

MODULE 2A: Preparing for and Beginning Services Facilitation

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Welcome to Part A of Module 2 in the series of four training modules for Services Facilitators in Virginia. Completion of all four modules and successful completion of the corresponding learning assessments will satisfy the DMAS training requirements to provide consumer-directed Services Facilitation in Virginia.

Again, please note that this training is meant to serve as a supplement to information that you are responsible to obtain and understand through regular review of the applicable regulations and provider manuals.

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Parts A and B of Module 2 cover the first three steps in this flow chart—the “front end” of Services Facilitation, so to speak.

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In Module 2, Part A, we will look at:

- What happens before a referral is made to a Services Facilitator, and how does a referral get to you?
- What is involved in accepting a referral -- and how do you initiate the services? In this section we will cover the conditions needed for Services Facilitation to begin, setting up a record, and contacting the individual.

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First, let's review what has already happened before a referral gets to you.

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Before a Services Facilitator receives a referral:

- The individual has already been screened and found eligible for the CCC Plus, CL or FIS Waiver, or the EPSDT Program; and
- The individual has selected both the consumer-directed model and you to provide Services Facilitation.

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As we mentioned in Module 1, there is a different screening process for CCC Plus Waiver, EPSDT Program and the DD Waivers (CL and FIS).

In the DD Waivers (CL and FIS), the individual will be screened by a qualified support coordinator or case manager using the Virginia Individual Developmental Disabilities Eligibility Survey (VIDES) level of functioning tool. The VIDES assessment determines the level of eligibility and identifies the individual's areas and levels of support need. There are three versions of the VIDES which are used depending on the age of the individual. Adults (18 and older) must meet criteria in 3 of 8 categories to be eligible. Children under 18 and infants, from birth to 3 years old, must meet 2 of 8 categories to be eligible.

It is important that you receive a copy of the screening instrument and related documents prior to initiating Services Facilitation. For example, in the CL and FIS Waivers, the Support Coordinator will have a copy of the Supports Intensity Scale ("SIS") which measures the frequency and intensity of supports an individual with a developmental disability needs to meet quality of life goals. You should receive a copy of the SIS.

Other documents completed at the time of screening in addition to the LOF include: Virginia Home and Community-Based Waiver Choice of Provider (DMAS-460); and Documentation of Individual Choice between Institutional Care and Home and Community-based Services (DMAS459C).

Please note that these forms, and all DMAS forms that are mentioned as we proceed, can be accessed for use directly from the DMAS website by going to the Virginia Medicaid Web Portal, clicking Provider Services, clicking Provider Forms Search, and entering the number of the form.

To learn more about the screening process, please refer to the following Module 2 Training Materials: Virginia Individual Developmental Disabilities Eligibility Survey (VIDES); and A Guide for Long-Term Care Services in Virginia (DMAS Division of Aging and Disability Services). Copies of the UAI and other screening forms mentioned can be accessed directly through the DMAS Virginia Medicaid Web Portal.

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Waiver services are offered to an individual as an alternative to avoid admission to an institution when the individual is in imminent risk of institutional placement. "Imminent risk of institutional placement" is defined as "needs to enter a facility within one month if he or she does not receive waiver services."

For the CL and FIS Waivers, the facility is an ICF/IID, and for the CCC Plus Waiver, the facility is a nursing facility. Waiver services should always be considered by screeners when an individual meets the institutional criteria specified in the waiver and is at risk of institutional placement without waiver services.

Screening is not contingent upon a person applying to determine financial eligibility for Medicaid coverage. Often the financial eligibility for Medicaid occurs at the same time an individual seeks to qualify for assistance. Even though they may be eligible, individuals may be placed on the single prioritized DD Waiver waiting list until funding for waiver services is available.

In the CCC Plus Waiver, a Community Screening Team of the local Department of Social Services and the local Department of Health uses the Uniform Assessment Instrument (UAI) to screen for eligibility for admission to a nursing facility. The criteria include medical needs and functional capacity. In addition to the UAI, the following forms are completed by the Screening Team: the DMAS-96; DMAS97; and DMAS-95 Addendum for CD-PAS (if applicable). In addition to a Community Screening Team of local social services and health department representatives, screening can also be provided by some hospitals.

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In the EPSDT program, a Medicaid-eligible individual under the age of 21 is screened for EPSDT by the primary care provider completing the Functional Status Assessment (DMAS-7). Primary care providers authorized to complete the Functional Status Assessment include Medical Doctors (MD), Doctors of Osteopathic Medicine (DO), Nurse Practitioners (NP) or Physician Assistants (PA).

Remember, screening is not contingent upon a person applying to determine financial eligibility for Medicaid coverage. However, the individual or an authorized representative will need to apply for Medicaid coverage. You will need to maintain a copy of the DMAS-7 screening instrument and verify Medicaid eligibility prior to initiating Services Facilitation.

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Once an individual has been screened and determined eligible, choice of waiver instead of facility and choice of provider must be documented when services are initiated:

- In the CCC Plus Waiver and the EPSDT Program, the DMAS-97 documents choice of providers.
- In the CL and FIS Waivers, individuals use the DMAS-459C to document choice of waiver instead of facility, and the DMAS-460 to document choice of providers.

In all three Waivers, the individual reviews and signs the Individual Selection of Consumer-Directed Services, the DMAS-489. In the CCC Plus Waiver, the form must be maintained by the Services Facilitator. In the CL and FIS waivers, the form is maintained by the Support Coordinator.

It is important that you receive a copy of all of the relevant forms prior to initiating Services Facilitation.

These forms can be obtained for use directly through the Virginia Medicaid Web Portal, clicking Provider Services, clicking Provider Forms Search, and entering the number of the form.

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The CD service plan will not be included in the overall service plan unless the individual is transferring from another Services Facilitator. It is important to know what is included in the overall plan and how CD services complement other services.

A common feature of all service plans is that the planning process should incorporate person-centered practices.

- In the CCC Plus Waiver and the EPSDT Program, there may be multiple service plans prepared by different providers. If, for example, an individual has transitioned out of an institution through Money Follows the Person (MFP) and worked with a Transition Coordinator, or the individual will continue to use AD services in addition to CD services, the agencies providing the AD services may already have a service plan in place for the individual.

In the CL and FIS Waivers, each individual will have a Person-Centered Individual Supports Plan prepared by the CSB or BHA or a contracted private case management provider and alongside the individual and their planning team. Part 3 includes a list of outcomes shared by those supporting the individual. If the existing Part 3 does not contain outcomes that would relate to supports provided by a particular CD service, the CSB can work with you and the individual and family to arrive at outcomes that are meaningful and measurable for the CD plan for supports.

Be sure to get a copy of any existing plan prior to initiating Services Facilitation.

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Now you are ready to accept a referral for Services Facilitation. You receive a referral because the individual has chosen you from a list of available Services Facilitators enrolled with DMAS. For those enrolled in the CCC Plus Waiver and managed care program, the care coordinator provides the member with a list of the Services Facilitators enrolled with the Managed Care Organizations (MCOs). The list of contracted MCOs can be found on the DMAS website. Search the Provider Search Link for “Case Management – Waiver and Service Facilitation” by clicking on the link at the bottom of the slide.

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First, accept a referral only when you are available to initiate and provide Services Facilitation on an ongoing basis.

For example, if your caseload is full and your agency has no other Services Facilitators available, you should not accept the referral.

You also have the right to refuse a referral if the individual is not appropriate for CD services. We will look at this in greater detail in just a minute.

Second, make sure you have received the screening instrument and related forms discussed in the previous section.

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In the CCC Plus Waiver and EPSDT program, you will then need to complete the DMAS-225 (the “Medicaid Long Term Care Communication Form”). Form 225 allows the Local Department of Social Services (LDSS) and providers to exchange information related to:

- The Medicaid eligibility status of an individual;
- A change in an individual’s level of care;
- Admission to or discharge from an institution or community-based services, or the death of an individual;
- Transfers to another Services Facilitator;
- Service Authorization Number for Medicaid Services; and
- Other information known to you or other providers that might cause a change in the eligibility status or patient pay amounts of an individual.

After completing the DMAS-225, you will return it to the Local Department of Social Services to let them know the individual is receiving Services Facilitation from you as of a certain date. Also distribute it to all relevant parties as directed on the form. The Department of Social Services will share this form with the CCC Plus health plans.

In the CL and FIS Waivers, the DMAS-225 is completed by the Support Coordinator.

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You also need to obtain a signed form for consent to exchange information from the individual. The DMAS-219 can be used, as can the Uniform Authorization to Exchange Information form. You can access the DMAS-219 for use by going to the Virginia Medicaid Web Portal, clicking Provider Services, and clicking Provider Forms Search, and entering the number of the form. A copy of the Uniform Authorization to Exchange Information form is included in the Module 2 training materials. In the CL and FIS Waivers, you can also obtain a copy of a Consent to Exchange Information Form from the CSB Support Coordinator.

Additionally, you should give the individual a HIPAA privacy notice and a form to sign acknowledging receipt.

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Lastly, you should be aware that the individual receiving services may have to pay a portion of the attendant's salary (the "patient pay" amount), if applicable. The individual will be notified by the local department of social services of any patient pay responsibility. The EOR agrees to make sure the individual pays the attendant patient pay net wages on a regular and timely basis. The patient pay should be paid to attendants on the pay dates circled on the payroll schedule. This amount will not be included in the attendant's pay received from the Fiscal/Employer Agent.

If the individual is newly enrolled or currently receiving services under the CL or FIS Waivers and has a patient pay that must be collected, ask the Support Coordinator to designate this in writing and provide a copy to you.

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Now you are ready to verify Medicaid eligibility and contact the individual! Before you make contact, you can verify Medicaid eligibility by checking the Medicaid portal or by using the Automated Response System (ARS). Chapter 2 of the appropriate waiver Provider Manual has additional information.

For all Waivers and the EPSDT program, you will need to verify Medicaid eligibility. This can be completed by searching for the individual in the DMAS provider web portal (VAMMIS). The individual's Medicaid must be active for you as a services facilitator provider to be compensated for your work and for the individual to receive services.

In the CCC Plus Waiver and EPSDT program, the Medicaid type is important as they may be enrolled in the CCC Plus managed care program. If the individual is enrolled in the CCC Plus program, you will need to receive preauthorization from the Managed Care Organization (MCO) for consumer directed services facilitation billable activity. It is your responsibility to contract with the MCOs that you will be providing services facilitation with and to be familiar with their rules for authorizations and pre-authorizations before conducting services facilitation.

For a list of MCOs and more information about the CCC Plus managed care program, click on the links at the bottom of this slide.

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When you make contact, you will want to:

Introduce yourself and explain your role as a Services Facilitator. If possible, you may also engage in a brief discussion about the purpose of Services Facilitation, what an EOR is and the EOR's role, the role of the Fiscal/Employer Agent, information about who can be attendants, and timeframes for meetings, visits, training, and beginning services. The amount of information you share will differ with each individual.

Although it is not always possible, you should also try to determine who the EOR will be. If you can, it allows you to complete and fax the "Fiscal Agent Services Request Form" (FARF) to the Fiscal/Employer Agent (F/EA) prior to the initial comprehensive visit, so that a Welcome Packet can be mailed to the EOR, which will save time getting attendants enrolled. The following slide contains information about obtaining and sending the FARF form.

Finally, schedule a day and time for the Initial Comprehensive Visit – and ensure that there is adequate time for the visit. The time required will, of course, depend on whether the initial comprehensive visit will include EOR Training.

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Following the phone conversation, if you identified the EOR, you can complete and send the Fiscal Agent Services Request Form (FARF) to the F/EA. Upon receipt of a completed FARF, the F/EA is to send a Welcome Packet to the EOR. If you did not identify an EOR, you will need to do so at the initial visit and complete and send the FARF form at that time.

You can download the FARF form at the link provided in the "Websites Referenced" document in the Module 1 training materials.

It is important to know that delay in determination of the EOR and completion of the FARF will lead to a delay in the F/EA's ability to request the required tax ID number from the IRS, which will delay processing of attendant timesheets.

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You can use the time between the referral and the initial visit to set up a record. DMAS prescribes the documentation that must be maintained by Services Facilitators. This slide shows the information DMAS requires you to keep:

- All assessments (in other words, the UAI, VIDES or physician's letter);
- All referral documents, including choice of waiver and choice of provider Documents;
- Any service plans;
- Each Individual Service Authorization Request;
- Service Authorizations received;
- For the CCC Plus Waiver, the current DMAS-225 from the local Department of Social Services;
- Consent and authorization forms;
- Guardianship and Power of Attorney documentation;
- Letter to the physician (if applicable);
- For the CCC Plus Waiver, the DMAS-95;
- Documentation of all contacts with the individual;
- Documentation of quarterly reviews (face-to-face);
- For the CL, and FIS Waivers, the DMAS 99LOC (Level of Care review); and
- Any Adult or Child Protective Services complaints filed.

You can refer to Chapter 2 of the Provider Manuals for more details.

If you work for an agency, it is also important to include any other forms or information your agency might require. Be sure to check with your supervisor.

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For additional record-keeping and documentation requirements, always refer to the applicable and current regulations and DMAS Provider Manual for the applicable Medicaid service. You can find all current manuals at the website referenced on this slide.

For the FIS Waiver, select Individual and Family Developmental Disabilities Support Waiver Services;

For the CCC Plus Waiver, select Elderly or Disabled with Consumer Direction Waiver Services; Tech Assisted Waiver and the EDCD/TA Crosswalk Guide

For the CL Waiver, select Intellectual Disability Waiver Services; and

For EPSDT, select EPSDT Manuals.

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When documenting, be sure to:

Sign the forms where appropriate;

Fully complete the form;

Write legibly; and

Be accurate.

Never ask an individual to sign a blank form, and never submit blank or incomplete forms or plans.

Do not white out information.

For additional documentation information, click the link on the slide.

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You have now completed Part A of Module 2 of the online training series for meeting the requirements for training as a Services Facilitator.

Please note that all of the web links provided in this Module are contained in the accompanying training materials.

Please complete the learning assessment for Module 2, Part A before proceeding to Module 2, Part B.

Thank you for your participation!