that are relevant to the services they provide.

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PCSP Review and Modifications

The PCSP must be reviewed and updated at least annually, but may be reviewed more frequently upon request by the participant or in response to a significant change in the participant's condition, circumstances, or providers. **Renewal plans must be submitted by the last day of the month prior to the plan renewal date.**

Modifications to a participant's PCSP must be submitted into EMWS at least seven (7) calendar days prior to the date that the modification is to take effect. The case manager must ensure that they account for this timeline when they establish the effective date of the modification, or the modification may be rolled back to them, which can further delay the implementation of the change that is being submitted.

Participant-Specific Training

Chapter 34 of Wyoming Medicaid Rules requires the case manager to provide participant-specific training to one provider staff member designated by the provider agency. The provider representative must receive participant-specific training prior to the PCSP start date, or before any changes to the person-centered service plan occur.

Case managers are not expected to provide skilled training, such as providing nursing training to a nurse. 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, are all important things to know. Participant-specific training helps to frame services and supports through the eyes of the participant based on their unique needs, desires, goals, and preferences. If applicable to the specific participant, the case manager may include the following topics when training providers:

Care	Communication Style
• Personal illness experiences/attitudes • Care engagement / involvement level • Attitude about receiving care • Participant care goals, personal motivations • Environmental safety concerns • Physical determinants to care - comfort, temperature, lighting, noise, privacy • Social determinants to care - presence of family/friends	• Preferred name/way to address (title) • Verbal, vocal, nonverbal & behavioral cues • Physical determinants to communication - comfort, temperature, lighting, noise, privacy • Social determinants to communication - presence of family/friends • Memory / level of understanding / physical impairments

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Cultural Considerations	Collaboration
● Conversational style, pacing ● Time orientation / personal space ● Touch / gestures ● Language ● Traditions / customs ● Beliefs / cultural influences on health ● Hobbies / interests	● Important family, friends, influences ● Loves/must-haves - Dislikes/must-nots ● Essential routines ● Participant's Concerns/Worries/Fears ○ Economic / social /environmental ○ Health / safety / medication ○ Seasonal ● Participant Needs/Preferences/Risks: ○ Mobility, positioning, touch ○ Meals, snacks, beverages ○ Adaptive equipment use & maintenance ○ Personal Environment / Home

Case managers may use their discretion on how to document that training occurred - it does not need to be face-to-face. It is recommended that case managers 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.

If the case manager chooses another method of providing the training, the elements of the participant-specific training must be shared with the provider in writing, and they must obtain the provider's signature that demonstrates the provider received the training. This information must be available to HCBS Section staff upon request.

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Section 6. Service Denials, Reductions, and Discontinuations

Throughout the course of providing case management services, the case manager may need to recommend that the HCBS Section deny, reduce, or discontinue a waiver service or terminate a participant's waiver enrollment. Service denials, reductions, and discontinuations may occur for many reasons, including:

- Participant indicates in writing that they no longer wish to receive waiver services;
- Participant refuses to meet with their case manager as required;
- Participant is not responsive to service requests or is consistently unavailable to receive services;
- Participant requires supports that are outside the scope of the service or exceed the service limitations; and
- Participant requests waiver services that duplicate Medicaid State Plan or are offered through other funding sources.

While a case manager can recommend a denial, reduction, or discontinuation, the HCBS Section is the sole authority responsible for notifying a participant of the adverse action and the participant's associated rights and responsibilities. The case manager must ensure that the participant agrees in writing to removing services from their service plan. If the participant does not agree, but the case manager feels that services need to be reduced or eliminated from the service plan, the case manager must contact the BES assigned to the county in which the participant resides to discuss the next steps in notifying the participant of their rights.

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Section 7. PCSP Monitoring

Case managers must conduct person-centered service plan monitoring and follow-up activities in order to ensure that the PCSP is effectively implemented and adequately addresses the needs of the participant. Person-Centered Service Plan monitoring is purposeful and must relate directly to the participant's PCSP, health and welfare.

Monitoring must occur monthly; however, monitoring activities and contacts with the participant, family members, service providers, or other entities or individuals may occur as frequently as necessary to:

- Ensure services are being furnished in accordance with the participant's PCSP;
- Review the participant-directed monthly budget allocation, including evidence of EVV compliance;
- Evaluate the effectiveness of the PCSP in meeting the participant's needs;
- Identify any changes in the participant's condition or circumstances;
- Periodically screen for any potential risks or concerns;
- Periodically verify with the participant that the Personal Emergency Response System (PERS) equipment is operational, and report concerns to the PERS provider;
- Periodically assess the participant's satisfaction with the services and supports; and
- Identify any necessary adjustments in the PCSP plan or service arrangements with providers.

During the monitoring process, case managers have a responsibility to communicate with the providers that are listed on a participant's PCSP. Communication with service providers is necessary to:

- Ensure services are being furnished in accordance with the participant's PCSP;
- Evaluate the effectiveness of the PCSP in meeting the participant's needs; and
- Make any necessary adjustments in the service plan and service arrangements with providers.

Monthly service plan monitoring activities may be conducted via phone or HIPAA compliant video conference; however, face-to-face monitoring of the participant in their home must occur at least once per calendar quarter. The case manager should schedule service plan monitoring visits at a time that is convenient for the participant.

Case managers may be required to conduct monitoring for a participant who is temporarily admitted (30 days or less) to a hospital or nursing facility. When this occurs, case managers should contact the facility and coordinate with the participant and facility staff regarding the participant's discharge. This coordination will help to assure the participant has services in place upon discharge and that the services address the needs of the participant, which may have changed.

Any monitoring conducted may lead to follow-up activities that the case manager must complete, including the modification of a participant's person-centered service plan. Monitoring activities may also result in the case manager taking additional actions such as reporting a critical incident or making a referral to Adult Protective Services, law enforcement, the Medicaid Fraud Control Unit, or any other regulatory agency.

PCSP monitoring is not a social interaction with a participant. While it may be likely that a case manager and participant see each other out in the community in which they live, this incidental contact does not count as monitoring and should not be documented as such. For example, if a case manager sees a participant while grocery shopping and they discuss weekend plans, this does not constitute a monitoring activity and should not be documented.

Monitoring Service Utilization

Case managers are responsible for monitoring the participant's utilization of waiver services by reviewing the provider documentation submitted to the case manager on a monthly basis. Providers are required to make documentation available to the case manager each month by the tenth (10th) business day of the month following the date services were provided.

Service utilization data available in EMWS should not be relied upon. The case manager must compare the units used by the participant to the units authorized in the PCSP to identify any potential problems with service access or delivery. Case managers must document identified concerns and address these concerns with the provider. Waiver providers have 365 days from the date of service to submit a claim, which may impact the utilization the case manager sees in EMWS.

Participants have the right to refuse services and, from time to time, other circumstances in the participant's life may cause them to miss scheduled services. The case manager should encourage the participant to notify the provider in advance, if possible, when these circumstances occur. As a component of monitoring service utilization, the case manager is responsible for identifying trends related to these occurrences and addressing them with the participant to understand issues and potential barriers to services. The case manager must work with the participant to identify solutions to identified problems, which may result in a modification to the PCSP to more accurately reflect the participant's needs, such as adding a new provider, finding non-waiver resources to meet the participant's needs, or adjusting the units authorized.

If a participant is admitted to a hospital or nursing home for a short period of time, or if they need to suspend their services for a short time, the case manager should use the On Hold process to notify providers that services should not be provided during the hold time frame. It is important to remember that if the participant remains in a facility setting for thirty (30) consecutive calendar days, the case manager must initiate a closure of the participant's case.

Monitoring for Potential Risk

Case managers must be familiar with the information in the participant's assessment and know the participant's person-centered service plan, risk mitigation strategies, and any other relevant information about the participant to effectively monitor for health and safety. The PCSP and risk mitigation strategies are key to ensuring a participant is receiving the right kind of support, in the right amount, and at the right time to minimize identified risks.

Case managers should complete the following tasks during regular monitoring to determine if a service plan is being implemented effectively and assess the potential for risk.

- Ensure that support is provided according to the PCSP.
- Engage with the participant, their family, significant others, and providers.
- Pay attention to the participant's mood and observe their physical state. Notice the environment and atmosphere of the home or place of service and observe the other people who are there .
- Notice the stress level of the participant, family, and providers. Are those working directly with the participant using their own processes to proactively determine if risks are being identified and addressed? Look for evidence that the participant is healthy, safe, and shows a sense of well-being.
- Reassess the participant's risk strategies and modify them when necessary.
- Discuss what's working and what's not with the participant and when appropriate, with the provider and significant others.
- Provide the necessary resources to anticipate and address situations of risk.
- Maintain ongoing coordination of services to support risk mitigation.
- Engage participants in managing their own risk.

Monitoring for Abuse, Neglect and Exploitation

Participants have a right to be treated with dignity and respect and to receive services and support in an environment that is safe and free from abuse, neglect, and exploitation.

Any person who has reasonable suspicion or knowledge that an adult is being abused, abandoned, exploited, neglected, intimidated, or is neglecting themselves is required by law to make a report to the Wyoming Department of Family Services and/or law enforcement as indicated by the nature of the incident. When a case manager is interacting with a participant, either in-person or via phone or video conference, and has concerns related to abuse that present an immediate danger, the case manager should call for emergency services or local law enforcement officials.

When conducting service plan monitoring activities, case managers must be vigilant about recognizing potential risks for participant abuse, neglect, and exploitation. Some participants require more monitoring than others, and more frequent monitoring may be needed during different times in a participant's life. Any time a participant's condition, behavior, or environment is out of the ordinary, case managers should be aware of signs of abuse, neglect, or exploitation. Heightened monitoring should be conducted when a participant:

- Exhibits signs of stress or increases in challenging behavior;
- Has unexplained injuries or is injured repeatedly; or
- Lives with a family member who is overworked, ill, abuses drugs or alcohol, has been laid off from their job, or has other stressors.

The following considerations may help the case manager identify increased risk of abuse, neglect, or exploitation.

Observation of the participant's home or service setting

- Are staff consistently working multiple shifts?
- Is a supervisor on-site or immediately available?
- Do staff members work well together?
- Is the site clean and well cared for?
- Are participants supported during transition times?
- Are there orderly routines in place, including at shift change?

Observation and discussion with direct support staff and family members

- Is the environment calm or stressful?
- Are participants treated with respect overall and when receiving assistance with transferring or personal care?
- Are appropriate professional and personal boundaries maintained?
- Are participants treated roughly or with impatience when they receive assistance?

Consideration of participant's vulnerabilities

- Does the participant have restricted movement or limited ability to communicate?
- Does the participant have family support?
- Is the participant dressed appropriately for activities and the weather?
- Does the participant have adequate personal hygiene?
- Has the participant kept appointments, or have absences from activities and appointments been reasonably explained?

Discussions with participant

- What is working well for you right now?
- What do you need to make things easier for you?
- What do you eat for breakfast? Lunch? Dinner?
- What do you like about your direct service staff and others who live or work with you? What do you wish you could change about them?

Case manager instincts

- If a case manager notices something that causes them concern, they must follow up to determine if there is a reasonable explanation.

Case managers must not try to conduct an investigation or confront an abuser. Chapter 34 of Wyoming Medicaid Rules requires case managers to report all suspected abuse, neglect, or exploitation to the appropriate authorities and the HCBS Section. If, during monitoring activities, a case manager becomes aware of a reportable incident that has not yet been reported by the provider to the HCBS Section, the case manager must complete and submit an incident report. Case managers must also report all participant deaths to the HCBS Section - even those that occur outside of other waiver services.

Incident Response

A part of the case manager's monitoring activities should include a review of critical incident reports filed on behalf of the participant. When the case manager receives or reviews incident reports, they must always take immediate action to reasonably assure the health and welfare of participants. If the participant's health and welfare is in jeopardy, the following actions are within the authority and responsibility of the case manager:

- Notifying the participant's family;
- Transferring the participant from the place of the incident;
- Making a referral for a medical examination or mental/behavioral health evaluation;
- Implementing the participant's backup plan to provide needed support;
- Assisting the participant to change providers;
- Modifying services or scope, frequency, or duration of services in the person-centered service plan; and
- Referring the participant to other support agencies such as the Wyoming Long-Term Care Ombudsman Program or Wyoming Protection and Advocacy.

The case manager must monitor issues related to an incident until they are resolved. A new Participant Profile assessment, risk mitigation strategies, or service plan updates may be required, and all information must be documented in EMWS. The case manager must document the participant's current status, any outstanding issues related to the incident, how issues will be resolved, by whom, when, and specific expected outcomes. An incident is not considered resolved until all the necessary follow-up activities have been conducted.

More information on the case manager's obligation to report incidents can be found in the CCW Provider Manual.

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Section 8. Case Management Documentation

Documentation of Case Management Services

Case managers must create and maintain sufficient documentation to substantiate the claims submitted for Wyoming Medicaid reimbursement, and demonstrate that the services were delivered in accordance with Division requirements. The required elements of documentation are outlined in Chapter 34 of Wyoming Medicaid Rules. At a minimum, case managers must document the following information for their case management services:

- The location of services;
- The date of service, including year, month, and day;
- When applicable, the time services begin and end, using either AM and PM or military time, with documentation for each calendar day, even when services span a period longer than one calendar day;
- An initial or signature of the staff member performing the service; and
- A detailed description of services provided.

All documentation must be made available to the Department upon request. Case managers that fail to make documentation available, may receive corrective action. Case managers are required to document all monitoring and evaluation activities, and follow-up on the Case Manager Monthly Review (CMMR) in EMWS.

Review of Provider Documentation

As established in Chapter 34, Section 20(g), providers must make service documentation available to the case manager each month by the tenth (10th) business day of the month following the date that the services were provided. For example, if the services were provided on March 7th, documentation is due by April 10th. If services are not provided during a month, providers are still required to report that information to the case manager. Daily documentation for services that span a period longer than one calendar day is also required.

Provider documentation should include a summary, which includes the date, time, type of service (home health, skilled nursing, homemaker), location if it was outside of the participant's home, and the name of the staff member. Providers do not need to make billing documentation available to case managers, unless specifically requested to do so.

Case managers will use the provider documentation to review service utilization and ensure that services are occurring in accordance with the service referral. 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 and determine the best approach to address the issue.

Table 2 describes the service documentation that providers must make available to case managers. Documentation requirements will vary, based on the service the provider is delivering.

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Table 2
Required Provider Documentation to be made available to CCW Case Managers.

Service	Documentation
Direct Services • Adult Day • Assisted Living Facilities • Home Health Aide • Personal Support (participant-directed EORs should refer to the EOR Manual) • Respite • Skilled Nursing	• Participant name • Date and time of service • Location of service (if outside of participant's home) • Name of service provided
Home Delivered Meals	• Participant name • Month of Service • Number of meals delivered • Date of delivery or shipment
Homemaker Services	• Participant name • Date and time of service • Location of service
Non-Medical Transportation	• Participant Name • Date and Time of Service • Number of trips • Service type (accessible/non-accessible vehicle)
Personal Emergency Response System (PERS)	Monitoring • Participant name • Month of service • Date of last event (SOS call) or other "clear alert" procedure - if more than a month, case manager must follow up with participant to ensure system is working Installation • Participant name • Participant address • Date of installation

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Participant Files

It is important for case managers to maintain accurate participant files and service documentation. Specifically, the case manager needs to assure that all information, including but not limited to, guardianship paperwork, physical and mailing addresses of the participant, their legal guardian, and other contacts is up-to-date and accurate at all times. **The case manager must notify the Division and other providers of any changes.**

CMMR

The Case Management Monthly Review form (CMMR) is the formal monthly documentation that the HCBS Section requires case managers to complete for each participant on their caseload, and serves as the official case record for CCW participants. This documentation, which covers the work that the case manager does throughout the month, demonstrates the work that the case manager has completed and justifies the payment that they receive for the services they have provided. It is also the HCBS Section's mechanism for proving to CMS that the CCW program requirements for case management and person-centered planning are being met.

When completed in accordance with the standards established by the HCBS Section, the CMMR form provides a detailed accounting of what a participant is doing, where they are struggling, and where they are finding success. The discussions that the case manager documents on the form are an extremely important piece of the participant's overall case file.

Case managers are expected to document each contact they have with or about the participant in the CMMR. Documentation must include facts, so the case manager's opinions must be clearly identified as such. Case managers must submit documentation that is complete, accurate, and descriptive. Documentation must be written professionally and answer:

- Who was involved in each contact;
- What occurred or was said during each contact;
- When and where the contact occurred; and
- Specific circumstances that precipitated the contact.

The case manager is responsible for talking to the participant, the legally authorized representative, and providers in order to monitor the participant's health and satisfaction with services and providers. Case managers should ask questions in order to get as much information as possible, and describe the participant's overall condition, including any health concerns noted at the time of the contact. For example, the case manager should be aware of signs of participant stress and depression, take note of bruises and other injuries, and provide a detailed accounting in the CMMR of what they observed and what the participant reported. If the contact occurs in the participant's home, information about the general condition of the participant's home environment should be documented.

The CMMR is considered legal documentation, and as such can be reviewed by multiple parties, including CMS, Program Integrity, and other state and federal officials.

CMMR Timeline

It is recommended that the case manager document the work that they do throughout the month in the CMMR within five (5) business days of doing the work. For example, if the case manager has a phone call with a participant on Tuesday, then the documentation should be entered into the CMMR by the following Monday. Each time work is documented on the CMMR, the case manager must select *Save* at the bottom of the CMMR to save their work.

Once the case manager has entered all of their documentation and uploaded any supporting documentation for the month, they must submit the completed CMMR by selecting *Submit* at the bottom of the CMMR. The CMMR cannot be submitted prior to the last day of the month, but must be submitted no later than the tenth (10th) business day of the month following the date of service.

When the case manager submits the CMMR, they are verifying that the information on the CMMR is accurate and complete. Once the CMMR is submitted, the case manager can bill Medicaid for the month.

CCW Quarterly Visit Verification Form

Case managers must conduct an in-person visit at least once every calendar quarter. During this visit, the case manager must complete the CCW Quarterly Visit Verification Form, which is intended to verify that the quarterly visit occurred.

The case manager must record general notes and topics, as well as any decisions or needed follow-up, on the form. The participant or legally authorized representative must sign the form, which verifies that the information on the form was discussed during the visit. The case manager must then document a more detailed account of the visit in the CMMR and upload the form into the CMMR that coincides with the month that the visit occurred in EMWS.

The topic areas that are noted on the form must align with the more detailed documentation that is included in the CMMR documentation in EMWS. Although it may feel redundant, it is important that the participant have a general understanding of the information that the case manager will be including in the participant's permanent record.

The Quarterly Visit Verification is located on the HCBS Document Library of the HCBS Section website, under the *CCW Case Manager Forms* tab.

Retention & Destruction

Case management agencies may maintain records in addition to those required by the HCBS Section. All required documentation must be sufficient to substantiate case management services. Case managers must securely store and retain all confidential case management documentation and documentation received from other providers for a period of at least six (6) years from the date(s) of service listed on the claim, or as otherwise required by Chapter 3 of

Wyoming Medicaid Rules. After which time, case managers should follow safe destruction policies that maintain participant confidentiality . Safe retention and destruction of documentation is required even if the participant changes case managers or is no longer receiving case management services from the case manager or case management agency.

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Section 9. Navigating the Electronic Medicaid Waiver System

The Electronic Medicaid Waiver System (EMWS) is a web-based portal used by the case manager to navigate and manage the service plan development process. EMWS uses role-based processing, referred to as a workflow, to assign tasks within the system. After a task is completed by an assigned user, EMWS automatically sends the case to the next user in the working queue. Users are notified via email and on the EMWS task bar when a task needs to be completed.

Since the case manager's login information and ongoing communication is tied to their email address, they must submit a new EMWS access request through the EMWS portal at https://wyowaivers.com if their email address changes. Additionally, the case manager must submit a Provider Update Form to their assigned Credentialing Specialist or by emailing the Certification and Credentialing team at wdh-hcbs-credentialing@wyo.gov in order to ensure that their contact information is accurately reflected on the provider list. Case managers must always ensure that their contact information is up-to-date in each participant's service plan.

Case managers will be required to upload documents during the course of using EMWS. They must use a standardized naming convention for all documents saved to a participant's file. This naming convention can be found on the CCW Providers and Case Managers page of the HCBS website, under the *CCW Case Manager Resources* toggle.

The case manager has five (5) business days to complete most tasks on the EMWS task list. The case manager must follow the timelines established in the Documentation Timelines section for completing and submitting CMMR documentation.CMMR Timeline

Although this section of the CCW Case Manager Manual is intended to walk case manager's through functionality available in EMWS, it is critical for them to remember that participant evaluations and assessments, service planning and development, and service monitoring and follow up are all part of a person-centered process. Case managers must complete these activities while ensuring that the participant's strengths, preferences, and self-determined goals are promoted throughout the these processes. Please refer to the Person-Centered Planning section for more information.

EMWS - Logging into EMWS

Case managers can access EMWS at https://wyowaivers.com.

The first time a case manager accesses EMWS they must complete the certification process and then submit a request through the web based portal by selecting Continue with Google/ Microsoft Account or selecting the sign up link. Once the request has been reviewed and approved, the case manager will receive an email verifying that the request has been approved.

For ongoing access to EMWS, the case manager can enter their username and password, or can select Continue with Google/Microsoft Account, depending on how their account was created. They will be directed to their EMWS homepage.

Case managers can reset their password by selecting the Forgot Password? link. Users are encouraged to store their username and password in a secure location.

When case managers log into EMWS for the first time, and every 90 days thereafter, they will be presented with the Medicaid Waiver System Confidentiality Agreement, commonly known as the End License User Agreement (ELUA). Case managers are responsible for reviewing, accepting, and adhering to the terms and conditions of the ELUA.

EMWS - Task List

When logging into EMWS, the case manager will be directed to the Task List screen. This screen will display several task lists that the case manager can use to organize their work. The first list shows the case manager's active working queue, which lists their assigned cases, the case status, and required tasks. The work queue is displayed as a grid that contains up to 10 entries. To see additional entries, the case manager must select the page numbers in the lower left corner of the grid.

The second list displays the Case Manager Monthly Review forms for each participant on the case manager's caseload. These forms will populate at the beginning of each month, and will remain on the task list until the form is submitted. Case managers must ensure they are documenting and submitting these forms within the required time frames.

The third list displays the active status of cases that do not require the case manager's immediate attention and was designed to help users track the status of each case.

Administrators of case management agencies will have an additional task list that displays the cases that are the responsibility of other case managers within their agency.

EMWS - New Participant Cases

When a participant selects a case management agency, the agency will receive a task to associate a case manager from within their agency to work with the participant. The agency must consult with the participant on the available case managers. The selected case manager must review the initial demographic and contact information for the participant, and update as needed.

Contact Screen

The case manager is required to enter contact information, including phone numbers and email addresses, for the participant, case manager, backup case manager, medical professionals, and

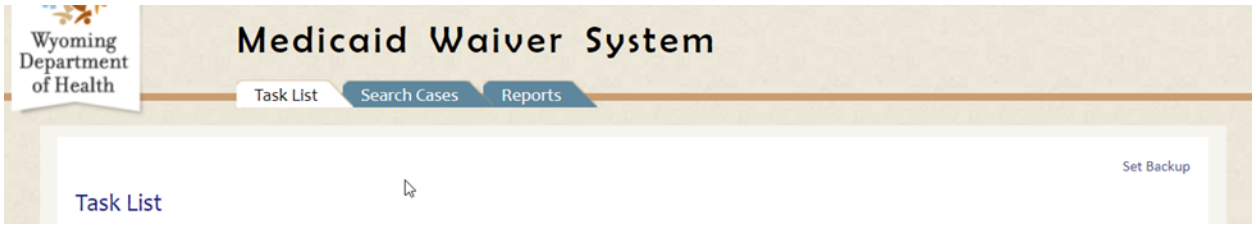
other relevant entities on the Contact screen. If the participant has a legally authorized representative, or has designated an employer of record for participant-directed services, this information must be added and relevant documents must be uploaded to the *Document Library*. The case manager must review this information regularly and ensure that it is up-to-date. The BES will roll back service plans and modifications if case manager contact information is missing.

Backup Case Manager

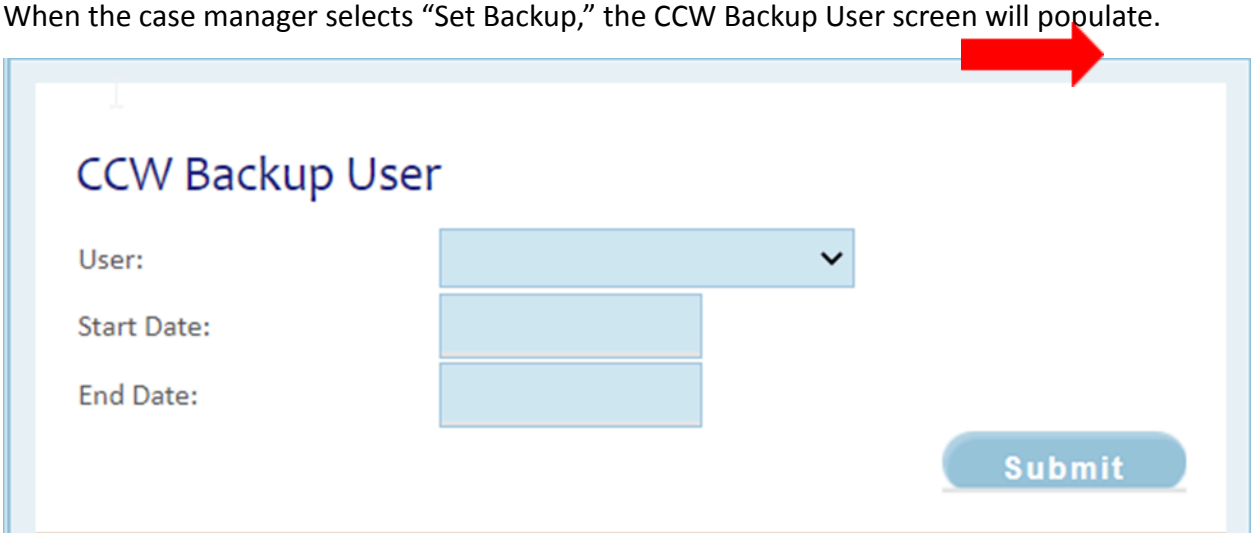
To identify a backup case manager, the case manager must use the drop down menu in the Contact section and select Backup Case Manager. The BES will roll back service plans and modifications if the backup case manager is not identified on the service plan.

Assigning a Backup Case Manager During a Leave of Absence

The case manager may assign a backup case manager to monitor their task list if they will be gone for a leave of absence. This option can be initiated in the top right corner of the Task List screen, and should only be used when the assigned case manager will be gone and unavailable to monitor tasks.



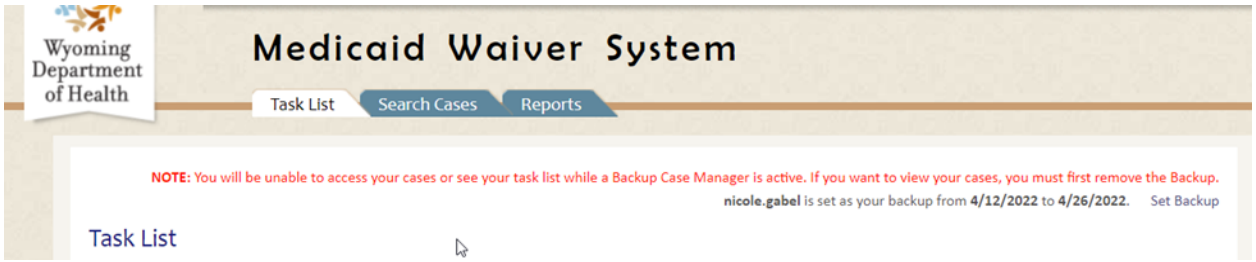
When the case manager selects “Set Backup,” the CCW Backup User screen will populate.



A list of case managers will populate in the user drop down menu. The case manager will select the backup case manager and add the start and end dates. Once "Submit" is selected, the backup case manager will be scheduled for the timeframe identified in the start and end date fields. The case manager may adjust the end date at any time. The backup case manager will

begin receiving tasks for the participant on the identified start date, and the regularly assigned case manager will no longer see their task list.

A message at the top of the Task List screen will appear:



Removing a Backup Case Manager at the End of a Leave of Absence
In order to remove the backup case manager early, select "Set Backup" again and change the end date. The task list will be restored to the regularly assigned case manager on the day after the identified end date.

EMWS - Developing the Initial or Annual Service Plan

The CCW person-centered service plan is presented as a checklist to guide the case manager through the steps of developing a person-centered service plan. Each step is either manually completed by the case manager or completed by the system based on data entered into EMWS. As the case manager completes each step of the checklist, status indicators will display to help identify the status of each step.

If the step is completed, a green check mark will be displayed next to the task.

If the step is in progress, a yellow circle will be displayed next to the task.

If the task does not meet criteria, a red X will be displayed next to the task.

The checklist is designed to be completed in a specific order. Skipping around can cause EMWS to become non-responsive and may prevent the case manager from completing the plan development process.

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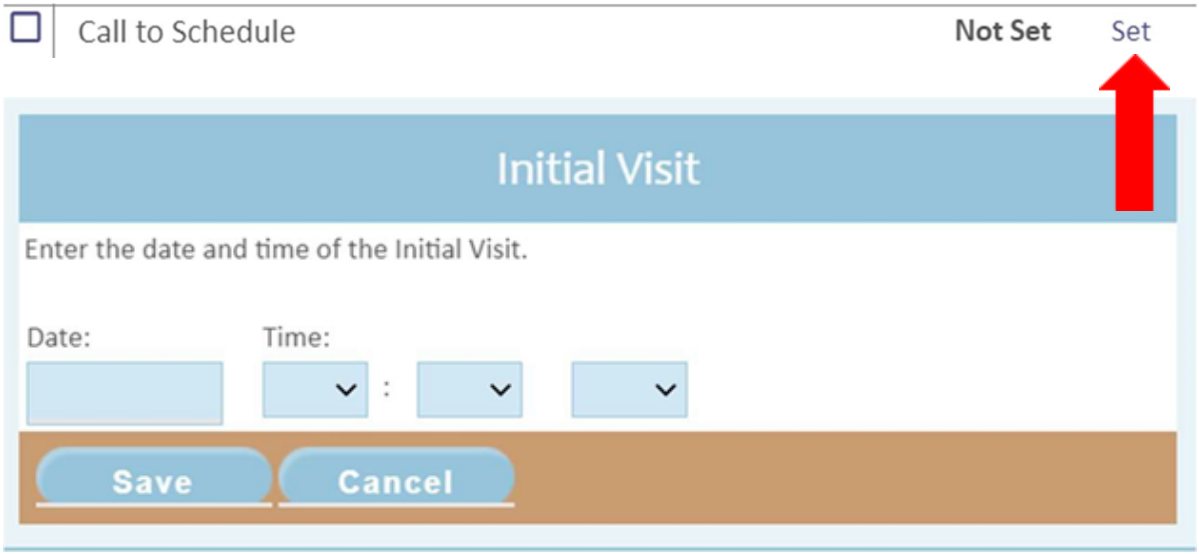
Assessment and Service Plan Preparations

This section lists the first steps in the service planning process. Financial eligibility and level of care determinations must be met before an individual can be found eligible for CCW services.

- **Initial Medicaid Financial Eligibility Confirmation** - Information populated by EMWS based on data entered in the eligibility process.
- **Level of Care Determination** - Information populated by EMWS based on the results of the LT101 assessment. The case manager can select *Select/View LT101* to view the assessment.
- **Target Population Determination** - Information populated by EMWS based on eligibility data. The case manager can select *View Determination* to view the criteria.
- **Call to Schedule** - Case manager marks as complete once finished. Select *Set* and enter the date and time of the initial visit.



- **Coordinate with Natural Supports (if applicable)** - Case manager marks as complete once finished. Please refer to the Referring Participants to Non-Waiver Services section for more information.
- ***Print Participant Handbook & Other Program Documents*** - Case manager marks as complete once finished. Please refer to the Overview of Case Management Services for more information.

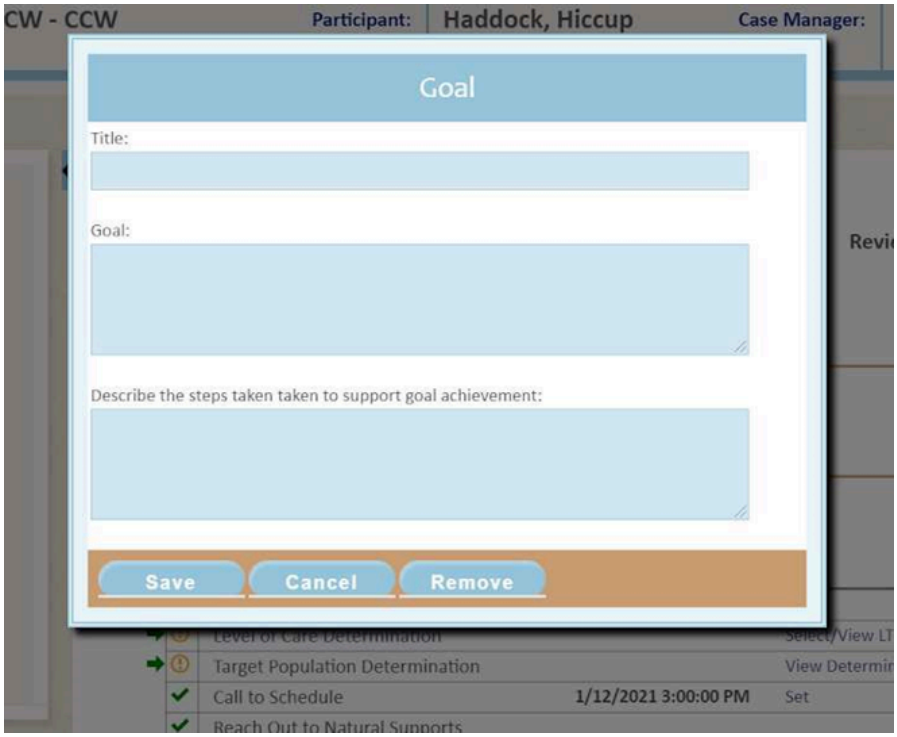
Assessment

The case manager is required to complete the Participant Profile assessment, which will gather information on the following topics:

- Supported decision-making
- Participant direction
- Housing and environment
- Community relationships

For more information on completing the Participant Profile assessment, please refer to the Completing the Participant Profile Assessment section.

- **Discuss Participant Goals** - Case manager marks as complete once finished. Please refer to the Establishing Participant Goals section for more information.
- **Goals** - Case manager adds goals to EMWS. When all goals have been added, the case manager marks as complete.

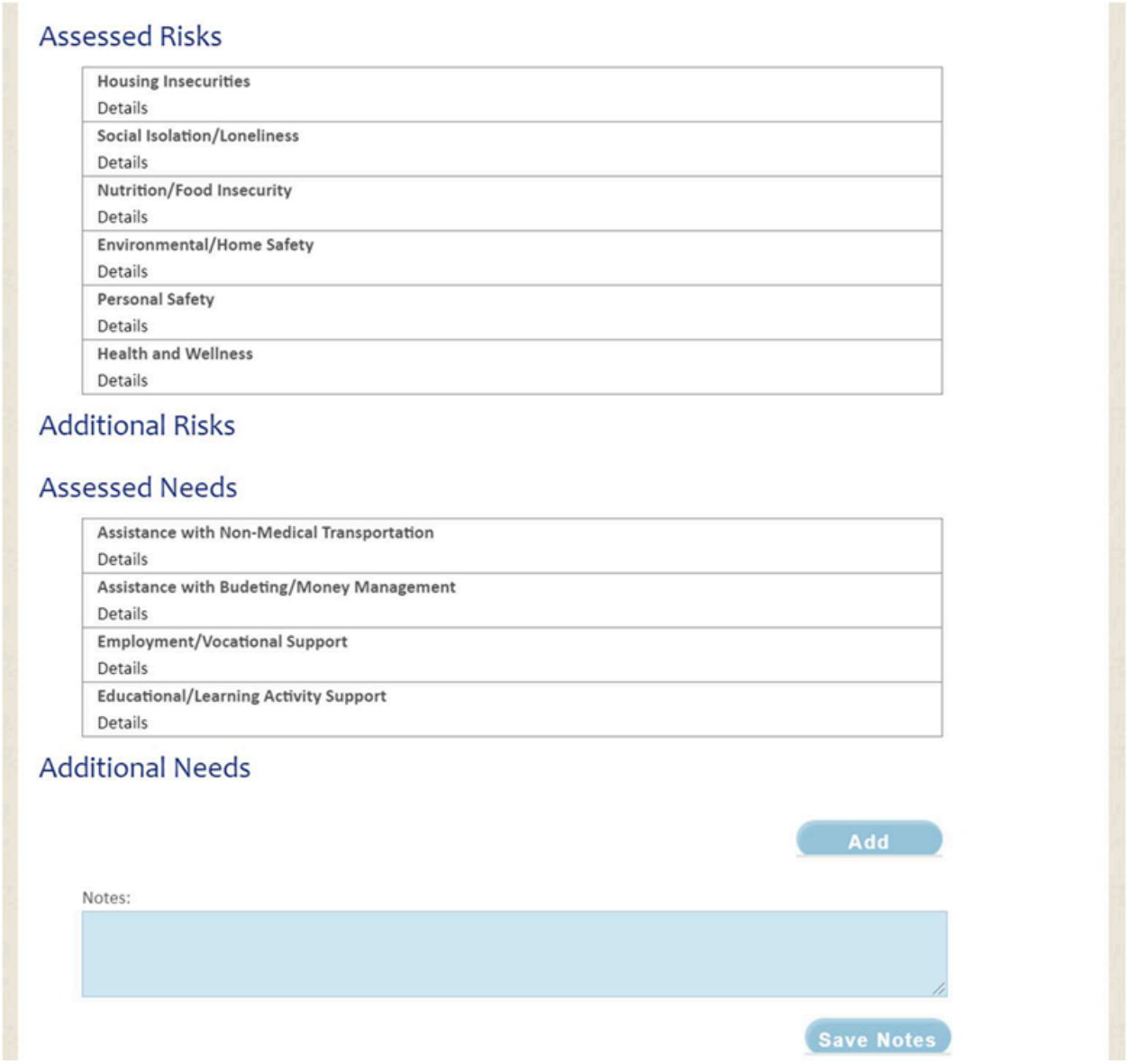


- **Print Assessment Summary** - The case manager must generate and review the Assessment Summary, and add any additional needs or risks that have not been identified through the Participant Profile or level of care assessments. Once finished, the case manager marks as complete. To print the Assessment Summary select *Print Report*.

PCSP Development

- **Review Assessment Plan Summary with Participant** - Case manager marks as complete once finished. Please refer to the Assessment Summary section for more information.
- **Discuss Needs to be Addressed** - Case manager marks as complete once finished. Please refer to the Person-Centered Planning section for more information.

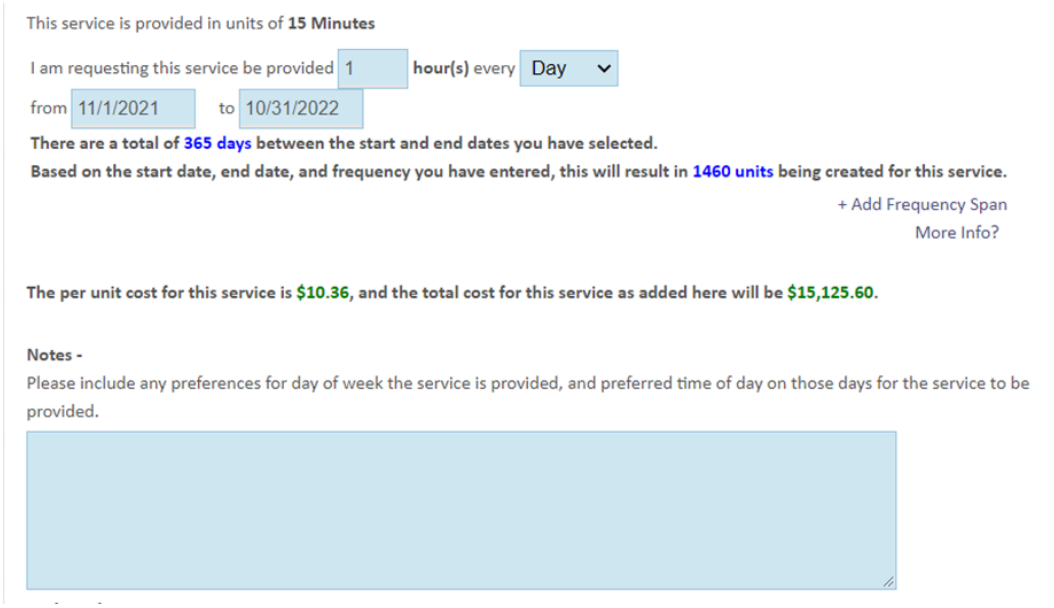
- **Discuss Potential Risks** -Case manager marks as complete once finished. Please refer to the Risk Mitigation section for more information.



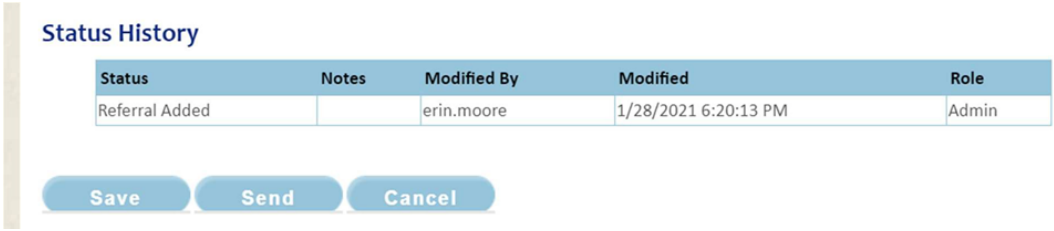
- **Add Services, Supports or Risk Mitigation Plans** - Case managers must add waiver services, non-waiver services, and risk mitigation strategies based on the needs of the participant. Select *Add Services, Supports, and Risk Mitigation Plans*.
- Select *Add Services.*

To add a waiver service, select *Add Waivers Services*

The case manager must enter the service provider the participant has selected, as well as the frequency and details of how the service is to be provided and what need or risk the service is meeting. A list of questions, including a back-up plan for critical waiver services, will populate depending on the service selected. The case manager must answer these questions and upload any requested documents such as ALF agreements, or the Good-to-Go document provided by the FMS.

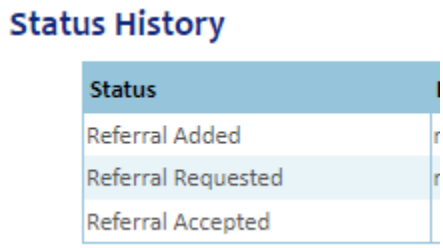


Once the case manager enters all required information, select *Send* to forward the request to the provider.



If the participant selects a participant-directed service, please review the Participant-Directed Budgets section for more information on calculating the participant's budget for these services.

When the case manager sends the request, the selected provider will receive the service referral in the WHP portal. The provider must accept or deny the service request within two (2) business days, or request a modification, and the response will be sent back to the case manager. Requests for modification may require some back and forth with the provider, which can happen as many times as needed until the provider accepts or denies the service request.



The Referral Added status indicates that the referral was added but not sent to the provider. The Referral Requested status shows that the referral was sent to the provider to review. The Referral Accepted status demonstrates that the provider has accepted the referral.

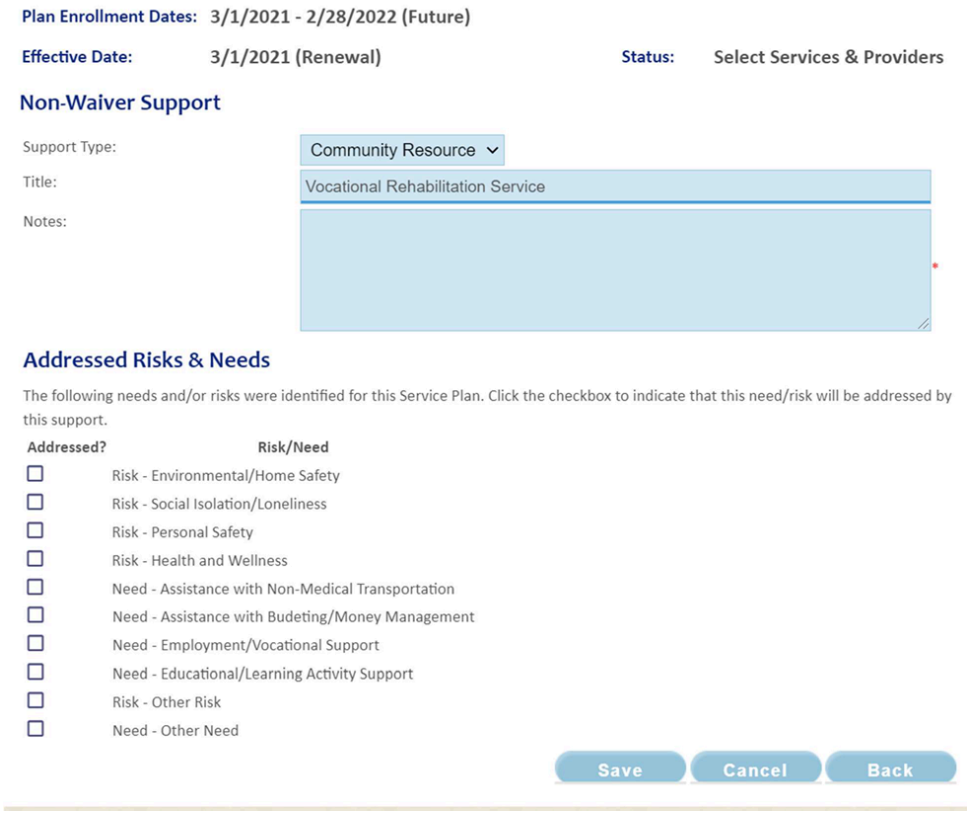
If the service request is accepted, EMWS will recognize the service as complete and will add it to the plan. Once the entire service planning process is complete, EMWS will send the services for prior authorization.

If the service request is denied by the provider, the system will recognize the service as complete, but will **not** forward it for prior authorization. The case manager must follow the process for adding the service with a different provider.

Case management services do not follow this process. When the case manager adds case management services to the service plan, the system will automatically recognize the service as complete.

- **To add a non-waiver service**, select *Add Non-Waivers Support*

The case manager must enter the support type, title, and details of the service being provided, and indicate the risks and needs addressed through the service. Select *Save* to add the service to the plan.



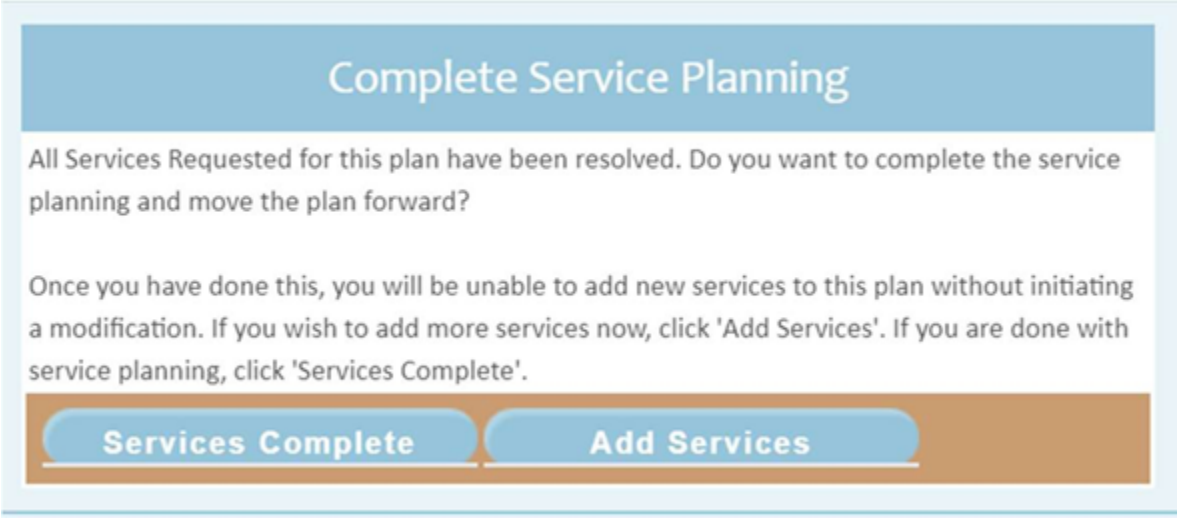
- **To add risk mitigation**, select *Add Risk Mitigation*

Risk mitigation must be added when a risk or need will not be met by a waiver or non-waiver service. Once a risk mitigation is selected, the case manager must enter the contributing factors, title of the risk, and the strategies to mitigate the risk. The case manager will then need to mark the identified risks or needs that will be covered by the mitigation strategies. Select *Save* to add the risk mitigation to the service plan.

- **Await Waiver Service Provider Confirmation** - Information populated by EMWS once all services have been accepted by providers.
- **Print Participant Service Plan Summary** - Once all services have been confirmed by providers, the case manager can select *Print Participant Service Plan Summary* to

generate a PDF document for the participant and service planning team members to sign. A checkbox will populate once the PDF is generated.

- **Complete Service Planning** - Once all service and risk mitigation information has been completed, all services are accepted by providers, and all needs and risks have been addressed, the Complete Service Planning option will be available for the case manager to mark as complete.



Finalize Service Plan

- **Review Service Plan Summary with Participant** - Case manager marks as complete once they have reviewed the service plan with the participant.
- **Upload Participant Agreement** - Checkbox populated by EMWS once the case manager uploads the participant service plan summary and signed Participant Agreement.
- **Finalize Service Plan** - When all steps have been completed, the option to finalize the service plan will change to “Submit Plan”.
- **Submit Plan** - Case manager selects “Submit Plan” to send the plan forward for review. Case manager will be asked if they want to submit the plan for prior authorization. Once *Yes* is selected, the plan will be sent to the Benefits Management System. Initial plans must be submitted no later than the 15th of the month prior to the month of the initial plan start date. Renewal plans must be submitted by the last day of the month prior to the plan renewal date.

Send Services to BMS

- **Medicaid Eligibility Activation** - Completed by Medicaid Eligibility staff
- **BMS Approva**l - Completed by EMWS after the prior authorization has been issued
- **Address BMS Errors** - Will only be populated if an error in BMS occurs
- **Acknowledge BMS Approval** - Case manager must mark as complete when the PAs are received from BMS and the case manager has reviewed the plan for accuracy.

- **Plan Complete** - Completed by EMWS once the case manager acknowledges BMS approval.
- **Print Service Plan** - The case manager must distribute copies of the service plan, in an agreed upon format, to the participant and any direct service providers listed on the plan.

Congratulations! The service planning process is complete!

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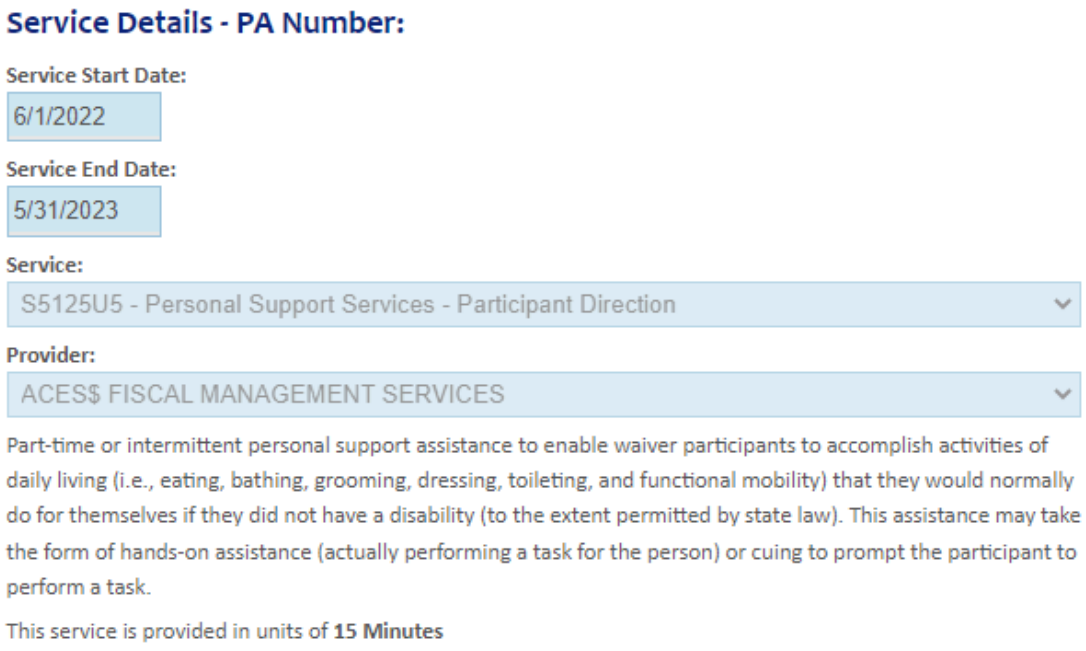
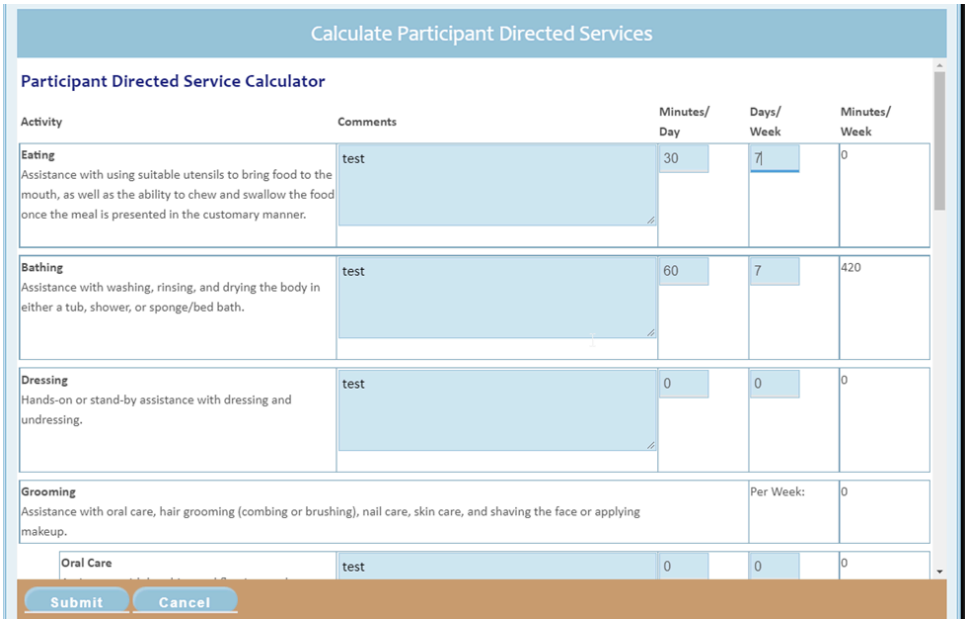
EMWS - Participant-Directed Budgets

When a participant chooses the participant-directed service delivery model, the case manager must enter the frequency, scope and duration of the service in order for the system to calculate a distinct participant-directed budget. When adding the service, the following window will populate.



- The case manager must add Fiscal Management Services as the provider and select *Save and Continue*. The option to select the budget calculator will then be available.
- The case manager must select *Calculator* to open the budget worksheet and input the required information.

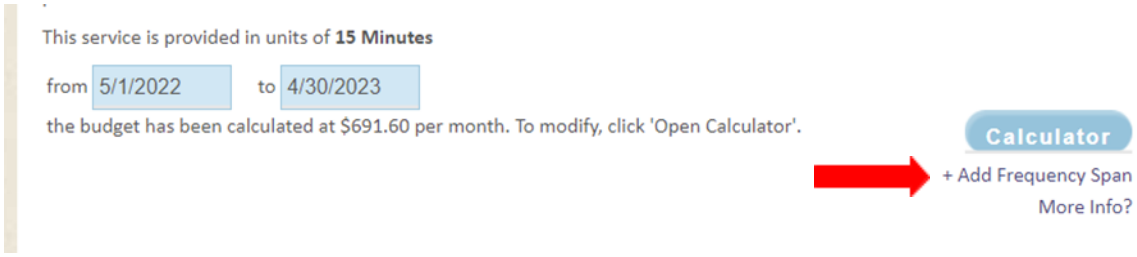


- Comments should include a detailed description of the specific support that the participant needs with each activity.
- When all sections are completed, select *Submit*. The participant's budget for participant-directed services will populate on the service details screen.

Participant Directed Services Monthly Budgets

Dates	Budget
5/1/2022 - 5/31/2022	$691.60
6/1/2022 - 6/30/2022	$2964.00
7/1/2022 - 7/31/2022	$2964.00
8/1/2022 - 8/31/2022	$2964.00
9/1/2022 - 9/30/2022	$2964.00
10/1/2022 - 10/31/2022	$2964.00
11/1/2022 - 11/30/2022	$2964.00
12/1/2022 - 12/31/2022	$2964.00
1/1/2023 - 1/31/2023	$2964.00
2/1/2023 - 2/28/2023	$2964.00
3/1/2023 - 3/31/2023	$2964.00
4/1/2023 - 4/30/2023	$2964.00
Total Budget:	$33,295.60

- If changes need to be made, select *Calculator* again and make changes as needed. Once the budget is correct, submit the request to the provider.
- If the case manager needs to modify a service plan that includes the electronic budget worksheet, they will have the option to add a frequency span. Select *Add Frequency Span* and add the dates for the modification. This will open a new span so that the budget may be calculated for the new time frame. Complete the budget worksheet and select Submit to populate the new budget for upcoming months.



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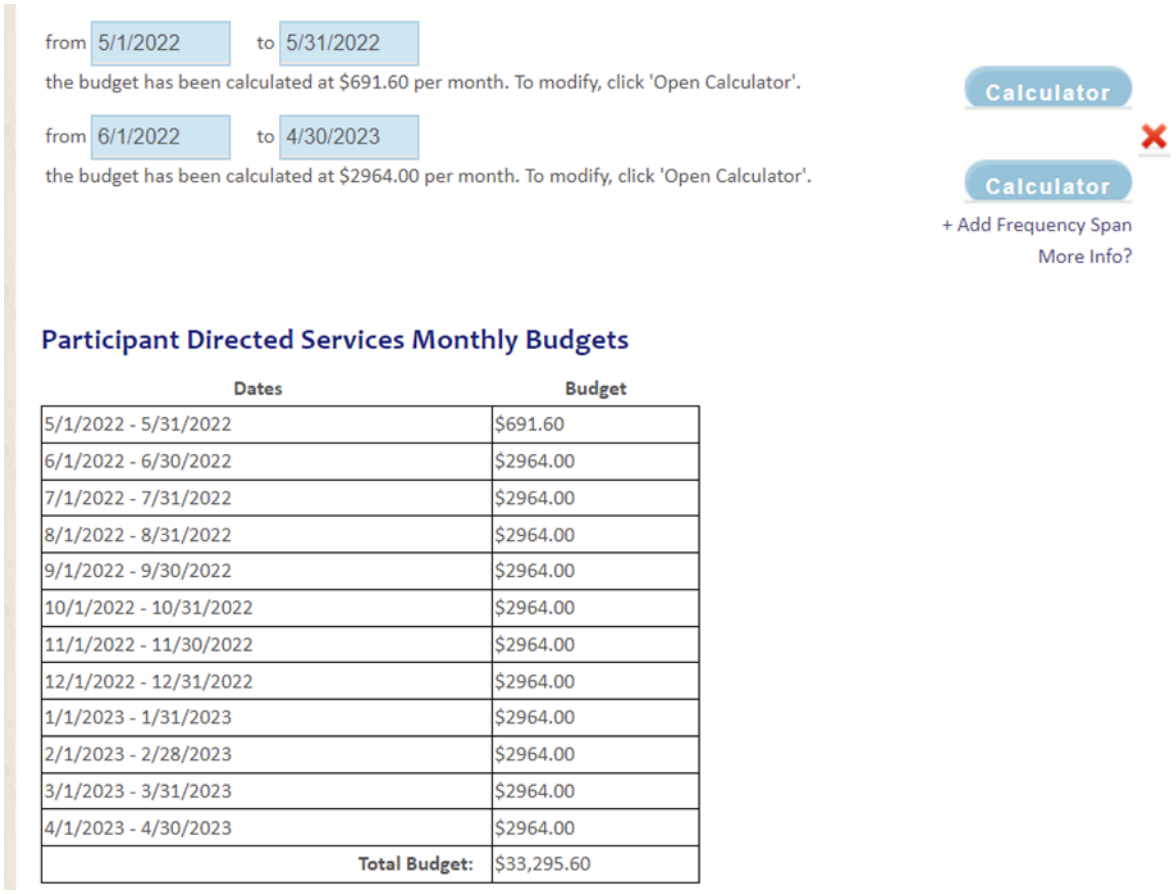

- Once the budget information has been updated, proceed with the modification.

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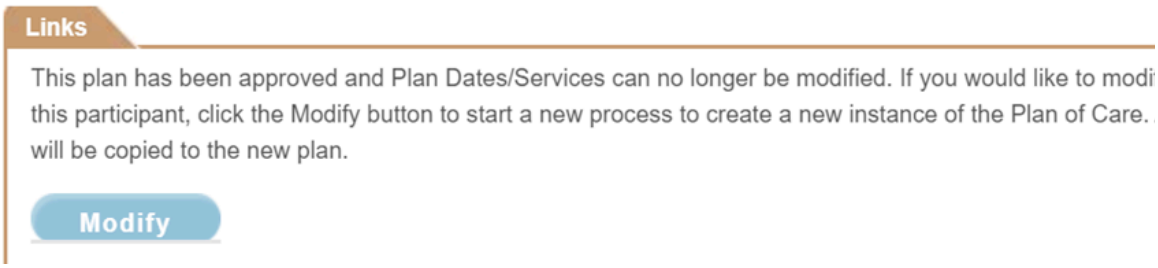
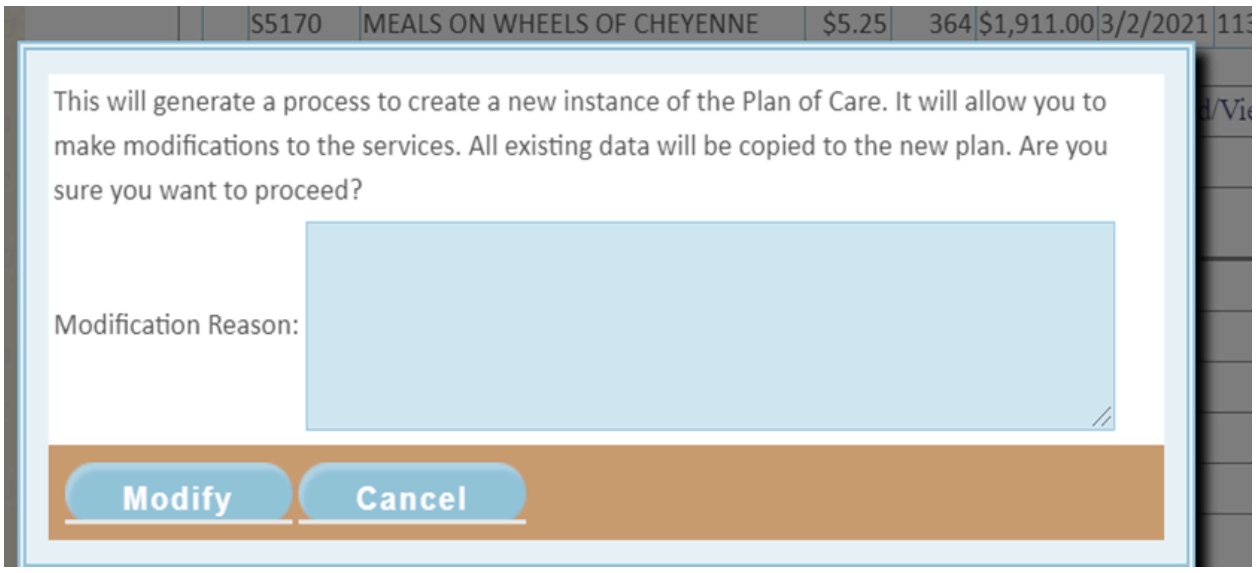
EMWS - Modifying a Service Plan

When changes occur in a participant's life, including their needs, preferences, or goals, the case manager is required to update their service plan to reflect their current situation and service needs. This section outlines the process for modifying a service plan. Please note that additional modifications cannot be implemented until the first modification is complete. For example, if a modification to change case management is submitted on the 10th of the month and is effective on the 1st of the following month, another needed modification cannot be effective until the 2nd of the following month.

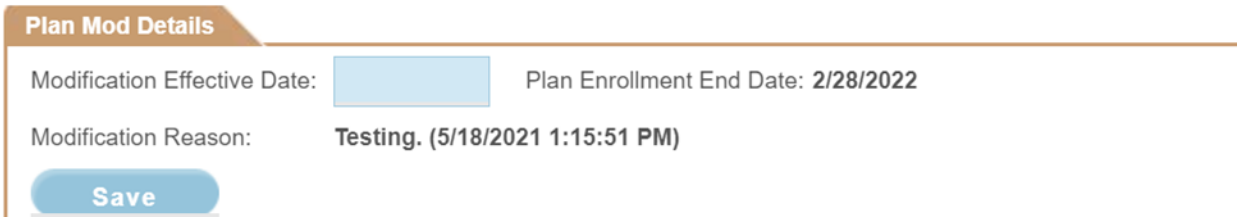
- To begin a service modification, the case manager must select *Modify* at the bottom of the service plan page.



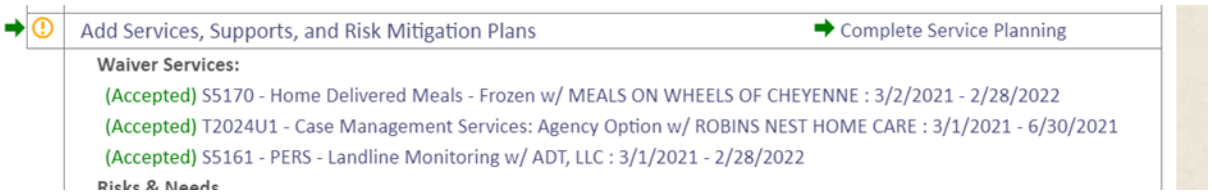
- Describe the reason for the modification and select *Modify*.



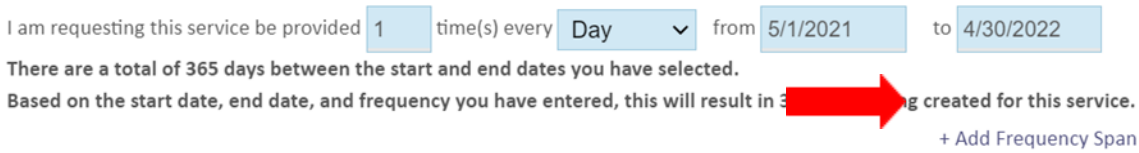
- A modification page will populate. Enter the effective date, which must be at least seven (7) calendar days from the date of submission of the modification and select *Save*. This date may be updated later but it is needed to help set the dates for the services.



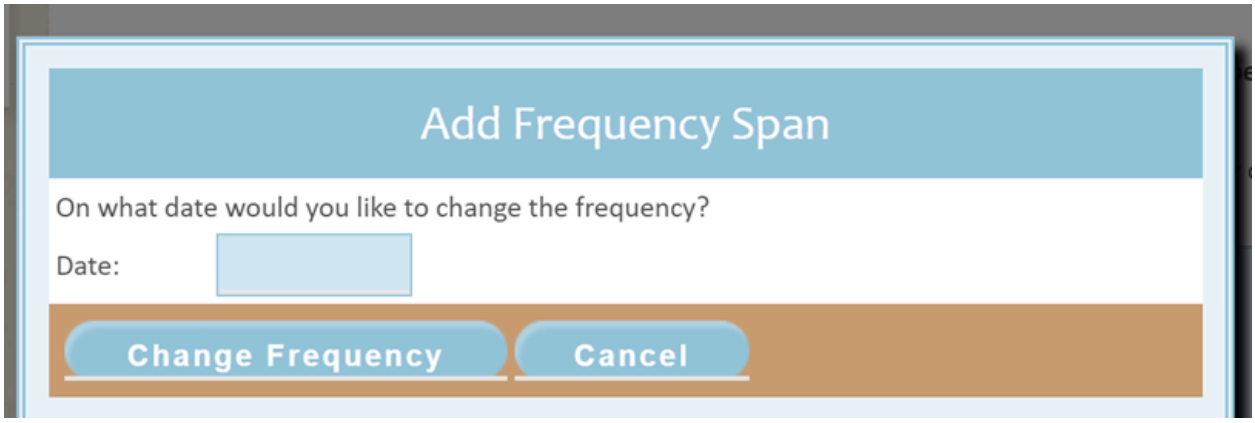
- Select the service to be modified or select *Add Service, Support and Risk Mitigation Plan* to add a new service to the service plan.



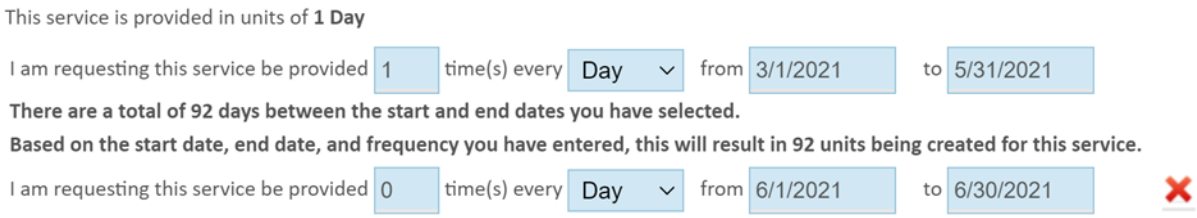
- At the bottom of the service referral page select *Start Modification*. This will allow for editing of the service.
- If the purpose of the modification is to change the number of times the service is being provided for the entire span of the service, enter the new frequency which has a date span that must begin after the date of the modification. Services cannot not be backdated.
- If the purpose of the modification is to end a service the participant is no longer using, change the end date of the service to reflect the date the service should end.
- If the purpose of the modification is to change the number of times the services will be provided in the future, select *Add Frequency Span*.



- Enter the date the modification of the change in service units is to begin and select *Change Frequency*.



- A new service line will display on the screen. Enter the frequency in the time span indicated. The day/week/month options may also be changed. If the new service line is not needed, select the X to delete the line.



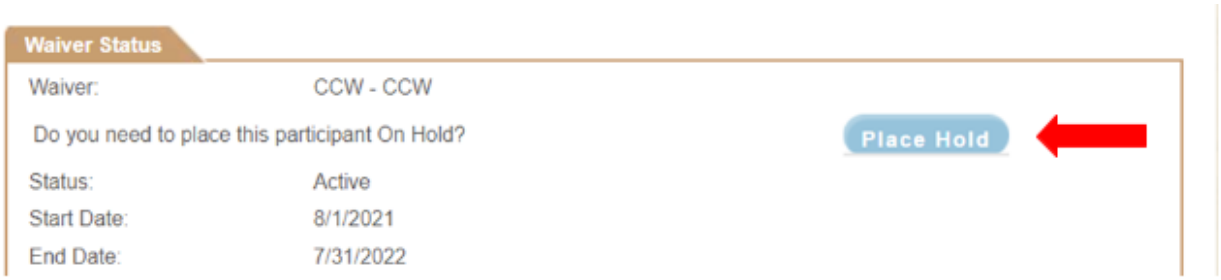
- Once the details for the service have been added, select *Send Edited Service* to send the service to the provider to review and respond.
- After all modifications have been made, select *Complete Service Planning* on the main Service Plan (checklist) page to complete the service editing step.
- Complete the modification by moving through the required checklist items, and submit the plan once all sections are complete.

Placing a Case On Hold

When a participant is admitted to a hospital or nursing home for a short period of time, or any other time the participant needs to suspend services for a short time, the case manager should use the On Hold option to notify providers that services should not be provided during the hold time frame.

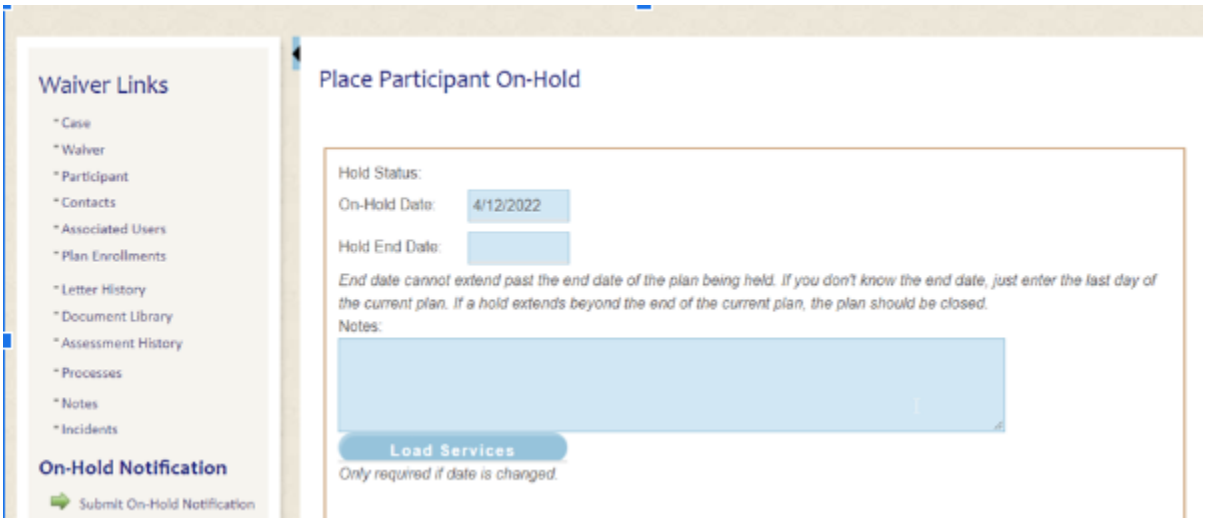
It is important to remember that if the participant remains in a facility setting for thirty (30) consecutive calendar days, the case manager must initiate a closure for the participant's case.

- Select *Place Hold*, which is found on the main waiver screen of the participant's case.

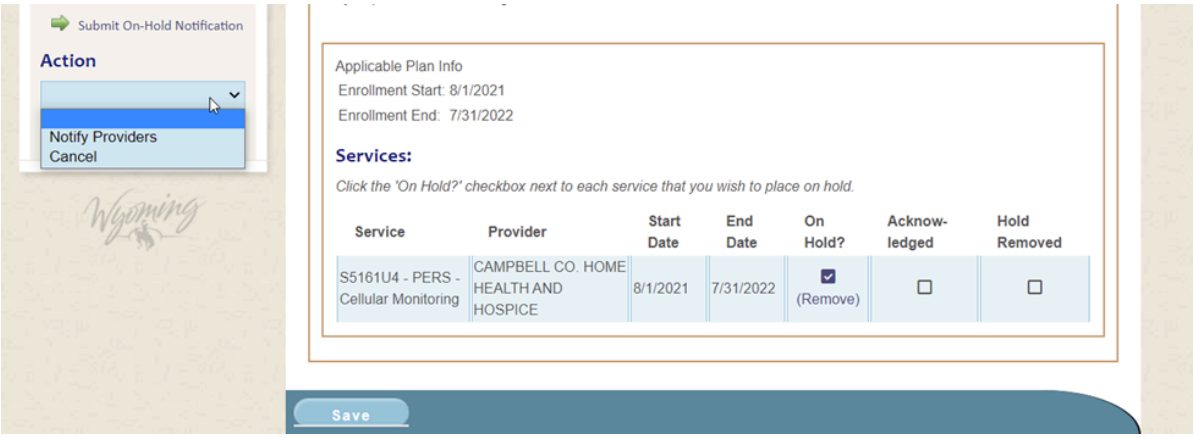


- The Initiate Hold window will appear. Enter the day the hold starts and select *Submit* to start the process. The start date cannot be in the past.

- Enter the hold end date. This date can be an estimate, but must be updated if the date changes and cannot extend past the end of the current service plan year. Explain the reason the case is being placed on hold.



- EMWS will populate the list of providers from the service plan that should be notified that the case has been placed on hold. Select *On Hold* for the services that should be placed on hold, and select the action to *Notify Providers* in the drop down box.

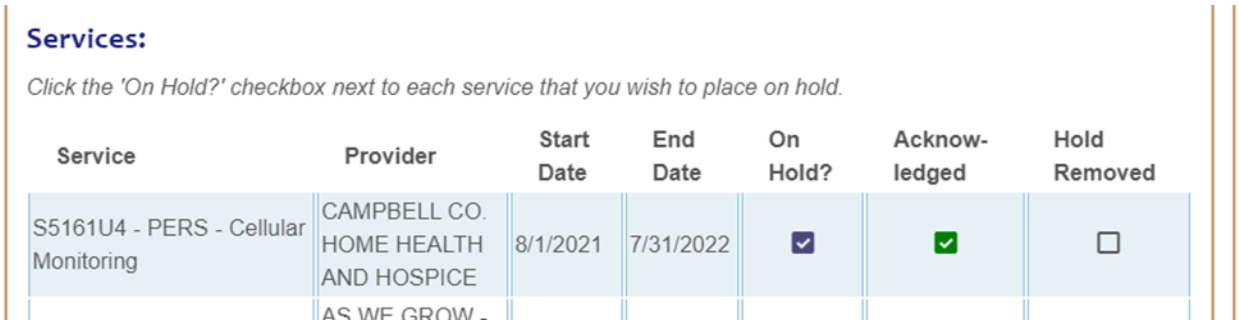


The provider will receive a task in the WHP portal to acknowledge the service hold. The provider should acknowledge the task within two (2) business days, and ensure that they do not provide services during the hold time frame.

Please note that the Personal Emergency Response System (PERS) monthly monitoring service can be billed if the provider delivered services at any time during the month. If monitoring services are not required at any time during the calendar month, the provider cannot bill for the monthly monitoring unit.

The participant's status in EMWS will change to Submit On-Hold notification. The case manager should reach out to the provider if they have not acknowledged the task within two (2) business days.

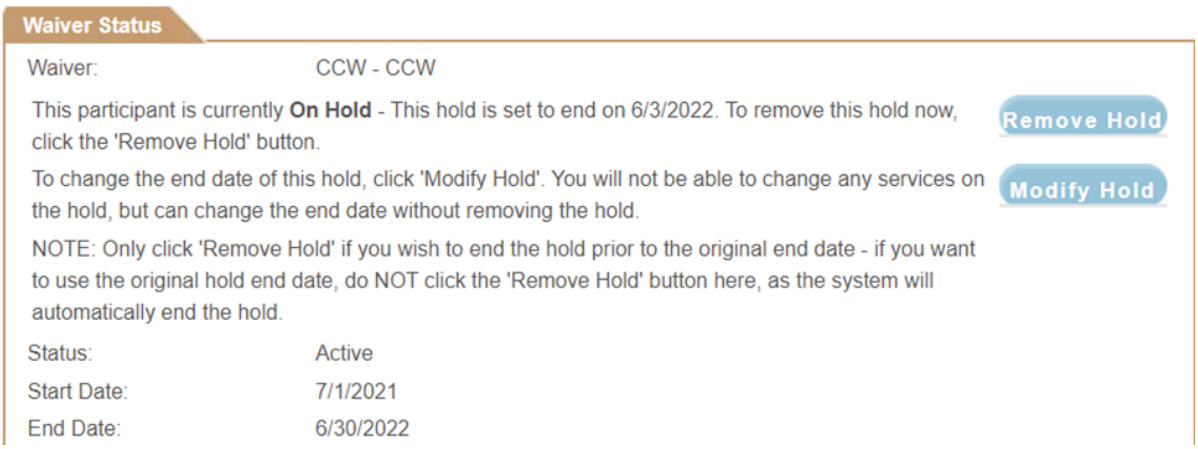
Once all providers acknowledge the hold, the "On Hold" notification status reminder will change to "Complete", and all check marks in the Acknowledged column will be green.



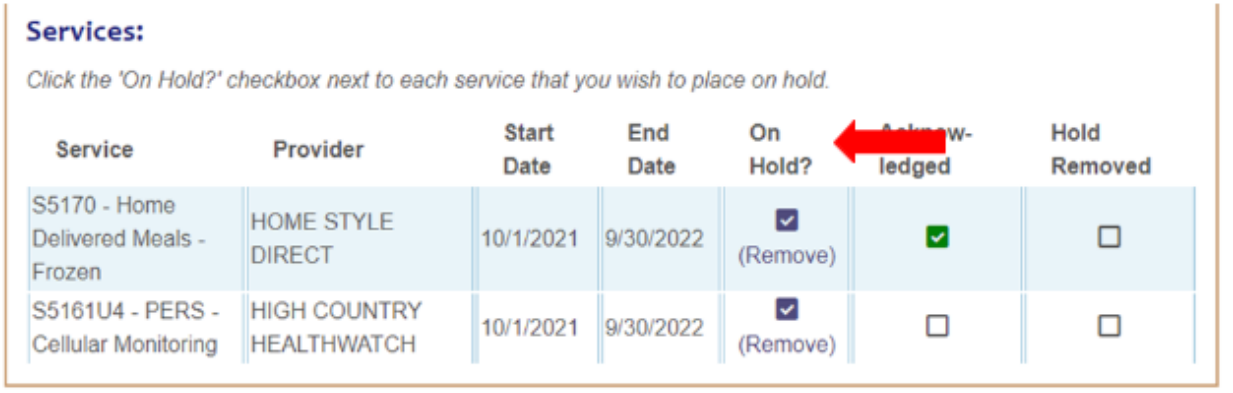
The On Hold process is now complete and will remain on hold until the end date. Please note that the system cannot allow the case manager to complete modifications while the case is on hold.

If the hold needs to be ended early or extended for a longer period of time, the case manager must modify the hold end date.

- Select *Modify Hold* or *Remove Hold* options on the main waiver screen.



- If **modifying** the end date, enter the new end date. The provider will be notified of the change and must acknowledge the change using the same process used when initially placing the hold on the case.
- If **removing** the hold, enter the new end date, unmark the checkboxes that are currently marked on hold, and enter a note explaining why the hold is being removed. The provider will be notified of the change.



- Once the provider acknowledgements have been completed, the hold modification will be complete.
- Case managers do not need to remove the hold if they are closing the case. They can initiate the closure and this process will remove the hold as well.

Closing a Participant's Case

When the case manager closes a service plan in EMWS, the closure status must read "Pending BMS" before service providers are notified of the impending closure through the WHP portal. This status means that until the case manager, BES, and Medicaid Long Term Care worker acknowledge the closure tasks in EMWS, the provider will not be notified. It is important for case managers to monitor the closure status to ensure that it doesn't linger in EMWS.

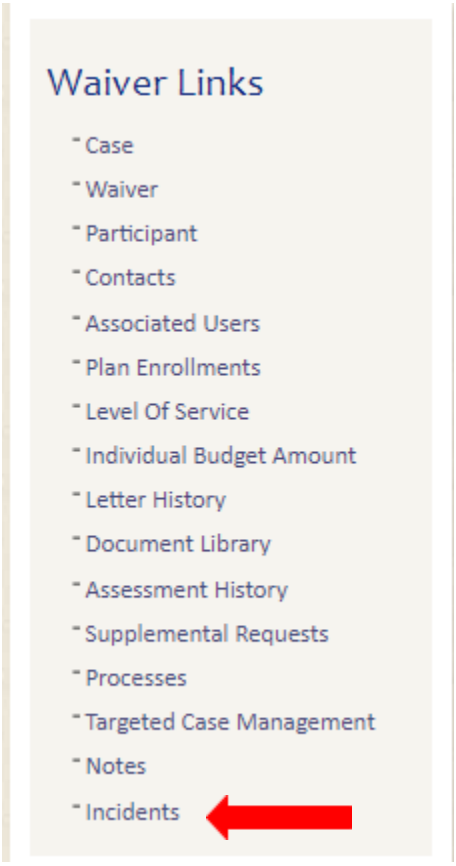
Case Managers must monitor closures carefully and frequently. If a closure seems delayed, case managers must contact the assigned BES. If the closure isn't complete in EMWS within seven (7) business days, the case manager should contact providers immediately to notify them of the impending end-date. It is critical that case managers take this step and notify all active providers to ensure that providers halt services on or before the termination date. Services cannot be backdated and are not billable after this date.

This is especially true for closures of service plans utilizing Participant-Direction. First, the case manager must submit a plan modification in EMWS to end Personal Support Services. The case manager must also ensure that the employer of record knows the PCSP end-date and notifies their Provider-Employees accordingly. The employer of record must understand that Personal Support Services (PSS) Providers are not allowed to bill (and will not be paid) for any services provided after the service termination date.

EMWS - Submitting Incidents

Case managers must submit incidents in accordance with Division requirements. To submit an incident:

- Proceed to the participant's case within EMWS
- Using the navigation menu on the left hand side of the screen, select *Incidents*



- Select *Enter New Incident*
- Complete the incident report by indicating the incident type and adding the required data. For more information on submitting incident reports, refer to the CCW Provider Manual.
- Once the incident report is complete, select *Submit Incident for Review* from the status section at the bottom of the screen.
- Select *Update Status* to submit the incident.

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Appendix 1: EMWS Task Timelines

The following table is intended as a quick-reference tool designed to assist case managers with the suggested EMWS task timelines found throughout this manual. Adherence to these timelines is strongly encouraged and will help with collaboration and execution.

Task	Timeline
Upon enrollment approval of initial applicants, complete the **person-centered service planning process** within	30 calendar days
Upon enrollment approval, contact the participant and legally authorized representative to schedule the **Participant Profile Assessment and service planning meeting** within	5 business days
Upon receiving notification that the participant meets CCW eligibility criteria, complete the **Participant Profile Assessment** within	10 business days
Upon completion of the Participant Profile, conduct the **service planning meeting** within	5 business days
Enter **Participant Profile Assessment** responses into EMWS within	5 business days
Enter **PCSP modifications** into EMWS	7 days in advance
Submit **initial plans** no later than the 15th of the month prior to the initial plan start date	By the 15th of the month before
Submit **renewal plans** before the last day of the month prior to the renewal plan start date	By the last day of the month before
Complete EMWS **tasks** within	5 business days
Entered case management work into the **CMMR** within	5 business days
Respond through EMWS to Department **requests for additional information** on PCSPs within	2 business days
Report any **emergency use of restraint** or **other reportable incident, including death,** to the Department within	3 business days
Report **all critical incidents** (abuse, neglect, exploitation and unexpected death) to the Department	Immediately after ensuring participant health & safety
If **PCSP closure status** has not completed in EMWS within **7 days**, or providers have not acknowledged a closure in EMWS within **2 business days**, contact providers	Immediately

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