



Community Choices Waiver

Submitting Quality Service Plans

Wyoming Department of Health
Division of Healthcare Financing
Home and Community-Based Services Section
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Good afternoon. My name is Jennifer Adams and I am a Benefits and Eligibility Unit Assistant Manager for the Home and Community-Based Services Section of the Division of Healthcare Financing (Division). Thank you for joining us today



Explain the components of a quality service plan, and review the case manager's role in submitting a quality service plan.

The purpose of today's training is to explain the components of a quality service plan, and review the case manager's role in submitting a quality service plan.

Training Agenda

- Explain the assessment process and how the assessment paves the way for a quality plan
- Review the purpose of person-centered planning
- Explore the characteristics of a quality service plan
- Review billing options available July 1, 2021

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

- First, we will explain the assessment process, the Division's expectations of case managers when completing assessments, and how assessments are used to develop a quality service plan.
- We will review the person-centered planning process and the importance of using person-centered planning when developing a service plan.
- We will explore the characteristics of a quality service plan and the Division's expectations of case managers when developing a service plan.
- Finally, we will review the Service Plan Development and Monthly Monitoring billing units that will be in place beginning July 1, 2021.

Choice



A quality service plan ensures that the participant's choices are documented and honored.

Choice is a basic tenet of home and community-based waiver services. Waiver participants must have the freedom to exercise choice in who provides their services, where they live, with whom they spend time, and what they want for their future. Having choice is paramount to human dignity.

It is the case manager's responsibility to develop and submit a quality service plan, which is the guiding document for what the participant wants their services to look like, how they want their services delivered, and how the services are going to meet their specific needs. A quality plan clearly describes a participant's choice, and demonstrates that the participant was included in the planning process. When the participant has a quality service plan, their choices are not only documented, but much more likely to be honored.

The Assessment Process



In order to develop a service plan that meets the participant's needs, case managers must conduct a comprehensive assessment with the participant. The assessment process is completed in the Electronic Medicaid Waiver System (EMWS). All identified assessments must be completed before case managers can start the service plan development process. The assessments are part of an overall checklist in EMWS that is designed to be completed in a specific order. Skipping around can cause EMWS to become non-responsive and may prevent the case manager from completing the plan development process.

What is the Assessment Process?

- Determines a participant's needs, preferences, and goals.
- Determines the participant's need for medical, educational, and social supports.
- Identifies risks to the participant's health and welfare.

The assessment process is designed to help the case manager and participant determine the participant's needs, preferences, and goals, and help identify any medical, educational, social, or other service needs that should be addressed in the service plan.

The answers that the participant gives during the assessment process determines the need for additional assessments. Ultimately, these assessments identify risks to the participant's health and safety and determine the services that the participant will need to have on their service plan.

When the case manager completes the Participant Profile assessment, and any other assessments that are populated based on the answers a participant gives, the service plan that results will be more reflective of the participant's needs, goals, strengths, and preferences.

Assessment Modules

Assessment	Description
Supported-Decision Making Assessment	Assess the participant's ability and comfort in making decisions regarding their service plan and other life circumstances
Community Relationships Assessment	Assesses the participant's level of engagement and interest in employment, educational, and/or other social/cultural opportunities
Housing and Environment Assessment	Assesses the stability of the participant's living conditions and whether those conditions are supportive of the participant's overall health and welfare
Caregiver Assessment	Assesses the availability, strength, and stability of the participant's natural support system as well as identifies potential support needs for the natural support system
Participant-Direction Assessment	Assesses the participant's desire, comfort, and capability to direct his or her own care

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There are several assessment modules. All participants must complete the Participant Profile assessment module, which is used to gather basic information on the participant's background, family and natural support system, home environment, participation in the community, interest in participant-directed service options, and overall health status. EMWS will automatically populate additional assessments based on the answers in the profile. If the case manager feels that another assessment is necessary, they can complete other assessments as needed. If a case manager believes that an additional assessment is necessary, but the assessment did not automatically populate, they should review the Participant Profile to ensure that the information included is comprehensive and paints an accurate picture of the participant's circumstances.

This module is also necessary to help the case manager build rapport with the participant. During the assessment the case manager will identify the participant's strengths, preferences, support needs, and potential risk factors, which will be used to develop meaningful goals. The assessment is designed to identify areas that require a more in-depth assessment. Based on information obtained in the Participant Profile, case managers may be required to conduct additional assessment modules, including:

- Supported-Decision Making assessment, which assesses the participant's ability and comfort level in making decisions about their service plan and life circumstances;
- Community Relationships assessment, which assesses the participant's engagement and interest in employment, educational, and other social or cultural opportunities;
- Housing and Environment assessment, which assesses the participant's living conditions, and if the conditions support the participant's overall health and welfare;

- Caregiver assessment, which assesses the availability and stability of the participant's natural support system and identifies that system's need for support; and
- Participant-Direction assessment, which assesses the participant's desire and capability to direct their services through the participant-directed service delivery model.

Participant Profile

- Participant history;
- Level of care assessment results;
- Diagnosis and other relevant medical information; and
- Information provided by others who know the participant.

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As case managers work their way through the Participant Profile assessment, they should ensure that the following information is reviewed and documented:

- The participant's history, including medical, social, and other health needs or concerns;
- The participant's current LT101 assessment results to ensure that there hasn't been a change in the participant's condition that may result in the need for an updated assessment; and
- A review of the participant's diagnoses and other relevant medical information.
- If requested by the participant, information can be provided by others, such as friends or family members, who know the participant. The participant must give the case manager permission to speak with others and the case manager must document the names of anyone the participant has given them permission to speak with as well as what information they have agreed to let them share. It is important to remember that protected information should only be shared in a manner that is compliant with Health Insurance Portability and Accountability Act (HIPAA) requirements.

Assessment Requirements

- Initial assessment - within 10 business days of participant eligibility
- Annual reassessment - 15 to 60 calendar days of the current service plan end date
- Must be scheduled at a time and location convenient for the participant

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Case managers must meet specific timeframes when completing participant assessments.

The case manager must conduct participant assessments when the participant initially enrolls in the CCW program, and at least annually thereafter when the case manager develops the annual service plan. Case managers may need to conduct additional assessments during the service plan year if there are major changes in the participant's life, such as the participant moving from their own home to an assisted living facility (ALF) due to deteriorating health concerns.

Within five business days of being notified that the participant's enrollment has been initiated or a funding opportunity has been given, the case manager must contact the participant to schedule the Participant Profile assessment and other assessments as applicable. Case managers must complete this initial Participant Profile assessment within ten business days of being notified that the participant is eligible for CCW services. The annual reassessment must be conducted no sooner than 60 calendar days, and no later than 15 calendar days, prior to the service plan end date.

The assessment should be scheduled at a time and location that is convenient for the participant.

— Assessment Practices

- Approach the assessment as a conversation.
- Ask open ended questions.
- Ask follow-up questions.
- Ask questions to understand the task or goal.
- Ask specific questions for each module.
- Document information within five business days.

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While each assessment module has specific questions that need to be addressed, case managers should approach each assessment as a conversation, rather than a series of questions and answers. As often as possible, case managers should ask open ended questions to start the conversation, and ask follow-up questions to get more details. Case managers should ask questions that provide information related to the scope, frequency, and duration of the supports the participant will need in order to complete tasks or achieve their goals. For example, if the assessment process indicates a participant needs assistance with bathing, the case manager should ask questions such as:

- Do you prefer to have a male or female help you with bathing?
- Do you prefer showers or baths?
- How often do you need to bathe? How long does it usually take for you to bathe?
- What type of support do you need? Help washing your hair? Help getting into and out of the tub? Help with all bathing activities?
- What will you do if support is not available?

Case managers should ask any other questions that will paint a comprehensive picture of how the participant accomplishes bathing, their support needs, and their preferences. Answers to these types of questions will help the case manager and participant develop a more comprehensive service plan that addresses the participant's needs and preferences. In addition, answers to these questions will help the case manager determine the number of units to authorize for services.

Case managers must enter all assessment information into EMWS within five (5) business

days of completing the assessment.

Although case managers are required to complete the assessment modules identified, it is important for case managers to understand that a complete assessment of the participant's needs is a process, and may include other activities to determine the need for services.



Service Planning Process

It is the case manager's responsibility to develop a thorough and accurate service plan that ensures the health and welfare of participants. The service plan must be based upon the information obtained from the assessment process. A well-executed and person-centered service planning process is crucial to ensuring that participants receive quality CCW services.

A Word About Person-Centered Planning

The case manager must use person-centered planning to understand the needs, preferences, goals, and desired accomplishments of the participant.

— What is Person-Centered Planning?

An ongoing process used to help people plan for their future. In person-centered planning, the plan of care team focuses on the participant and that individual's vision of what they want their life to be.



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Person-centered planning is an ongoing process used to help people plan for their future. In person centered planning, the plan of care team focuses on the participant, and their vision of what they want their life to be. The plan of care team identifies opportunities for the participant to develop personal relationships, participate in their community, increase control over their own life, and develop or maintain the skills and abilities needed to achieve these goals. Person-centered planning relies on the commitment of the team to make sure that the strategies discussed in the service plan meeting are implemented.

The participant is the team leader, and can choose anyone they'd like to be involved in the person-centered planning process, including individuals or support staff members who work directly with them on a day-to-day basis. The case manager serves as the meeting facilitator, and leads the team through the process, handles any conflicts that arise, and assures equal opportunity for all to participate.

The Purpose of Person-Centered Planning

- To look at the person's whole life.
- To assist the participant in gaining control over their own life.
- To increase opportunities for participation in the community.
- To recognize individual desires, interests, and dreams.

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When facilitating a person-centered planning meeting, it is up to the case manager to ensure that the meeting is conducted in a way that includes the participant and addresses the participant's life as a whole...not just their waiver services. There will be a need to talk about areas of concern, but the meeting should focus on the participant's strengths, how they can exercise control over their life, and how they can be an active and participating member of their community. The team needs to acknowledge the participant's desires, interests, and dreams, and work as a team to identify ways for the participant to get what they want out of their life.

The result of the person-centered planning process is a service plan, developed by the case manager with the input of the participant and plan of care team, that includes supports, activities, and skill development or maintenance activities that will help the participant live the life that they want.

Quality Plans

According to Merriam-Webster, quality means a degree of excellence, or the superiority of a thing. So what is a quality service plan?

— Components of a Quality Plan



- Accurate;
- Comprehensive;
- Person-centered; and
- Professional.

A quality service plan must have certain characteristics. Plans must accurately capture the participant's wants and needs to ensure the participant is able to live the life they want to live. Plans must be comprehensive in their content, encompassing not only participant needs and wants, but any support the participant needs to make decisions, achieve goals, or mitigate health and safety risks. Plans must be person-centered, and the participant must be involved in the plan development process. Case managers must execute a professional product, meaning that it must be well written and free of spelling grammatical errors. Case managers must ensure that the service plan aligns with the service index and the waiver agreement for how services may be provided.

Before the case manager submits the service plan in EMWS, they must acknowledge that the service plan represents a complete and accurate picture of where the participant is at this point in their life. Remember, service plans are legal documents that demonstrate that the participant is receiving needed services, justify the case manager's payment for services rendered, and may be reviewed by the Division at any time.

Paint a Comprehensive and Accurate Picture

- Desires and needed supports;
- Support with decision making;
- Health and safety risks; and
- Goals.

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As mentioned earlier in the training, the participant's responses to the assessments will help guide the case manager in developing the service plan and identify specific needs that must be addressed. The service plan is the road map for providers to deliver the services, so it is imperative that this important information is included.

- The assessments address considerations such as the participant's cultural, traditional, and personal values; times during the week or year that are important or significant; and preferences such as their provider's gender. When the case manager includes this information in the service plan, the provider is able to follow up on this information and encourage the participant to be involved in cultural events that are available, can avoid delivering services on days and times that the participant is involved in other activities, and can ensure that the individual who provides the service is someone with whom the participant will feel comfortable.
- Case managers have an important role in identifying when a participant may need or want assistance with decision making. The case manager will take the lead on connecting the waiver participant to necessary advocacy or legal services, but a legal solution may not need to be implemented. However, information on the participant's concerns related to decision-making should be included in the service plan, so that providers are aware of how this may affect service implementation.
- Health and safety risks are identified throughout the service planning process. Each risk must be addressed with waiver or non-waiver services, or the participant must acknowledge that they are aware that the risk is not being addressed. When the risk is addressed, there needs to be a clear explanation of how. For example, if the participant has a risk of falls that is being addressed with natural supports, the service

- plan should provide information on who the natural support is, how and when they will provide support, and what that support will entail. Simply saying “Daughter will provide support” does not provide enough information.
- The case manager must support the participant in developing meaningful goals that reflect what the participant wants in their life, and consider the services and supports that the participant may need in order to obtain that goal. The participant’s goal may be general in nature and will coincide with what is in the participant’s overall plan. This support must be reflected in the services the participant receives, and strategies to achieve the goals must be discussed with the participant and service providers as part of the plan development process. For example, the participant may chose to go to Adult Day Services to increase their socialization and decrease isolation.

Agreement Form

The Agreement Form is the case manager's evidence that they have met their obligations, and demonstrates that the participant agrees to the information, services, and any rights restrictions that are outlined in their service plan.

→ Agreement Form



Community Choices Waiver Participant Agreement

Participant Name: _____

Medicaid ID: _____

The participant (or legal representative, as appropriate) must indicate agreement and understanding of the following by initialing each line.

- Case manager attests that they have reviewed all required information with the participant
- Documents that the participant understands and agrees to their service plan

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Case managers must demonstrate to the Division that they have reviewed necessary information with the participant, including the Participant Handbook, the participant's rights and responsibilities, the participant's right to choose from community or institutional services, the participant's right to choose their providers and services, person-centered planning, fair hearings, information about the Long Term Care Ombudsman, and how to contact their case manager and their case manager's supervisor.

The Agreement Form documents that the participant understands and agrees to their service plan. The Agreement Form also demonstrates that the participant was part of creating their service plan, as opposed to only the case manager and providers being involved.



Billing for Services

Beginning July 1, 2021 case managers will use new billing codes and will be reimbursed with new rates. The rates were developed as part of the Division's rate study, which was performed in 2020. The study can be found on the [Public Notices, Regulatory Documents, and Reports](#) page of the Division website, under the *Public Notice on Changes to Statewide Methods and Standards For Setting Provider Payment Rates for the Community Choices Waiver toggle*.

Service Plan Development/ Annual Update Unit

→ Service plan development activities:

- ◆ Participant education;
- ◆ Assessment process;
- ◆ Plan of care team meeting for plan development;
- ◆ Provider acceptance of services;
- ◆ Participant direction activities related to the plan; and
- ◆ Plan development and submission.

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The case manager may only bill the service plan development and annual update unit once a plan year. The unit takes into account the activities that the case manager will typically conduct when they develop an initial service plan, or develop a service plan renewal. This unit is intended to be delivered in one lump sum to recover costs incurred during the development of the service plan. The case manager can bill this either at the end of the plan year or the first month of the new plan year.

Service plan development activities include:

- Participant education, such as the time that the case manager spends reviewing the Participant Handbook, explaining the participant's rights and responsibilities and the role of the Long-Term Care Ombudsman, discussing the participant's right to a fair hearing, and offering the participant choice in their services and service providers.
- Conducting the assessment process, which was described earlier in this training.
- Scheduling and conducting the plan of care team meeting, and ensuring that the participant is involved in that process.
- Interaction with providers as they evaluate the resources, expertise, and capacity needed to deliver the services, and ultimately accept or reject service referrals.
- Participant direction activities related to service plan development, such as ensuring that participants who express an interest in participant direction are informed of the potential benefits, liabilities, risks, and responsibilities associated with participant direction; determining if participants meet the additional criteria for participant direction; assisting the participant or designated employer of record (EOR) in obtaining and completing required documents; and determining the participant's monthly budget allocation.

- Developing the service plan in accordance with the standards outlined in this training, and submitting it within the established timeframes.

Monthly Monitoring Unit

→ Service plan monitoring and follow-up activities:

- ◆ Monthly and quarterly participant evaluations;
- ◆ Contacts;
- ◆ Scheduling appointments as needed;
- ◆ Plan review;
- ◆ Plan modifications; and
- ◆ Follow-up activities as necessary.

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Case management activities should be documented in the CCW Monthly Review Form, which can be found under the *Processes* tab in EMWS. The case manager may bill the monitoring unit every month in which they conduct the required monitoring activities. This unit may be billed on the same month that the case manager bills the service development unit as long as the monitoring activities have been completed. When billing the monthly unit, the case manager cannot submit the CCW Monthly Review Form before the last day of the month for which they are billing. Once they have submitted the Monthly Review Form they can then bill for the unit of service completed.

The monitoring unit takes into account the activities that the case manager will typically conduct when they monitor a service plan and follow-up on identified concerns.

- Monthly and quarterly participant evaluations, which include evaluating the effectiveness of the service plan in meeting the participant's needs, identifying changes in the participant's condition or circumstances, screening for potential risks or concerns, and assessing the participant's satisfaction with their services and supports.
- Activities and contacts that are necessary to ensure that the service plan is effectively implemented and adequately addresses the needs of the participant. Contacts with the participant, legally authorized representative, family members, service providers, or other entities or individuals are included.
- Determining the participant's need for medical, educational, social, or other services, and supporting them in scheduling needed appointments. This may mean that, upon the request of the participant, the case manager is scheduling appointments for the

- participant.
- Ensuring that services are being furnished in accordance with the participant's service plan, including service utilization. This includes monitoring participant-directed services to ensure they are effective and align with the monthly budget allocation.
- Making necessary adjustments or modification to the participant's service plan and service arrangements, as necessary.
- Conducting follow-up on identified concerns in order to ensure that the concerns have been addressed and that the participant is receiving the appropriate services and supports.



Key Takeaways



1. Person-centered planning is specific to participant needs and goals, which leads to a fulfilling life.
2. A comprehensive assessment is necessary to develop the service plan.
3. Quality plans are those that are accurate, comprehensive, person-centered, and professional.
4. The case manager is acknowledging that the plan is complete and represents an accurate picture of the participant at this point in their life.

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As we end this training, we'd like to review some of the key items that case managers need to remember:

1. Person-centered planning ensures that a participant's choices are honored, and needs and goals are met, which lead to a more fulfilling life for the participant.
2. A comprehensive assessment is necessary to develop a quality service plan.
3. Quality plans are those that are accurate, comprehensive, person-centered, and professional. The service plan is the road map for providers to deliver the services in accordance with the participant's wants and needs, so it is imperative that accurate and comprehensive information is included.
4. When a case manager submits the service plan in EMWS, they are acknowledging that the plan is complete and represents a complete and accurate picture of where the participant is at this point in their life. Case managers must understand that the service plan is a legal document to which they will be held accountable.

Questions???

Contact your Provider Support or Benefits and Eligibility Specialist

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

Thank you for participating in the training on submitting quality service plans. 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.