

Mandatory Case Manager In-Service Webinar
Q & A - 04/23/2015

Waivered Case Management	
Questions	Answers
Can the HCW be the Authorized Rep for Direct Contact? So, no 231 is required?	No, the HCW cannot also be a representative for the purposes of making a direct contact.
Is the skilled care required only if the case had been opened as waived prior to them going skilled?	Correct. If the individual starts off as receiving in-home or community based care, then moves into skilled care, the contact is still required while they are receiving that care. However, if the individual did not receive services prior to being on skilled care, then a contact will not be required.
If a case aide is doing the data entry on behalf of a CM who has completed a contact, do you have recommended narration guidelines they could use to help prevent confusion/penalty?	We will begin working on developing guidelines in the near future. Please stay tuned.
Is there a benefit to making direct contacts monthly, aside from the interaction with the consumer?	It is usually more beneficial to make direct contacts monthly, as this type of contact is more person-centered than an indirect contact. Keep in mind that direct contact with an individual is required if there are at least three high risks identified from their last assessment.
It's my understanding that per rule the paid caregiver can't be the authorized rep. Have I misunderstood that?	The in-home rules state that a paid provider cannot be an authorized representative; however, this isn't specifically stated in the Waivered Case Management rules. This will soon be updated.
Can the primary decision maker, without a 231 or similar designation, be a caregiver?	In no circumstances may a HCW be utilized as a direct contact. A HCW cannot be the representative for the consumer.
Does a client rep or POA suffice as a	If the client representative or POA is

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direct contact?	the primary decision maker for the individual (due to the individual being unable to make appropriate decisions), they can be utilized as a direct contact.
Does it cause problems if more than two contacts are made each month?	There are no problems if more than one contact is registered in a month for a particular consumer.
So Directs/Indirects must still be done if a CBC consumer is temporarily in Skilled Care (which might be up to 3 months)?	That is correct.
So does this mean that the State "bills" the feds for each direct or indirect contact?	In a sense, yes.
Our branch has case manager assistance input the indirect contacts after case manager review and signed the voucher. Does it count?	Yes, that counts. That Case Manager does need to take action if, after review, there are any concerns regarding what is being claimed on the voucher.
What happens if CM's consistently are not getting the contacts done?	Individuals that require contacts that do not receive it actually have their eligibility for services jeopardized. Although, this has not been specifically enforced, it could certainly happen in the future.
Just to clarify -- a manager can make direct/indirect contacts? Seems like we've heard both.	The rule says that contacts can be made by a Case Manager or higher level position. So managers can complete the contacts.
Is Risk Monitoring required for clients in an ALF, AFH and RCFs?	A Risk Assessment must still be completed when in a CBC setting, but Risk Monitoring is not required at CBC settings. Refer to APD-PT-12-007 .
Can an email from a client be considered a direct contact?	Yes, it counts as a direct contact when there is two way communications between the Case Manager and the

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	consumer.
Why do we have to a direct contact quarterly, even if a direct contact was made and logged the previous month?	<p>This is a CMS requirement. One direct contact is required once every quarter.</p> <p>1st Qtr. January – March 2nd Qtr. April – June 3rd Qtr. July – September 4th Qtr. October – December</p> <p>So in theory, you could complete a direct contact in March, then again in April, then not complete another one again until September.</p>
So, the spouse to a client who is involved in the care as natural support can be a direct contact?	Yes, if the consumer is unable to communicate & the natural support (spouse) is the authorized representative if they are the primary decision maker for the consumer.
Do we have to specifically ask if they had changes in health condition and if they are satisfied with their services each time we make a contact? Can we put RN service notes or Life Line report about client as indirect contact?	<ul style="list-style-type: none"> - You do not have to ask the same question of the consumer for each direct contact. The purpose of the direct contact is to check on the consumer's service plan & to see if there are any needs that aren't being met. - It is up to the person making the contact in what exactly should be asked. Common topics are related to health condition changes or if they are satisfied with their services. - RN services notes & ERS reports can be included as indirect contacts.
How many contacts on average are CM's doing per month?	The majority of Case Managers have been completing all or almost all of their contacts each month. So at least one per month per Case Manager.

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Voucher Replacement/50 Hour Cap Changes	
Questions	Answers
Why is this change happening?? To prevent fraud?	<ul style="list-style-type: none"> - Increase program integrity, in preparation for DOL requirements, to meet existing record keeping requirements, to consolidate payment solutions, increase business & technology maturity. - This will so assist with unemployment and PTO calculations. - Also move the business towards having consistent data across programs.
We will get vouchers with more hours for an activity then is authorized. Do we send them back?	<ul style="list-style-type: none"> - Vouchers with more hours than authorized will be dealt with the same way they currently are & have been in the past. - Depending on the branch procedure the CEP Specialist will return the voucher to the case manager. The case manager will determine if the issue can be reconciled over the phone. If it cannot, the voucher will be returned to the provider to address the needed changes.
Will the voucher come in different languages?	We are hoping to have the voucher translated into Spanish and Russian.
Do they have to write on a different line for every activity?	<p>No. How this works is dependent on CMS decisions.</p> <ul style="list-style-type: none"> - If CMS approves ADL/IADL roll-up all hours will be combined into one service type & the time in/time out shift will be reported.

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	<ul style="list-style-type: none">- If CMS does not approve the ADL/IADL roll-up the provider will be expected to document the time in & the time out (same as above). The provider will also be expected to report what portion of the shift was ADL & what portion was IADL. The system will have edits to make sure that time reported matched ADL/IADL reported & fits within the prior authorized hours.
<p>Can you make a rule recommendation that a provider cannot be given both live-in and hourly duties for the same client at the same pay period?</p>	<p>There is no rule that dis-allows a live-in also working as an hourly at the same pay period. They cannot be paid as an hourly caregiver for the same days they are paid as a live-in care giver. However, if they are a being paid as an hourly on the days that are not working as a live-in that is allowable.</p>
<p>Are you saying the current 230 hour cap per month is changing to 220? Also, policy has always said to use 4.3 weeks. Is this also changing?</p>	<ul style="list-style-type: none">- No, the cap will remain at 230 hours per month. The cap being implemented is on a single provider for a single consumer. A provider may only work 50 hours per week for a single consumer. There is not cap on the number of consumers a provider can work for at this time.- LTC policy has been using 4.4 to calculate hours for exceptions for some time. SNAP policy uses 4.3. So there is not a policy change, rather a clarification of different calculations.

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<p>Why did you choose 4.4 weeks when all other monthly to weekly calculations are 4.3?</p>	<p>LTC policy has been using 4.4 to calculate hours for exceptions for some time. This number has been used to ensure that 31 days months have enough hours to cover the entire month.</p>
<p>It sounded like the CEP will be entering in the hours worked STIM screen or will this be a function of support staff that pay the vouchers?</p>	<p>The CEP Specialist (support staff that processes vouchers) will be entering reported time into the STIM screen.</p>
<p>Will this form be made available in Spanish?</p>	<p>That is the intent at this time.</p>
<p>Has any work been done around looking at how much more time per voucher this will take our CEPs?</p>	<ul style="list-style-type: none"> - Yes, based on our initial assessments there will a time increase. - Based on existing time studies it takes CEP specialists 30-60 seconds to process a voucher at this time. - Because eXPRS has similar data entry it was used as a comparison for the future state. - The average time being spent by field staff to enter claims into eXPRS is about 3 minutes. - Based on analysis 3 minutes would be on the high end of the time needed to enter voucher information into STIM.
<p>What do we do for the care plans that have one provider with the max hourly plan of 221 hours?</p>	<ul style="list-style-type: none"> - The first option would be to adjust the authorized hours to a provider for 220 hours. - If the consumer really needs the additional hour they may be able to request an exception.
<p>Say a client had their CAPS and got their service plan renewed in February of 2015 and then the same client gets a</p>	<ul style="list-style-type: none"> - The 50 hour cap would apply to the new caregiver. - If the old caregiver had been

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<p>new replacement caregiver in October, following the new 50 cap, will the 50 p/ week cap apply to this new provider or not until the CAPS is renewed in February of 2016?</p>	<p>assigned more than 50 hours per week there would need to be an additional HCW added to the service plan.</p>
<p>Does the 50 hours also affect Agencies? Or can they work more than 50 hrs. a week?</p>	<ul style="list-style-type: none">- The 50 hour cap does not apply to service planning for contract agencies.- Agencies are responsible for managing their own staff & for compensating them appropriately.