AGENDA

- **Program Updates & Reminders**
  - Individualized Plan of Care Modifications
  - National Accreditation Tasks
  - National Core Indicator® - IDD Survey
  - Provider Owned or Operated Settings
  - Background Screening Requirements
  - Electronic Visit Verification Requirements
  - Outside Entity Inspection Reports
  - Rate Increases Funded through the American Rescue Plan Act
- **Training: Wyoming Vocational Rehabilitation - TJ Mechem, DVR Programs Manager**

TOPICS

Individualized Plan of Care Modifications

When a case manager makes a modification to a participant's individualized plan of care (IPC) that affects the services delivered by a provider, the provider must sign the Team Signature and Verification form acknowledging that they are aware of the changes. If a provider representative is unable to attend the team meeting, they must review and sign the form, and return it to the case manager as quickly as possible so the case manager has time to submit the modification. Case managers must submit modifications through the Electronic Medicaid Waiver System (EMWS) at least seven days prior to the modification effective date so that the Benefits and Eligibility Specialist has sufficient time to process the modification. If a provider delays signing the form, it can delay the changes that the participant needs.

National Accreditation Tasks

The Home and Community-Based Services (HCBS) Section recently deployed a new task for providers that are currently accredited through CARF or CQL. As established in Chapter 45, Section 25(f) of Wyoming Medicaid rules, *"An accredited provider shall submit all national accreditation report documents to the Division within thirty (30) days of receiving the report documents from the accrediting entity."* The HCBS Section is not receiving these reports consistently, so this task requires providers to upload the report from their accrediting agency, and note the expiration date of the accreditation.

Please note that this task should only populate for providers that are currently accredited. If a provider organization receives this task but is not currently accredited, they should contact their area Credentialing Specialist and request that the task be canceled.

National Core Indicator® - Intellectual and Developmental Disabilities Survey

The National Core Indicator - Intellectual and Developmental Disabilities survey is underway. In early September, participants who were randomly selected were sent a letter to notify them of their selection to participate, and provide them with more information about the process.

As a reminder, this survey collects and maintains data about the performance of public IDD systems across the nation, and the outcomes experienced by participants of these systems. NCI partners are committed to generating data that can be used to improve long-term care policies and practices at the state and national level, and to contribute to knowledge in the field in general. **This data is not used to determine participant budget amounts or provider rates.**

Providers should never discourage a participant from having a voice and providing feedback on their experiences. If a participant wants to talk to a surveyor, the provider should support participants in setting up and attending interviews, and answering any questions they may have. Please support participants in being as involved as they would like to be in this process.

Provider Owned or Operated Settings

The HCBS Section uses the information that providers input into the Wyoming Health Provider (WHP) portal to determine how it will process the provider's initial and renewal certification, as well as the tasks that the provider will receive over the course of these certification. Over the past few months, we have found several instances of providers delivering services in locations that they own or operate that are not identified as a service location in the WHP portal. Conversely, we have also found many locations that are not service locations, but are identified as such.

Providers must accurately identify the locations listed in their certification. If you have identified a location as a service location, but don't provide services there, you will receive inspection and other tasks that are not necessary and can cause confusion. Please note that the home of a participant is not considered a service setting if the home is not owned or leased by a provider or an employee of a provider. Providers that deliver services in a setting they own or operate, including employee homes if that is where services are provided, are required to meet very specific rules, which are outlined in Chapter 45, Section 13. If you are providing services in a location that you own or operate, but haven't identified it as such, you will be subject to corrective or adverse action. Please review your WHP portal account and ensure that you have identified all provider owned or operated locations accurately.

Background Screening Requirements

In April 2024, the HCBS Section updated provider requirements for background screenings. This change was implemented to address the time it was taking providers to receive DCI and FBI fingerprinted background screening results.

The new background screening requirements are as follows:

- A national name and social security number based criminal history database screening;
- A Department of Family Services Central Registry screening; and
- A United States, Department of Health and Human Services, Office of Inspector General List of Excluded Individuals/Entities database search.

It is important to note that the new requirement for criminal history screening includes a name ***and*** social security number. As we have stated previously, the HCBS Section does not recommend a specific screening vendor; however, any vendor you use must base the screening on both the person's name and social security number. As an example, Direct Screening, which is a vendor that is linked to the HCBS Section website, offers a national background check and an **enhanced** national background check. Only the enhanced check includes the name and social security number in the search.

Please ensure that your screenings meet the requirements. The Credentialing Team will reject background screenings that don't meet the screening criteria, and we certainly don't want providers to have to pay for an additional screening unnecessarily.

Electronic Visit Verification Requirements

As we have discussed in many of our provider support calls, Electronic Visit Verification (EVV) is a technology solution that is federally required by the 21st Century Cures Act. This 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 who are providing and receiving services, on a real-time basis.

EVV required services include Personal Care, Child Habilitation, Companion, Respite, and Skilled Nursing. Although providers can manually enter visits for these services, manual entries should not be used on a routine basis. The occasional forgetful moments or participant eligibility issues are exceptions, but are no longer accepted as the rule.

The HCBS Section has provided guidance that allows manual revisions associated with daily and 15-minute Respite units; however, outside of this guidance, manual entries should not be occurring. We acknowledge the challenges associated with rounding, which is currently prohibited in Chapter 45, and will address this challenge the next time Chapter 45 is reviewed.

Outside Entity Inspection Forms

The HCBS Section has received numerous requests for access to an outdated form that outside entities previously used to record their inspections of provider owned or operated locations. This form is no longer available, and will not be accepted by the HCBS Section. The outside entity will need to provide a written report, which includes a list of the areas inspected, verification that all areas are free of fire and safety hazards, and recommendations for any areas of deficiency, on a company form or letterhead.

Rate Increases Funded through the American Rescue Plan Act

On February 1, 2022, the Wyoming Department of Health implemented temporary rate increases for providers of Comprehensive and Supports Waiver services. This increase was based on a rate study and analysis that was conducted by Guidehouse Consulting, and was funded with enhanced federal medical assistance percentage (FMAP) funding made available through Section 9817 of the American Rescue Plan Act (ARPA).

This temporary increase was anticipated to be in place through March 31, 2025; however, the Department has determined that the funding can be extended through June 30, 2025. As of July 1, 2025, service rates that experienced this temporary increase will be decreased by the amount that was originally attributable to the ARPA increase.

The HCBS Section will publish an updated fee schedule early in 2025 so that providers can begin planning for the rate decrease.

WRAP UP

Next call is scheduled for February 24, 2025