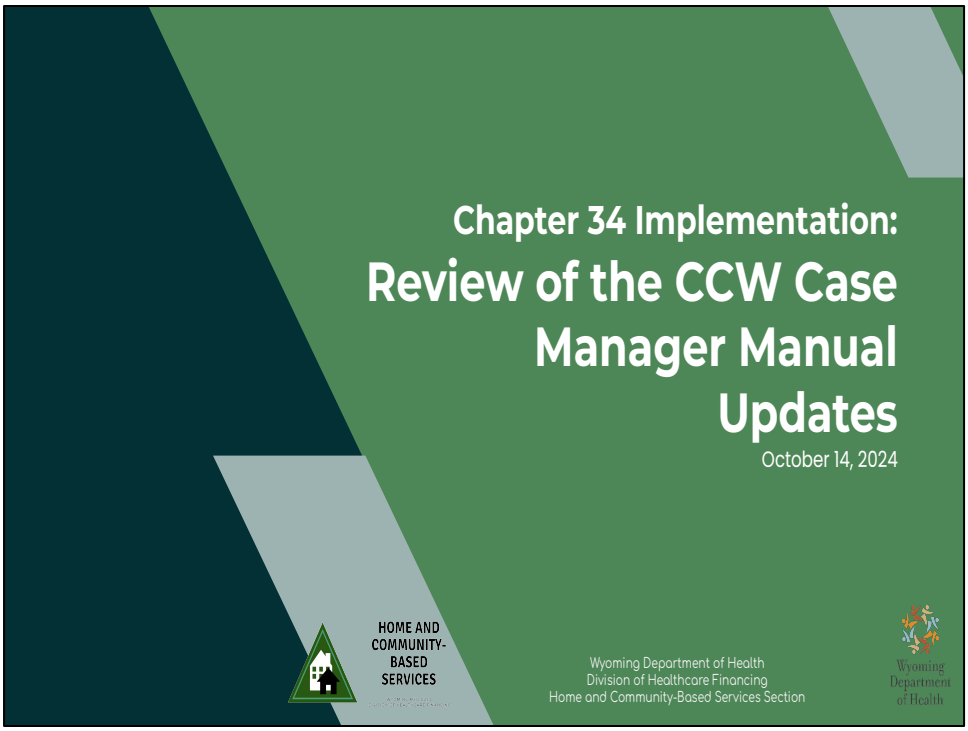
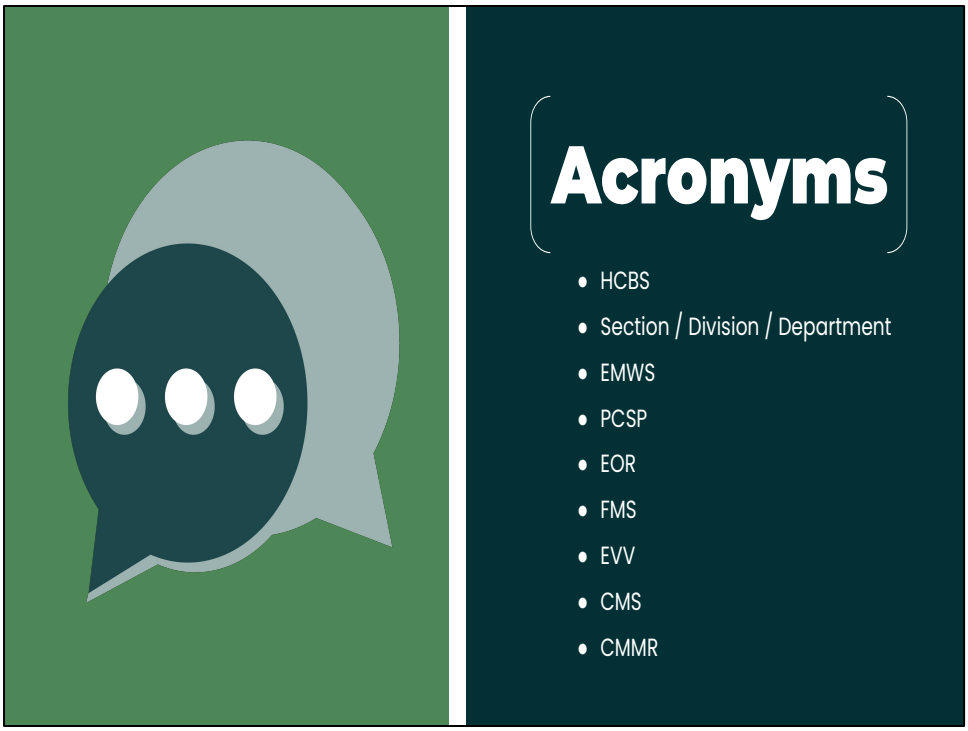


Welcome to the Division of Healthcare Financing (Division), Home and Community-Based Services (HCBS) Section case manager training on the updated Community Choices Waiver Case Manager Manual. The revised manual includes changes and updates from Chapter 34 of the Wyoming Medicaid Rules. My name is Leslie Emond and I am a Benefits and Eligibility Specialist with the HCBS unit. Thank you for taking the time to join us for today's training.

The purpose of today's training is to review some of the key revisions made to the CCW Case Manager Manual as a result of Chapter 34 being promulgated last January. We hope to clarify any areas of confusion and provide an opportunity to ask questions. Since this is our last scheduled call for the year, we want to be sure that after more than nine months of implementing Chapter 34, everyone is on the same page.

The Division has provided previous trainings specific to Chapter 34. However, during this training, we wanted to cover the topics found in the latest version of the Case Manager Manual that were added, modified or most impacted by Chapter 34. These can also be found on the Summary of Changes page within the manual and include:

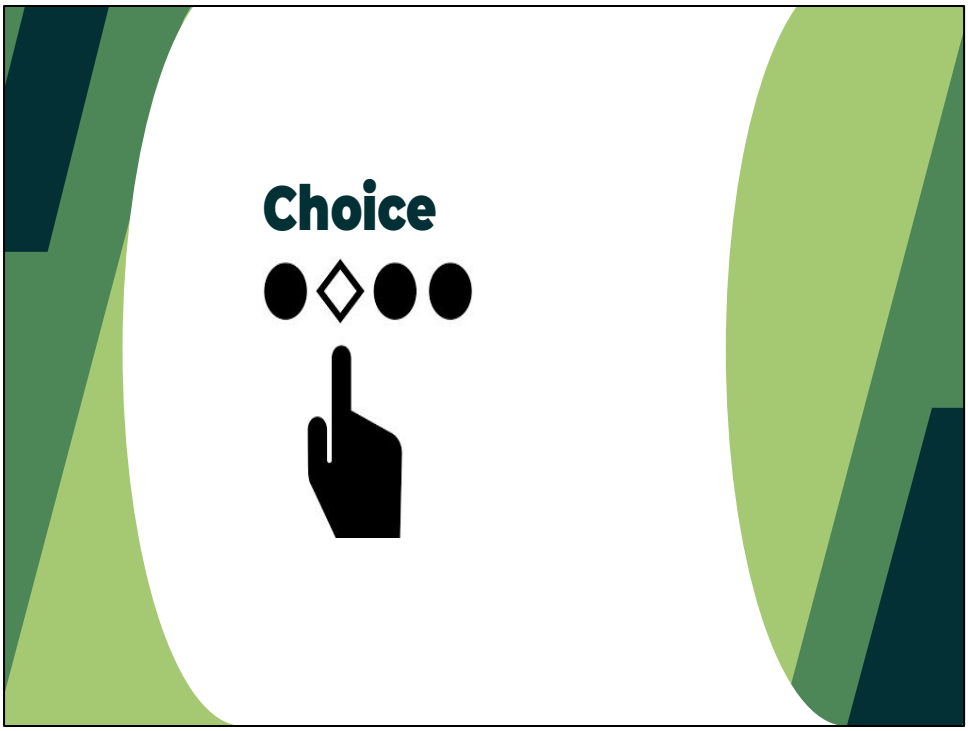
- Conflict Free Considerations
- Participant-Directed Service Delivery
- Risk Mitigation & Refusal of Services
- Rights Restrictions & Restraints
- Participant-Specific Training
- Service Documentation
    - Case Management Services
        - Backup Case Managers
        - Quarterly Visits
    - Provider Service Documentation
    - Documentation Retention & Destruction
- Referrals to Alternative Services
- Closing Cases
- Task Timelines
- Updated Documents & Web Pages



Before we get started, we'd like to go over some of the acronyms and abbreviations we will be using in today's training. The Medicaid system in general, and the home and community-based services program in particular, uses a lot of acronyms. Although most of you know these terms, for any new case managers, it can be confusing.

- We will often refer to the HCBS Section or HCBS program. HCBS stands for Home and Community-Based Services.
- The HCBS Section is organized under the Division of Healthcare Financing, which is a Division of the Wyoming Department of Health. We will sometimes refer to the Division or Department, which means Division of Healthcare Financing, or Department of Health.
- The Community Choices Waiver is most commonly referred to as the CCW or CCW program.
- The Electronic Medicaid Waiver System, which we refer to as EMWS, refers to the system that houses the participant's electronic record.
- The PCSP is the Person-Centered Service Plan. A person-centered service plan is a process that helps participants choose services and supports. The goal of the plan is to assist the individual to achieve their goal to remain in the community and live the life they want
- EOR refers to the Employer of Record for Participant Directed Services.
- Financial Management Services or FMS. The FMS is the agency that helps with the administrative responsibilities associated with being an employer of record such as withholding taxes and processing payroll.
- Electronic Visit Verification is often referred to as EVV.

- CMS stands for Centers for Medicare and Medicaid Services.
- We also refer to the CCW Monthly Review as the Case Manager Monthly Review or CMMR



We also want to remind everyone that home and community-based waiver services are based on the tenet that people have the freedom to make choices that impact their lives. Whether the choices are related to big decisions such as who provides their services, where they live, or what they want for their future, or small decisions such as with whom they spend time, what and when they eat, and how they spend their day, having choice is paramount to human dignity.

The philosophy of participant choice is fundamental to the CCW program and facilitating individual choice is a crucial part of being a case manager.

Let's begin with Conflict-Free Considerations. A conflict of interest occurs when an individual's personal interests such as family, financial, or social factors could potentially compromise his or her judgment, decisions, or actions.

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.
- Additionally, CCW case managers may not provide DD (or other) Waiver targeted case management services for the same participants on their CCW caseload.

Next, let’s revisit the participant-directed service option. Participant direction allows a participant increased decision making authority over select waiver services, and requires the participant take a direct role in managing their services.

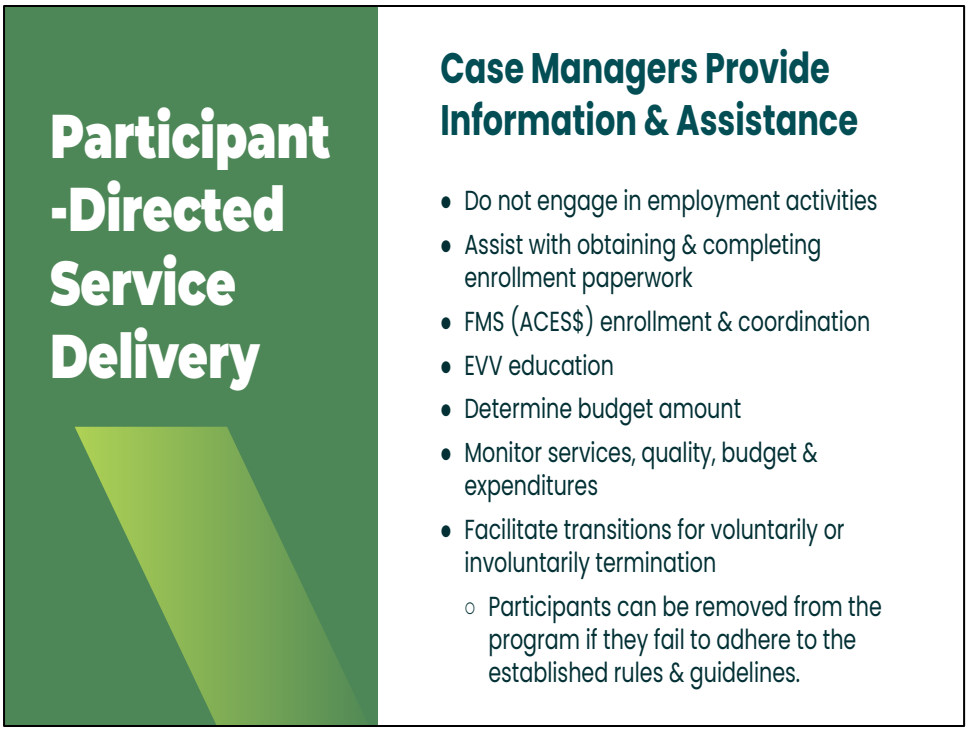
Case managers must inform participants about participant-directed opportunities available under the CCW when they are developing the service plan, at the annual service plan review, and any time the service plan is updated due to significant change in the participant's condition.

If a participant expresses an interest in participant-direction, the case manager must inform of the potential benefits, liabilities, risks, and responsibilities associated with this service delivery option. The case manager must ensure the participant-directed questions in the Participant Profile are completed and that the participant has access to the Participant-Direction Employer Manual. Case managers should encourage the participant to read the manual so they have a full understanding of their responsibilities.

Case managers must also know the Employer Manual well as it provides detailed information and includes required forms and the Participant Direction Service Plan. The Participant-Direction Employer Manual and links to other required forms can be found on the *Participant-Direction* tab of the HCBS Document Library.

The participant may choose to direct their own services, or may appoint another individual to direct services on their behalf and serve as the designated employer of record (EOR). Individuals in this role must be able to manage program 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.

As case manager you are responsible for providing information and assistance including, but not limited to the following:

- Assisting the participant in obtaining and completing the required documents for participant direction;
- Assisting the participant to enroll with the Financial Management Services (FMS) agency
- 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; The case manager is responsible for reporting over- and under-utilization of the participant-directed budget, and potential instances of fraud or misuse of participant-directed funds.
- 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.

If the case manager identifies violations of participant-directed requirements, they must re-educate the participant and 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. Participants can be removed from the program if they fail to adhere to the established rules and guidelines.

Let's now review Risk Mitigation and the Refusal of Services. 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 lessen those risks in order to reasonably assure the health and welfare of the participant.

Please remember, 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 (in the notes section) 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 are a form of rights restriction and can only be used if the participant receives services in an assisted living 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. A physician's letter is required.

Emergency Restraints

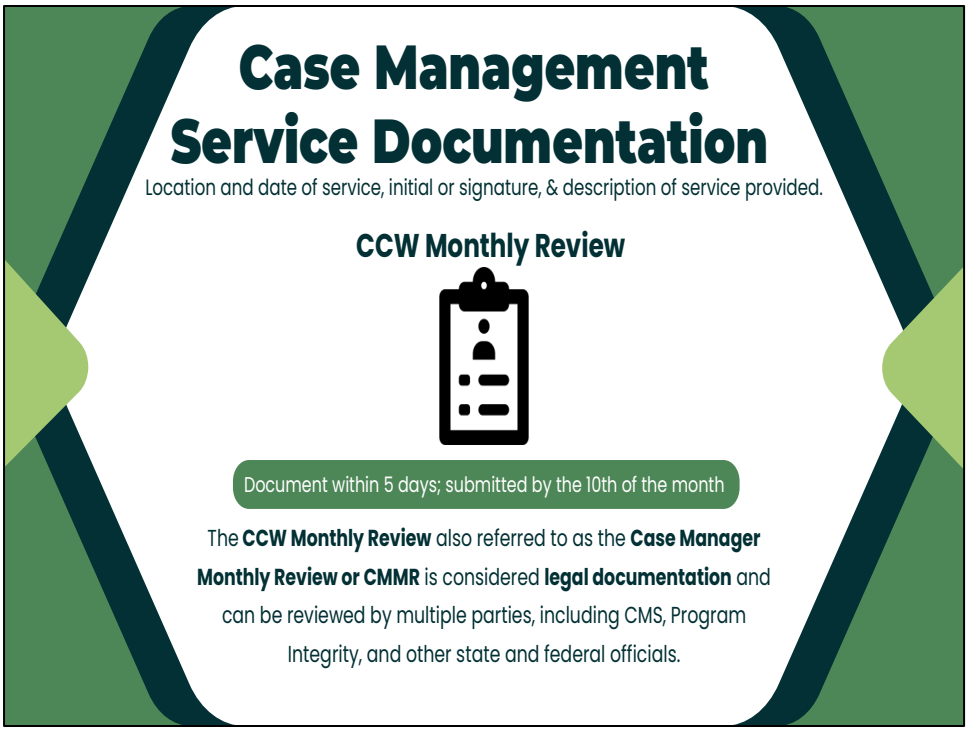
In emergency circumstances, restraints may be used only to ensure the immediate physical safety of the participant or provider when the risk of injury outweighs the risk associated with the restraint. Any emergency use of restraint must be reported to the Division within three (3) business days.

Participant-specific training helps to frame services and supports through the eyes of the participant based on their unique needs, desires, goals, and preferences. Chapter 34 of Wyoming Medicaid Rules requires case managers 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.

While case managers are not expected to provide skilled training, such as nursing training to a nurse, they should provide information on the participant's care needs, cultural considerations, communication preferences and information that furthers the collaboration across the care team. This might include the participant's personal routines, preferences and behavioral or safety concerns.

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 directly to the service referral. The Provider Evidence of Participant-Specific Training form on the HCBS Document Library lists some specific considerations case managers may want to include in the referral. A participant's essential routines, personal-space preferences, preferred name, and provider staff gender preferences are just a few examples. 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.



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 waiver services were delivered in accordance with Division requirements. The required elements of documentation are outlined in Chapter 34 of Wyoming Medicaid Rules

Monthly Review
The CCW Monthly Review form, also referred to as the Case Manager Monthly Review or CMMR in the manual, 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 form provides a detailed account 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. 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.

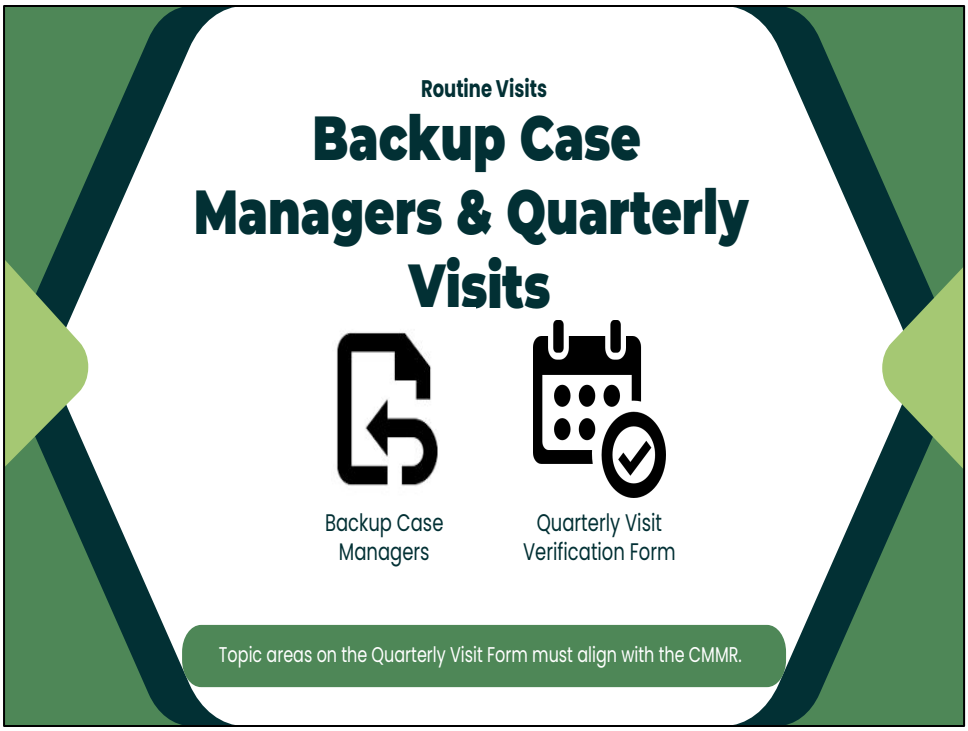
The case manager is responsible for talking to the participant, the legally authorized representative, and providers in order to monitor the participant's health as well as satisfaction with services and providers. Case managers should ask questions in order to get as much information as possible, and 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 account 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.

Suggested Timeline for CMMR

It is recommended that the case manager document the work that they do throughout the month 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, the case manager must remember to click *Save* in EMWS 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 form. 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 form, they are verifying that the information is accurate and complete. Once the CMMR is submitted, the case manager can bill Medicaid for the month.

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 CMMR in EMWS.

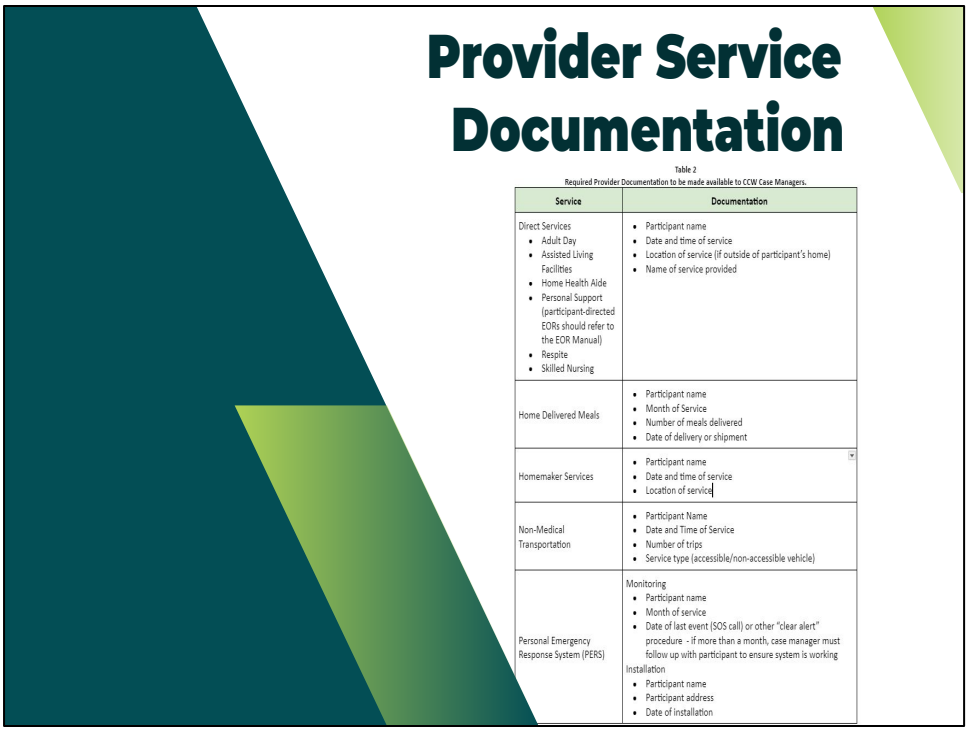


Backup Case Managers
Every participant must have a specific backup case manager assigned to their case. The backup case manager must be able to step in when appropriate to ensure that service plans are completed and submitted on time, and ensure that participants do not have a gap in needed services 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. The back up case manager's contact information must be listed in the contacts section of the case in EMWS.

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 *CCW* tab of the HCBS Document Library undering the Monitoring

heading.



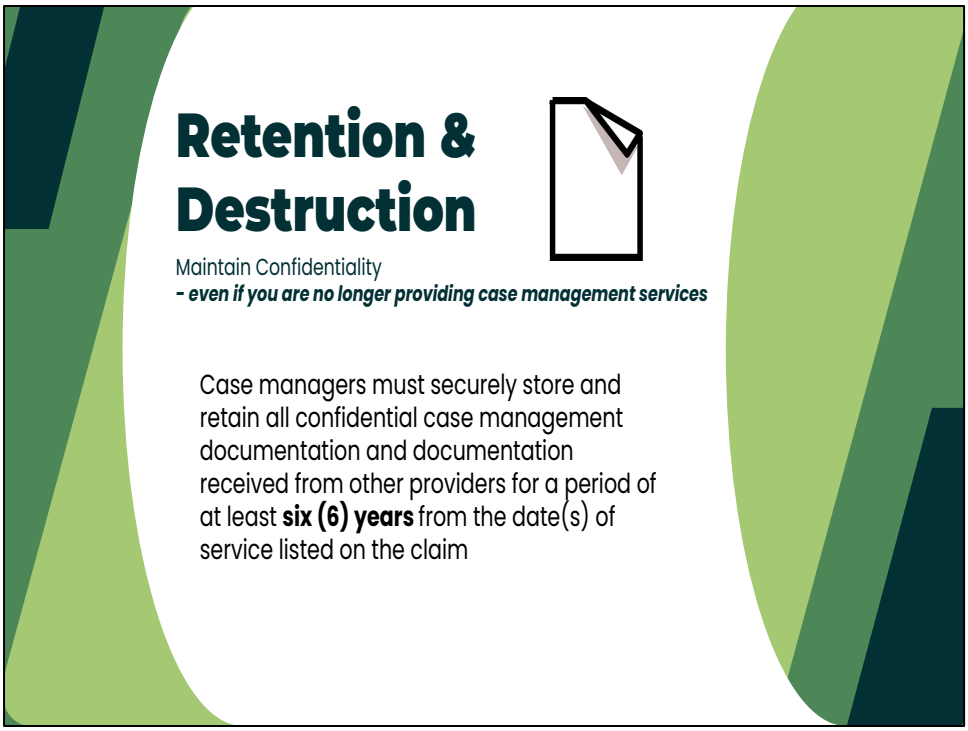
Review of Provider Documentation

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.

Documentation requirements will vary, based on the service the provider is delivering. Table 2 in the CCW Case Manager Manual lists the requirements by service type.



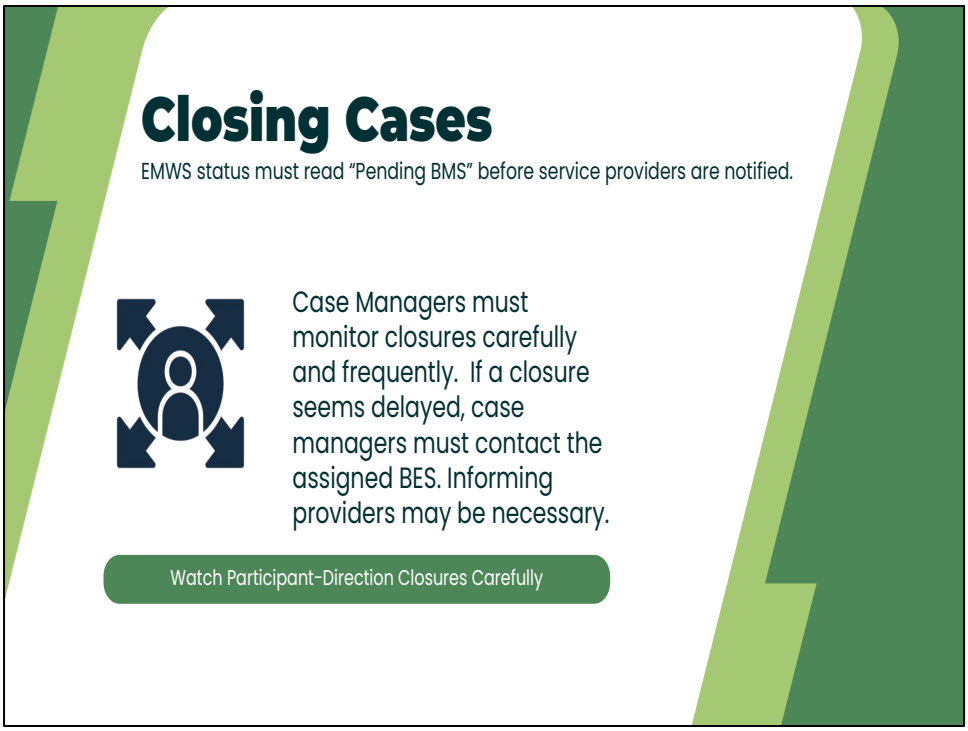
Retention & Destruction

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.

Referring Participants to Alternative, Non-Waiver Services

Services on a participant's PCSP are not 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 supplement, but do not supplant or duplicate services available through other funding sources.

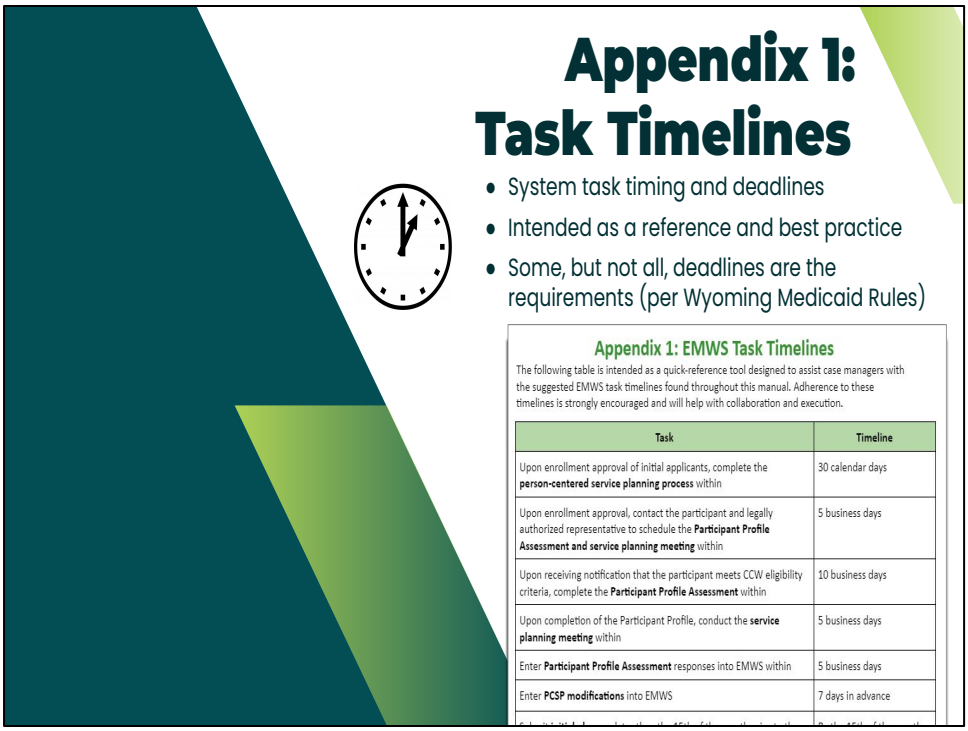
While these alternative support options may be discussed during the assessment process, it is also important to discuss them during the service plan development process in order for the case manager to provide more detailed information about each option so the participant is able to make choices that best address the participant's needs. The *Outside Resources* page of the HCBS website has a list of links to resources that case managers may find helpful.



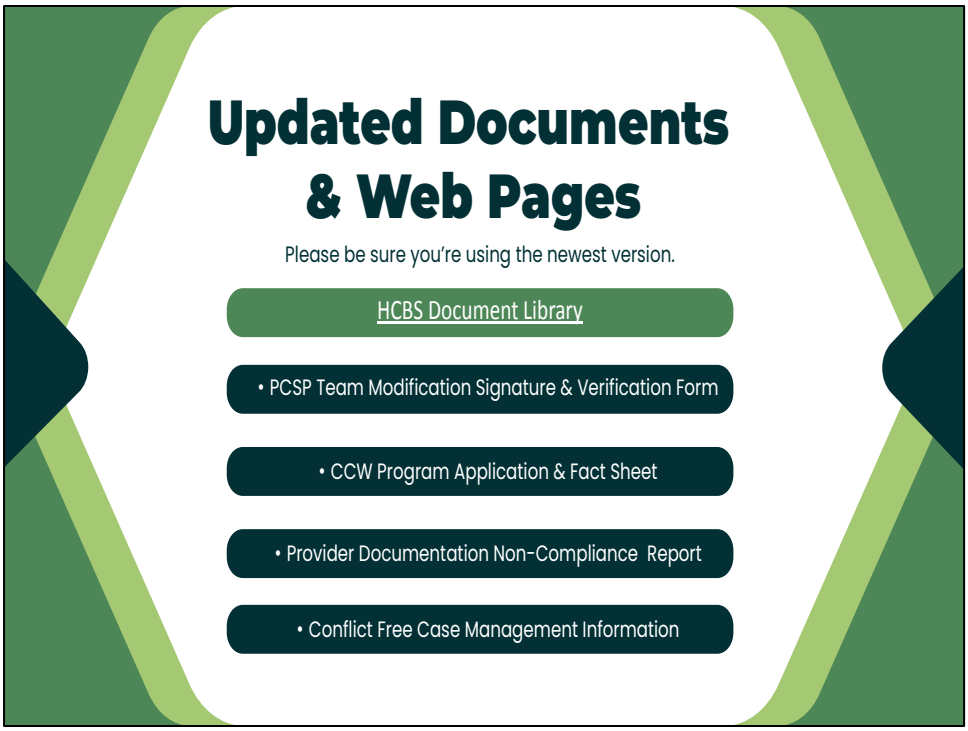
Closing Cases
When the case manager closes a service plan in EMWS, the closure status must read "Pending BMS" before service providers are notified of the impending closure through the WHP portal. This status means that until the case manager, BES, and Medicaid Long Term Care worker acknowledge the closure 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 of the closure effective date, 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.



Next, we want to highlight the addition of Appendix 1 to the CCW Case Manager Manual. This page was developed as a quick-reference tool to assist case managers with deadlines and the suggested EMWS task timelines. Best-practice adherence to these timelines is strongly encouraged and will help case managers meet rule requirements, facilitate collaboration among stakeholders, and aid in the execution of Person-Centered Service Plans.



Lastly, before we answer your questions, we'd like to remind everyone that the *CCW* tab of our HCBS Document Library webpage has links to our **most current** documents, forms, and tools. We also want to remind everyone that updates to these documents are ongoing (and never-ending). :-)

Some hyperlinks included on some of our forms and documents may no longer work properly as a result of the recent website reorganization project. If you notice any links not working (on documents or elsewhere on our website), please report them using the feedback form found on our "Contact Staff, Subscribe or Suggest" page. We encourage you to check the HCBS Document Library to ensure that you are using the most current version of the documents you need. This includes referencing the most recent versions of the EMWS & WHP Document Naming Conventions when uploading items in these systems. In addition to the updates made to the CCW Case Manager and Provider Manuals, this slide shows some of the other documents we've updated over the past several months.

Today we've highlighted some of the updates that were made to the CCW Case Manager Manual since the promulgation of Chapter 34 of the Wyoming Medicaid Rules. We hope this review has provided some clarity, helped you become even more familiar with the Case Manager Manual, and reinforced your understanding of how to follow the CCW rules. We thank you for joining us today, and are happy to answer any questions you may have at this time.