AGENDA

Program Updates & Reminders

- Participant-Direction Workers' Compensation
- Participant-Direction Background Checks
- Extraordinary Care Committee (ECC) Requests
- Adding Backup Case Managers
- Case Manager Monthly Review (CMMR) Due Date
- Participant Transitions
- Voluntarily Leaving Waiver Services and Closures
- Updating Plans of Care
- Service Observation and Meeting Notice Requirements
- EVV Guidance for Providers
- Provider Attestation Renewal Task

Training on Facility Discharging and Transitions

TOPICS

Participant-Direction Workers' Compensation

It has recently been asked if an employee who is providing Self-Directed services can apply for, or receive workers' compensation benefits. While ACES$ is the Financial Management Service (FMS) that assists in processing requests for Participant-Direction, they are not an agency that pays the Employee directly. The provider or direct service worker is not employed by ACES$, but is instead employed by the Employer of Record/Legal Guardian/Participant, treating this similar to self-employment by the employee.

ACES$ is only the middleman and is essentially just the payer or payroll processing entity. ACES$ does not provide workers' compensation on the employer or employee's behalf. During the participant's initial enrollment with ACES$, the employer signs a form in their employer packet that attests to their understanding of this.

Workers' compensation is state-funded in Wyoming, similar to unemployment. In fact, Wyoming is one of only four states that require employers to purchase workers' compensation through a state fund, rather than a private insurance company. However, in Wyoming, domestic employers are exempt from contributing to Wyoming Workforce Funds for workers' compensation. If you have additional questions or need further information on workers' compensation, please contact the Wyoming Department of Workforce Services.

Participant-Direction Background Check Process

ACES$ has successfully implemented the first phase of the DD background screening project, which is sending updated enrollment packets to DD Participant-Directed employers. These packets include information on ACES$'s new administrative process for background screenings. ACES$ will continue to accept enrollment packets that have either the new process (with all screenings done through ACES$), or the old process (with fingerprint cards done through HR) through the end of the year. However, beginning October 1st, any packets received by HR will be returned to the employer with instructions to contact ACES$.

Extraordinary Care Committee (ECC) Requests

The July updates included information regarding ECC requests, what is needed to move these cases forward, and the authority of the Division to not move cases forward if necessary documentation is missing or other rule requirements are not met. Since that update, we continue to receive cases that do not include all necessary documentation our BES staff needs in order to present the case.

Cases that are submitted with incomplete documentation will be rolled back and cannot be presented. This includes letters from current doctors that are not on official letterhead, or not signed and dated by the doctor. The ECC checklist clearly defines what is required and must be completed. The ECC Request form instructs case managers to include how the request meets Chapter 46, Sections 14 and 15, to cite the specific criteria being met, and the reason for the request. This information is not optional and must be answered thoroughly and completely. ECC funds are finite and are only available for situations as described in Chapter 46. The process requires the submission of documentation and evidence that meets Division guidelines. Please ensure that you submit everything required so that cases can be reviewed in a timely manner. Technical assistance will be given to case managers who continue to submit incomplete requests. Cases will not be reviewed until all necessary information is present.

Adding Backup Case Manager Information

The Division would like to remind all case managers of the importance of ensuring that all contact information is current and accurate. Please ensure that along with the current case manager's information, you are adding information for the backup case manager as well. This allows for quick access in case we need to contact the backup case manager. The contact information can be added under the contact type "*Case Worker*". When the *Contact* screen populates to allow you to add the name of the backup case manager, please type the backup case manager's name followed by a dash with the words "back-up case manager", and then add their contact information. For example, John Doe - Backup Case Manager.

Case Manager Monthly Review (CMMR) Due Date

The Division continues to see quite a few case managers who are not completing their CMMRs on time. Per the most current Service Index, which is incorporated into rule by reference, the monthly case management review must be completed ***before*** billing for services and must be submitted by the 10th business day of the month following the month that services were rendered. The Division expects case managers to adhere to this submission date and complete this documentation as required. The CMMR is the documentation that not only justifies the services a case manager provides in order to bill Medicaid, but it is also the source of critical information used by multiple entities. The Division has conveyed this expectation in multiple ways including past trainings and case manager support calls. Please note that failure to complete CMMRs as required is a compliance issue and could result in further technical assistance, corrective action, and possible sanctioning depending on the seriousness of the noncompliance.

Participant Transitions

Chapter 45, Section 22 of Wyoming Medicaid rule establishes requirements that case managers must meet when they support a participant with transitioning to a new provider. Section 22 (e) specifically states that, when a transition occurs, the case manager must complete the transition checklist required by the Division, and schedule a transition meeting with the plan of care team. They must notify all current and new providers, the participant, legally authorized representative, and the Division at least two (2) weeks prior to the meeting.

The HCBS Section has received complaints that some case managers have neglected to inform the current provider when a participant has requested a provider change. It is important for the current provider to be notified, and for them to participate in the transition meeting. Unless the participant or legally specifically asks that the current provider not attend the meeting, the expectation is for them to attend and participate. In the event that the participant or case manager requests that they not attend, the case manager must still notify them that the transition will be taking place.

Voluntarily Leaving Waiver Services and Closures

When placing a case into closure due to a participant moving out of state or voluntarily leaving Waiver services for other reasons, please be sure to upload a signed and dated written statement from the participant/LAR.

Updating Plans of Care
The Division is reminding all case managers that the plan of care is a living document. This means that you are expected to keep the plan, including the contact section up to date with the most current information. If a participant moves or if there is other information that needs to be updated, such as medical appointments, this must be done as soon as possible. The expectation is that when completing a modification, any other updates or significant changes are also added to the plan at that time. Please do not wait for the annual plan renewal to update or make changes.

Service Observation and Meeting Notice Requirements
During many of the certification renewals for DD Waiver case managers, the Provider Credentialing team has had to cite case managers for not being able to demonstrate that they have conducted service observations or notified parties of meetings in accordance with Medicaid rule.

The Comprehensive and Supports Waiver Service Index contains the definition of case management services. Case managers are responsible for conducting semi-annual service observations of each non-habilitative service a participant receives, and conducting quarterly service observations of each habilitation service received. In addition to the notes that are recorded in the CMMR, the case manager must complete the Home Visit and Service Observation Form, have it signed by the Provider, and upload it in EMWS.

Chapter 45, Section 10 addresses the requirements for a participant's IPC and person-centered planning process. Section 10 (c) states that the case manager must provide written notice of the plan of care meeting to all team members at least twenty calendar days prior to the meeting. This notification must also be uploaded into EMWS to demonstrate that adequate notice has been provided.

EVV Guidance for Providers
Many providers are still using manual entries when entering visits for services that require electronic visit verification (EVV). EVV is a technology solution federally required by the 21st Century Cures Act. The solution validates services billed for home and community-based personal care and home health services, and provides accountability and safeguards to ensure that participants actually get the services they expected. In addition to mitigating fraud, waste, and abuse, EVV verifies the date, location, duration, and type of service, as well as the individuals providing and receiving services, on a real-time basis.

Although manual entry is available for providers to use in exceptional circumstances, manual entries should not be used on a routine basis. The occasional forgetful moment or participant eligibility issue are exceptions, but will no longer be accepted as the rule. It is imperative that providers and staff members use the EVV application, in real time, as intended in the federal requirement.

Incident Management Specialists have been contacting providers that currently enter manual entries 75% or more of the time, and the Provider Support Team will continue to contact providers that are not using the EVV application as intended. If case managers get questions or complaints from providers regarding these discussions, please remind providers that they are required by Federal law to use EVV technology.

Provider Attestation Renewal Task
As communicated last week, all providers were assigned the Attestation Renewal Document task in the Wyoming Health Provider portal on June 25th. Unfortunately, many providers did not complete this task before the August 31st deadline. As a result, providers that were receiving the agency rate have had their agency status suspended and are no longer allowed to bill at agency rates. The HCBS Section has asked that these providers immediately complete and submit the task and work with case managers to modify participant plans of care to allow for the agency rate.

Please keep in mind that agency status will not be reinstated until the month following the month the attestation is submitted and plan modifications are complete. For example, if the attestation and plan modifications are completed after the 15th of the month, agency status will be delayed an additional month (i.e., attestations and modifications

submitted after September 15th may not be in effect until November 1st). We understand the additional work this creates for our case managers and we appreciate your efforts and patience when working with providers to modify IPCs accordingly.

WRAP UP

The next DD Case Manager Support Call is scheduled for

January 13, 2025