

Provider Training Series

Chapter 45, Section 22, Transition Process (Module #12)

Wyoming Department of Health
Division of Healthcare Financing
DD Waiver Provider Training Series



Welcome to the Division of Healthcare Financing (Division), Home and Community-Based Services Section's Provider Training Series for Chapter 45 of the Department of Health's Medicaid Rules (Rules). These rules govern the home and community-based Comprehensive and Supports Waivers, hereinafter referred to as the DD Waivers.

Chapter 45, Section 15(d) requires waiver providers to complete training in specific areas prior to delivering services. Individuals who complete all of the Series training modules and associated training summaries will be in compliance with this specific requirement. Please note that providers are responsible for ensuring they meet **all** training requirements, which are established throughout Chapter 45, prior to delivering waiver services.

This module covers Section 22, which addresses the process that must be followed when a participant changes providers or case managers, or when a provider requires a participant to change residences.

Purpose of This Training



To clearly outline the notification requirements, timelines, and standards for information sharing when there is a transition in the participant's life, in order to ensure the transition is smooth and successful for the participant and the plan of care team.

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Training Agenda

- ▶ Notification requirements and timelines for all involved parties
- ▶ Specific case manager and provider responsibilities
- ▶ Team meeting and information sharing requirements

By the end of this module, the following topics will have been introduced and explained.

- Notification requirements that participants, providers, and case managers must meet once the need for a transition is identified;
- The responsibilities that case managers and providers have in the transition process; and
- The importance of the team meeting, the requirements that must be met when scheduling and holding a team meeting, and the need for all team members to participate and share information during the team meeting.

Choice



Freedom to make choices is a human right. A participant or legally authorized representative may choose to change any provider at any time for any reason.

A theme throughout all of the Division's provider training modules is the fact that home and community-based waiver services are based on the tenet that people have the freedom to make choices that impact their lives without negative repercussions. A participant's right to choose providers is specifically established in Federal law and the Department of Health's Medicaid Rules. Section 22 further states that a participant or legally authorized representative may choose to change any provider at any time for any reason.

Transitions



The transition process must be followed every time a participant, provider, or case manager chooses to make changes related to a participant's service provider.

There are several changes in a participant's life that can result in the need for the team to follow a formal transition process. This process must be followed every time a participant, provider, or case manager chooses to make changes related to a participant's service provider.

Types of Transitions

- ▶ Change in case manager
- ▶ Change in provider
- ▶ Change in physical location within Wyoming
- ▶ Residential move within a provider organization

The transition process must be followed when a participant anticipates a change in case manager or provider, or when the participant plans to move to different part of the state that could result in a change to most or all of the providers on their plan.

If a participant is receiving community living services in a provider owned or operated setting, and the provider wants the participant to move to a different service setting, then the transition process must be followed as well. It is important to note that a provider cannot just require a participant to move to a different provider owned or operated setting. The point of the transition process is to ensure that the participant has the opportunity to choose where they live, rather than being placed in a setting based on provider convenience.

Requests for Transitions

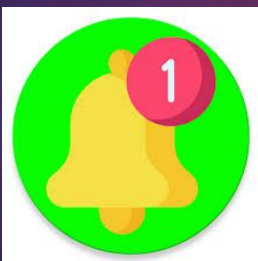
- ▶ Participant request
- ▶ Provider request
- ▶ Case manager request
- ▶ Emergency situations



A request for a transition can come from several places. Of course the participant has the right to change providers at any time and for any reason. Additionally, the provider or case manager may terminate services with proper notification. Finally, transitions may be the result of an emergency situation that is defined in Chapter 46, Section 14 of the Department of Health's Medicaid rules. Emergencies include situations such as the incapacity or death of an independent provider, or a health or safety concern that would require immediate changes to a participant's services or providers.

Transitions can be stressful for participants, even if it is a transition that they specifically request. Transitions that are the result of a provider or case manager request, or are the result of an emergency, can be highly emotional and downright scary. Everyone on the participant's plan of care team needs to be especially sensitive and do everything they can to work together to ensure a transition that is as smooth and stress free as possible.

Notification Requirements



Notification requirements are in place to ensure that all parties are aware of the changes so they can meet their responsibilities within the process.

The individual or entity that decides that a change is needed is required to meet notification requirements that are established in Section 22. These requirements are in place to ensure that all affected parties are aware of the changes so they can meet their responsibilities within the process.

Notification Requirements - Request of the Provider

- ▶ Provider must notify the participant, legally authorized representative, case manager, and the Division in writing at least 30 calendar days prior to ending services.
- ▶ The Division may approve a shorter transition period.
- ▶ Failure to provide services during this time may result in technical assistance, or corrective or adverse action.

If a provider is terminating a participant's services, they must notify the participant, legally authorized representative, case manager, and the Division. This notification must be in writing, and must occur at least 30 calendar days before they intend to end services. In limited circumstances, the Division may approve a shorter transition period. Exceptions may be made if the participant has already found another provider, or if the current situation poses a risk to the participant's health or welfare.

If a provider fails to provide services during the 30 days, the Division will consider the provider to have abandoned services, and the provider may be subject to technical assistance, or corrective or adverse action.

Provider Request to Change Service Setting

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- ▶ Participant must be offered choice from all available options.
- ▶ Provider must notify the participant, family, case manager, and legally authorized representative at least 30 days prior to scheduled move.

If a community living services provider requires a participant to move to another service setting, the participant must be offered the opportunity to choose from all available options, and cannot be limited to that provider's properties. The provider may have an available room in a group home, and this is certainly an option if a participant wants the provider to deliver community living services. However, is that room in a group home the only option? What about other group homes? What if the participant would like to live in an apartment, either alone or with a friend? What if the participant would prefer to receive services from another provider altogether? These should all be options for the participant to consider.

The provider must notify the participant, family, case manager, and any legally authorized representative of the move in writing at least 30 calendar days in advance so the participant can exercise their right to choose a new residence or provider.

Notification Requirements - Request of the Case Manager

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- ▶ Case manager must notify the participant, legally authorized representative, and Division in writing at least 30 calendar days prior to ending services.
- ▶ Case manager must provide services for the 30 calendar days or until a new case manager is added to the individualized plan of care, whichever is first.

A case manager who is ending a participant's case management services must notify the participant, legally authorized representative, and Division. This notification must be in writing, and must occur at least 30 calendar days before they intend to end services. Case managers must also upload the notification in the document library in the Electronic Medicaid Waiver System (EMWS).

The case manager must continue to provide case management services for the 30 calendar days unless a new case manager is added to the participant's individualized plan of care (IPC) before the 30 days expires. If the participant hasn't secured a new case manager at the end of 30 days, the back-up case manager is required to take over as case manager until the participant can get a new case manager in place. Case managers must ensure that the back-up case manager for each participant is listed on the *Circle of Supports* and *Contacts* screens so that case management services are seamless in this or an emergency situation. During the 30 days, the case manager is obligated to provide ongoing services, and support and assist the participant with the transition process.

If possible, case managers should schedule case management transitions to occur at the beginning of the month. The case management monthly unit can only be billed for a participant once per month. Monthly and 15-minute units cannot be billed for the same participant in the same month. If a participant transitions from one case manager to another in the middle of the month, both case managers must bill 15-minute units for the work that they do.

Notification Requirements - Request of the Participant

- ▶ Participant or legally authorized representative must inform the case manager of the decision.
- ▶ Case manager must notify the provider within three business days.
- ▶ Case managers and providers must maintain professionalism at all times.

When a participant or legally authorized representative chooses to change providers, they must inform the case manager of the decision. The case manager is responsible for notifying the provider of the participant's decision to discontinue services within three business days.

In most cases, the participant will let the provider know their intentions. Unfortunately, there are occasionally instances when the participant and their provider have a strained relationship that results in poor communication. It is the responsibility of the case manager to notify the provider of the upcoming transition so the provider isn't blindsided by this change.

Participants can also choose to change case managers. If the participant decides to select a new case manager, the current case manager must work with the participant, plan of care team members, and the newly selected case manager to ensure that the participant's transition goes smoothly. Case managers and providers must be professional and treat participants and legally authorized representatives respectfully at all times. Participants have the right to change providers. This right must be honored, and participants should not be made to feel uncomfortable as a result of exercising this right.

Provider and Case Manager Responsibilities



Providers and case managers are responsible for working together to ensure the participant experiences a smooth and seamless transition.

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Case Manager Responsibilities

- ▶ Notify the Division within three business days.
- ▶ Provide and review provider list with participant.
- ▶ Complete the Transition Checklist.
- ▶ Schedule a transition meeting.
- ▶ Submit IPC modification.
- ▶ Ensure all providers receive participant specific training.

Case managers are responsible for facilitating the transition process.

Once the case manager is made aware of the transition, they have three business days to notify the Division. This notification is most easily done by emailing the area Benefits and Eligibility Specialist (BES).

If a participant requests a change in provider, or if a provider notifies the participant that they will be ending services, then the case manager is responsible for reviewing the provider list with the participant. If the participant requests a change in case managers, then the case manager must make the provider list available, but is not responsible for reviewing the list with the participant. It is critical that the case manager complete this step to ensure that the participant has choice in their providers.

The Division requires the case manager to complete a Transition Checklist when facilitating the transition process. The checklist, which can be found on the [HCBS Document Library](#) page of the Division website, under the *DDForms* tab, lists the documentation, discussions, and actions that must be completed as part of the transition process. The case manager must complete the checklist in its entirety and upload it into EMWS.

Every transition requires a plan of care team meeting to ensure that necessary discussions have taken place and relevant information has been shared. The case manager must schedule the

meeting at a time and location that is convenient for the participant, and must notify all current and new providers, the participant, the legally authorized representative, and the Division at least two weeks prior to the meeting. The meeting may be scheduled sooner in an emergency situation, but the case manager must notify the Division of any emergency that requires a faster transition schedule. As the facilitator of the meeting, the case manager must invite cooperation and participation from all team members to ensure that the participant has the best chance at a successful transition.

After the transition meeting, the case manager must complete and submit IPC modifications to the Division at least seven business days before the new provider is scheduled to begin delivering services.

Before a new provider can begin delivering services, the case manager must ensure that the new provider has received participant specific training, including training on health and safety concerns and needed supports, positive behavior supports, and the IPC.

Provider Responsibilities

- ▶ Attend
- ▶ Participate and cooperate
- ▶ Share information
- ▶ Ensure capacity
- ▶ Ensure certification
- ▶ Be professional



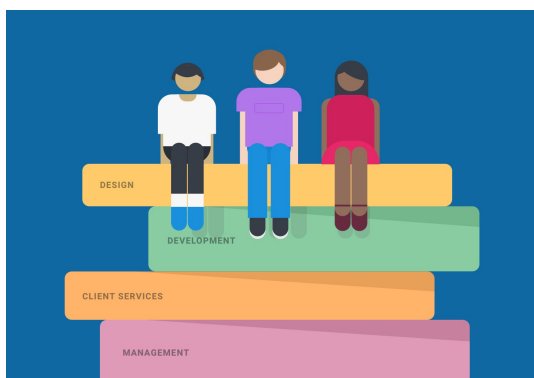
All providers, including case managers, have a responsibility to be part of the transition process. Providers should attend the transition meeting, and be prepared to participate and cooperate with other team members. If team members don't participate, valuable information can be lost. It is vital to the participant's success to have outgoing providers share relevant information with newly appointed providers. Outgoing providers have an obligation to provide input. Without the sharing of knowledge, the participant has less chance of success. Section 22 specifically requires all providers to share pertinent information in a timely manner.

It is extremely important for the new provider to understand participant preferences and behavioral and medical support needs, and ensure they have the capacity to meet those needs.

The new provider must be qualified and ready to accept the participant. The Division will not certify a provider or approve a new service setting without following the established procedures.

If a participant chooses a new case manager or provider, everyone involved is expected to behave in a professional manner. In order to ensure the best possible support for the participant, all team members must work together.

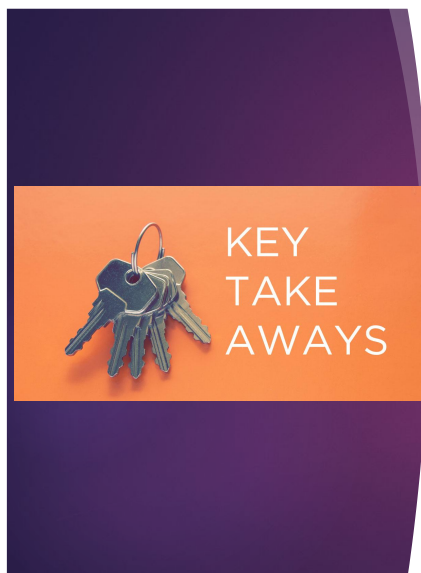
Provider Capacity



The provider must ensure that they have the capacity to address the participant's behavioral and medical needs ***before*** the provider accepts the participant into their services.

It is not uncommon for a provider to accept a participant with challenging behaviors into services only to find that they don't have the capacity or skills to support a participant's challenging behavioral needs. Once the provider determines they can't support the participant, the provider gives the participant a 30-day notice that they are terminating services and the transition process begins again. This quick transition can be very confusing for the participant and frustrating for the participant's plan of care team. Providers must be forthright about their ability to handle situations, and make decisions to accept or not accept a participant into services based on what is best for the participant, not based on potential income.

Chapter 45, Section 6 states that the provider must ensure that they have the capacity to address the participant's behavioral and medical needs before the provider accepts the participant into their services. Providers should consider the number of staff members available to support the participant, as well as the training and skills of those staff members. Providers should also consider the participants the provider already serves, and how a new participant may impact those who are currently receiving services.



1. Participants may choose to change any provider at any time and for any reason.
2. Timelines must be followed and responsibilities must be met.
3. Transition impacts the participant's life.
4. Providers must have the capacity to appropriately and safely serve the participant.
5. Participation from everyone is crucial.

As we end this training, we'd like to review some of the key takeaways:

1. Participants may choose to change any provider at any time and for any reason. One purpose of the transition process is to ensure that participant choice has been offered and honored.
2. Timelines have been established to ensure that the participant and plan of care team has time to thoroughly prepare for the transition. With limited exceptions, these timelines must be followed. Additionally, providers and case managers must meet their respective responsibilities, including professionalism, throughout the process.
3. Transition impacts the participant's life and may be stressful, even if it is a transition that they specifically requested. Everyone on the participant's plan of care team needs to be especially sensitive and do everything they can to work together to ensure a transition that is as smooth and stress free as possible.
4. Providers must ensure that they have the capability and capacity to appropriately and safely serve the participant before they accept the participant into services.
5. Participation from everyone is crucial. All plan of care team members should participate and cooperate with other team members. If team members don't participate, valuable information can be lost, which could impact the success of the participant's transition. Information should be shared in the team meeting to determine the best support for the participant.

Questions???

Contact your Provider or Benefits and Eligibility Specialist

<https://health.wyo.gov/healthcarefin/dd/contacts-and-important-links/>

Thank you for participating in today's training. If you have questions related to the information in this training, please contact your Division representative. Contact information can be found by clicking on the link provided in the slide.

Don't read this section as part of the live presentation

Please be sure to complete a summary of this training so that you can demonstrate that you received training on the rights of participants receiving services.