



AGENDA

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- **Training: Children's Mental Health Waiver** - *Rolando Fuentes, Rachel Mcken and Holly Mittelstadt of Magellan Healthcare of Wyoming*

TOPICS

Participant Direction Enrollment

When a participant chooses to utilize participant direction, case managers should start the enrollment process by completing the ACES\$ referral form. Once ACES\$ receives the completed referral form, they will send out all enrollment documents that need to be completed. Employer and employee must complete all required documents for ACES\$ to review. Once the enrollment process is complete, ACES\$ will send a secure email to the assigned case manager notifying them that the participant is "Good to Go". This means the participant's plan of care can now be modified to add participant directed services as well as the monies allocated for participant direction. Please ensure that participant direction is not added to a plan of care without the "Good to Go" email notification from ACES\$.

Once a plan of care is modified to add participant directed services, the Electronic Medicaid Waiver System (EMWS) will send the new plan enrollment to the Benefit Management System (BMS). Following BMS approval, the plan returns to the case manager for 'Acknowledgement.' This step is critical as the participant direction budget is only transmitted to ACES\$ when the case manager completes the acknowledgement task. If this task is delayed, the participant's budget will not appear in the ACES\$ portal, preventing the delivery of services as well as potential reimbursement issues. Please prioritize these acknowledgement tasks and allow 24–48 hours for ACES\$ to reflect the budget in their system.

Right Restrictions

This is a reminder that medical letters for rights restrictions must be updated annually to ensure ongoing monitoring and evaluation. When submitting a plan renewal, please do not include a rights restriction based

on a previous year's letter or submit a plan with a note that an updated letter will be provided later. If the updated documentation is not available at the time of submission, the restriction must be removed from the plan until the letter is received. When completing the rights restriction section in the Individualized Plan of Care (IPC), the case manager must reference the required documentation. Please note that a doctor's prescription stating that a participant's right should be restricted is not sufficient. The documentation must be on official letterhead or contain clear provider identification and include:

- The specific diagnosis and medical condition being addressed.
- The specific risk involved.
- The reason the restriction is necessary, and
- How the restriction is tied to the participant's medical or mental health condition.

In certain cases, a psychological evaluation may serve as the professional medical documentation. For further details, please refer to the IPC Guide in the [Document Library](#) on the Division website. If you have case specific questions, please contact the assigned Benefits and Eligibility Specialist (BES).

Forms

Please ensure that the most current version of the Division's forms are being used as forms are frequently updated. If assistance is needed with locating a specific form on the [Division website](#), please reach out to the assigned BES for assistance.

Case Manager Transition Timelines

The HCBS Section would like to remind case managers of the transition process, particularly the timeline for the submission of Case Management Monthly Reviews (CMMR), that must be followed when there is a change in a participant's case manager. The Division's expectation is that all documentation by the outgoing case manager be completed by the effective date of the transition. Allowing the outgoing case manager to have access to the participant's file in EMWS after the transition effective date does not support the importance of the transition timeframe and may violate the Health Insurance Portability and Accountability Act (HIPAA) regulations. If a case manager transition is occurring mid-month, the outgoing case manager may document in the CMMR but should not submit it. The incoming case manager will finalize the monthly documentation and submit the CMMR in EMWS. The first case note entry from the incoming case manager should indicate that the transition is complete and all remaining documentation in the CMMR will be completed by the new case manager. If the transition effective date is the first day of the month, the Division expects the outgoing case manager to complete the CMMR and all other documentation including outstanding Quarterly Reviews, prior to the transition and submit in EMWS on the last day of the month.

Case Management Delivery of Service

Case management is the only mandatory service for all participants. While participants maintain the right to refuse services, case managers must document such refusals within the Case Management Monthly Review (CMMR), along with any other attempts made to deliver the service as required. Please note that internal scheduling conflicts or case manager unavailability are not valid justifications for a lapse in service. It is essential that case managers proactively manage their schedules to ensure the consistent delivery of required monthly services.

Positive Behavior Support Plans

The Division of Healthcare Financing has filled the new Behavioral Health Transition Program Coordinator position. Please join us in welcoming Sophie Poste to the Division. Sophie, at the request of HCBS staff, may assist plan of care teams with the creation and/or review of Positive Behavior Support Plans (PBSP). Please note that while Sophie may assist with PBSPs, it is still the expectation of the Division that the case manager

ensures the PBSP is completed on the Division's PBSP template, and is reviewed and signed by each member of the plan of care team. The PBSP template is located on the Division's website in the [HCBS Document Library](#).

Providers Accepting Participants into Community Living Services Levels 3-6

Recently, the Division has seen an increase in situations in which participants are moving into provider owned Community Living Services (CLS) settings to receive CLS levels 3-6, at the out of pocket expense of participants or their caregivers. Providers should not accept participants into their programs contingent on a future Extraordinary Care Committee (or ECC) decision as no ECC is guaranteed. In order to move ECC requests forward, the request must meet at least one of the ECC criteria along with supporting documentation, as outlined in [Chapter 46 Rule, Section 14](#). Please note that in accordance with Chapter 45 Rule, providers should review each participant's referral information to make the determination as to whether or not they are able to meet the participant's needs based upon the current circumstances, funding, and level of service. If a provider cannot meet the needs of the participant at their current level of service based upon the referral information, they should not accept the participant into their program expecting an ECC to grant additional funding. The Division is requesting that case managers keep this in mind when working with participants, Legally Authorized Representatives (LARs), and providers during the planning process.

Applications and Legal Names

When completing applications and other legal documents please use the participant's legal name as it appears on their Social Security Card or birth certificate. A preferred name may be entered into the Electronic Medicaid Waiver System (EMWS) as well, but to prevent delays, or other problems with eligibility, we must have the legal name on the applications, and other program documents. Please ensure that you are verifying information when assisting with applications to ensure legal names are being utilized.

Institutional Admissions

Upon a participant's admission to an institution, case managers must immediately contact the assigned BES so they can initiate a hold on the participant's plan of care. For hospital or Skilled Nursing Facility admissions: If the participant remains in the facility for 30 consecutive days, the closure of the case must be initiated in EMWS. The closure effective date is the last day of the month following the 30th day. For example, if a participant enters a facility on September 12th and remains there on October 12th, waiver services should end on October 31st, with the EMWS closure date also set for October 31st. For incarceration or Wyoming State Hospital admissions: If a participant remains in the facility after 15 days, closure of the case must be initiated with an effective date 15 days from the date of the closure initiation. If the participant is discharged prior to the closure effective date, please notify the BES so that the hold can be removed. For closures due to admission to a rehabilitation facility, inpatient hospice facility or other facility, please work with the assigned BES. These actions are critical due to Medicaid program regulations; failure to process these closures expeditiously can result in significant financial burdens for participants and their families.

DD Waiver Amendment Public Comment Forum

We invite you to participate in the upcoming public comment forum regarding the proposed DD Waiver amendment. The session is scheduled for May 14th at 1:00 PM. This forum provides a vital opportunity to provide direct public comment on the proposed waiver changes. Please go to the [HCBS section webpage](#) under the *Public Notices* tab for information on how to join the zoom call.

Case Manager Contact Information

The HCBS Section would like to remind case managers to make sure their contact information is up to date in the Wyoming Health Provider (WHP) Portal. This includes ensuring the organization's contact person, their phone number, and email address are up to date. We will begin inviting case managers and providers to WYSERVES training sessions. We will use the contact information in the WHP Portal to send invitations to register for WYSERVES training. Case managers are strongly encouraged to participate in the upcoming WYSERVES training opportunities. Guidance on how to update contact information is located in the [Provider Change Guidance Manual](#) which is found in the [HCBS Document Library](#) on the Web Portal Guides tab.

Subscribe to the HCBS Email List

To receive regular updates and the latest information from the Home and Community Based Section (HCBS), case managers are reminded to subscribe to the HCBS email list. The subscription link is available on the [Contact Staff, Subscribe or Suggest](#) page. If you haven't received communications recently, please check your spam folder.

WRAP UP

The next DD Case Manager Support Call is scheduled for:

July 13th, 2026

[Link to Recorded Presentation](#)

QUESTIONS AND ANSWERS

Program Updates & Reminders:

To whom do we send our Relative Disclosure and Acknowledgement forms to?

Response: Relative disclosures should be submitted to either Alice Esquibel or Hannah Ostheimer. These are taking longer than normal but they will be processed as soon as possible.

If a plan of care already has participant directed services does a new modification have to be done to add a new provider?

Response: When a participant chooses to add a provider to their Individualized Plan of Care (IPC), the case manager must coordinate a transition plan. Following the transition meeting, the case manager must complete and submit plan of care modifications to the Division at least seven (7) business days prior to the scheduled start date of the new services. This process also applies if a brand new provider is being added to the IPC.

Children's Mental Health Waiver presented by Magellan Healthcare:

Can wrap around services be used at the same time as DD waiver?

Response: We can serve youth who are on the DD Waiver waitlist. Youth cannot be served on both waivers at the same time, however. **Is there a list of family care coordinators listed by area?**

Response: Yes, that information can be found here: <https://www.magellanofwyoming.com/home-2/find-a-provider/>