



# Community Choices Waiver

## CCW Service Index

Wyoming Department of Health  
Division of Healthcare Financing  
Home and Community-Based Services Section  
August 12, 2021

Good afternoon. My name is Erin Sparks and I am a Benefits and Eligibility Specialist for the Home and Community-Based Services Section of the Division of Healthcare Financing (Division). Thank you for joining us today



Introduce the CCW Service Index and review service definitions.

The purpose of this training is to introduce the CCW Service Index and review service definitions to ensure that case managers understand what each service is and what it offers the participant.

## Training Agenda

- Explain purpose, organization, and use of the CCW Service Index
- Outline service requirements and restrictions of CCW services
- Review the case management service definition

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

- First, we will review the purpose of the CCW Service Index, how it is organized, and its components. We will also discuss how case managers can use the Service Index when working with participants and plan of care teams.
- We will outline the general service definitions of the services that went into effect on July 1, 2021, including restrictions and recent changes.
- Finally, we will thoroughly review the case management service definition, and provide additional information on what is expected of case managers.

# Choice



Case managers must ensure that the participant's choice is being honored and respected during service delivery.

Choice is a basic tenet of home and community-based waiver services. Participants must have the freedom to choose the services they receive and 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. In order for a participant to make an informed decision about the services they receive, they must know what to expect from the service, and what is and isn't allowed as part of the service. It is the case manager's responsibility to provide this information. When monitoring services, case managers must ensure that the participant's choices are being honored and respected.

  
**COMMUNITY CHOICES WAIVER  
SERVICE INDEX****Effective July 1, 2021**[Table of Contents](#)

# An Introduction to the Service Index



The Service Index is intended to be a one stop shop for information about service definitions, billing codes, and rates. It is a guide for case managers, providers, and participants to use so they can understand the requirements and limitations of each service, as well as qualifications, required documentation, and other expectations that are specific to each service. The Service Index can be found on the [Service Definitions and Rates](#) page of the Division website.

## — Division Expectations

- Aligns with Community Choices Waiver agreement
- Provides additional guidance on:
  - ◆ Licensure;
  - ◆ Participant-directed service billing requirements; and
  - ◆ National Provider Indicators (NPI).

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The first section of the Service Index explains general service requirements. The first paragraph reads:

*The Community Choices Waiver (CCW) services defined in this document shall be performed in the manner described in the service definitions. Services must meet each participant's assessed needs. In accordance with the Wyoming Medicaid Provider Agreement, CCW providers and case managers must be knowledgeable of federal rules and requirements and the Department of Health's Medicaid Rules and guidance affecting CCW services.*

Case managers and providers are responsible for knowing and complying with all rules that govern their work. Every Medicaid provider signs a Provider Agreement as a part of the Medicaid enrollment and re-enrollment process. When they sign this agreement, they are verifying that they are knowledgeable about the program rules and agree to follow them.

The Division Requirements section provides some additional guidance on billing requirements related to participant-directed services.

It is important for case managers to know all of the information in the Service Index, but the service requirements established in the first section are critical!

# Billing Table

\* Please note that Prior Authorization is required for Waiver Services

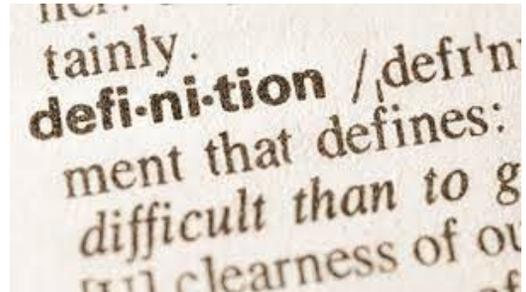
Service	Code	Rate	Unit	
Case Management	Service Plan Development /Annual Update	T2024 U6	\$507.81	Initial plan/annual update
	Monthly Monitoring	T2022	\$133.40	Monthly

- Service
- Billing codes
- Billing rates and units

The Service Index is organized in alphabetical order. Each service definition begins with a table that identifies the service, including specific models or options within the service. The table outlines the billing unit, such as a 15 minute or per event unit, the rate associated with the unit, and the code that should be used when billing for the unit.

## — Service Definitions

- Components included in service
- Billable activities



The next section of the Service Index is the actual service definition. The definition is copied, for the most part, directly from the approved Waiver agreement, but does include some additional guidance to ensure clarity. In addition to the general expectations of the service, the definitions may list components included in the service, such as personal care, billable activities and requirements, and necessary documentation.

## **Exclusions and Limitations**

- Service limitations
- Duplicative services
- Costs excluded from reimbursement rate
- Provider types

The next section of the Service Index lists the exclusions and limitations of the services.

This section establishes service limitations, such as limitations on the number of units a participant can receive, the number of hours that are required, or the overall dollar amount that can be spent on the service.

This section describes the limits on services that can be provided through another funding source, such as the Medicaid State Plan, and identifies costs that are not included in the reimbursement rate, such as personal care or transportation services. The last component of this section identifies provider types that are approved to deliver the service.

# Case Manager's Guide to the Galaxy



Case managers have several resources available to them to help them do their job, including the Case Manager Manual, the Waiver agreement, and various desk references and trainings. The Service Index is another extremely important resource that case managers must use when developing and monitoring participant service plans.

## Using the Service Index

- Know the information.
- Take it to plan of care team meetings and other meetings with the participant.
- Refer to it when developing and monitoring the service plan.

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Case managers must know the information that is outlined in the Service Index. They should refer to it when discussing service options with participants so that participants can make an informed choice on the services they select.

CCW services must be based on the participants assessed needs; however, a key component of person-centered planning is ensuring that a participant's services are selected based on their choice as well. Plan of care teams should never make an assumption that specific services should be included on a participant's plan, and then try to meet the participant's needs within the services. The participant's wants and needs should always be considered first. For example, the participant's team may feel that the services offered in an assisted living facility are in the best interest of the participant in order to address the risks identified during the assessment of the participant. However, the participant doesn't want to move from their home, and believes an assisted living facility is just one step away from a nursing home. A combination of several services, such as a few hours of personal support each day, a home delivered meal on weekdays, skilled nursing services three times a week to support the participant with wound care, and a personal emergency response device to ensure that the participant has help in an emergency may meet the participant's needs and be more in line with what the participant wants for their life.

Case managers should take the Service Index to meetings, refer to it when developing the service plan, and when they are monitoring the service plan. Having this information available, and referring to it often, will help the case manager to determine if the service is the most appropriate, based on the participant's wants and needs.

Case managers should ensure they are using the correct version of the Service Index, as the Division will occasionally make changes to add detail or clarity. The Division publishes the most current version on the [Service Definitions and Rates](#) page of the Division website, and will send a notification to its email list if there are changes to the Service Index. Typically, changes will be noted in blue lettering.



# Service Changes Effective July 1, 2021

The Community Choices Waiver renewal was approved on June 11, 2021, and went into effect on July 1st. The renewal includes several changes to service options, rates, units, and billing codes. These changes are summarized in the following slides, but it is the responsibility of case managers and providers of the services to know and follow the service definition and use the accurate information to submit claims.

## **Adult Day Services**

- Health and social service models.
- Billing unit has changed to a half-day unit.
- Billing codes and rates have changed.
- Service caps reflect new billing unit.

Adult day services are available as a health or social service model. The health model services include group socialization and companionship, assistance with activities of daily living, and supervision as specified in a service plan. The service plan must be individualized to the participant's assessed needs, and include realistic and measurable goals. The social model services include group socialization and companionship support to participants at risk for isolation or loneliness. Assistance with activities of daily living may be provided, but must be incidental to the service. Participants are not required to have a measurable goal if they are receiving social model services.

Adult day services are generally furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the service plan. As of July 1, 2021, the billing unit for these services changed to a half day unit. Billing codes and rates also changed. The caps for these services have been updated to reflect the new billing unit. Health model services are limited to a maximum of ten half-day units per week, or the prorated equivalent of five days per week at eight hours a day. Social model services are limited to a maximum of six half-day units per week, or the prorated equivalent of three days per week at eight hours a day.

## **Assisted Living Facility Services**

- Standard and memory care unit options.
- Additional services may be used to supplement services not covered under the facility's licensing authority.
- Billing codes and rates have been changed.

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Assisted living facility services include personal care and other supportive services, to the extent permitted under state law governing assisted living facilities. Services must be furnished in a residential setting that meets the home and community-based setting requirements, and must include 24-hour on-site response to address participant needs and to provide supervision, safety, and security. Services include social and recreational activities, and medication assistance permitted under state law.

In the event that a participant's needs extend beyond the facility's capability to support those needs within its licensure authority, the facility may consult with the participant's case manager to coordinate additional Medicaid or non-Medicaid services to supplement, but not replace, the care provided by the assisted living facility. The assisted living facility is responsible for coordinating services that are provided by third parties.

This service has undergone several changes. The previous tiers no longer exist; assisted living facility services are limited to standard care or memory care services. Memory care services cannot be billed unless the participant is receiving services in a memory care unit.

The billing unit remains a daily unit, but billing codes and rates have been changed.

## Home Delivered Meals

- Hot or frozen option
- Limited to two meals per day once PHE is over
- Cannot constitute a full nutritional regimen.



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Home delivered meals are available to participants as long as there is no one else in the home who is available to prepare the meals for the participant, meaning that the person who would normally prepare meals is not available to prepare the meal at the time the participant is ready to eat. If there are other people living in the home but they are not available to assist with meal preparation at the necessary time, then the participant can still receive home delivered meals.

The home delivered meals service now offers two meal options - hot and frozen, so rates and billing codes have changed. The type of meal is not really about the temperature of the meal, but more about the time and effort that is spent with the provider's preparation and delivery of the meal. Hot meals are defined as meals that are ready-to-eat and are delivered on a daily or semi-daily basis by the meal provider. Frozen meals are defined as meals that are prepared and packaged on a commercial basis, and delivered in bulk through a mail or delivery service.

Providers that deliver meals are held to incident reporting standards. If, while they are delivering the meal they note concerns with the participant's well-being, the provider must report the concerns to the participant's case manager and, if necessary, use the Provider Portal to report the incident to the Division.

Once the public health emergency is over, participants are limited to two meals per day through this service. During the remainder of the public health emergency, participants may receive three meals per day. These meals cannot constitute a full nutritional regimen, which means that they are not intended to provide the sole source of nutrition for the participant.

If food insecurity is identified as a risk on the participant's assessment, the case manager must ensure that the service plan addresses how the participant's additional dietary needs are being met.

Remember, hot meals cannot replace or duplicate meals provided as part of another waiver service or meals for which the participant has already paid to a residential provider as part of their room and board

## Home Health Aide

- Part-time or intermittent assistance with personal care and other daily living needs.
- Not intended to provide 24-hour care.
- May include general household tasks.
- May be provided in the home or community.

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Home health aide services include part-time or intermittent assistance with personal care and other daily living needs. The billing code and rate for these services have changed. These services are not meant to provide 24-hour care to the participant and should not be delivered in this manner. If the participant needs this level of care, the home health agency must contact the participant's case manager and ask that further discussion occur regarding the supports and services the participant may need.

These services may include general household tasks such as meal preparation, grocery and personal needs shopping, and light housekeeping. These tasks are incidental to the personal care provided during the visit, and should only be conducted if the participant is unable to complete these tasks and the individual regularly responsible for these activities is temporarily absent or unable to conduct these activities.

The services may be provided while the participant is at home or in the community, and cannot duplicate services available through the Medicaid State Plan or other applicable programs.

Transportation is not covered through this service and must be billed separately.

## — Non-Medical Transportation



- Public transit multipass
- Service route
- Wheelchair accessible
- Non wheelchair accessible
- \$80 monthly cap

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Non-medical transportation services are available in order for waiver participants to access waiver and other community services, activities, and resources. This transportation cannot be used for transportation to medical appointments or other medical purposes, as medical transportation is covered by the Medicaid State Plan. Whenever possible, participants must rely on family, neighbors, friends, community agencies, or other natural and unpaid supports to provide their transportation.

This service now offers several delivery options, including a public transit multipass, a service route, and wheelchair accessible and non-wheelchair accessible vehicles. The service route and vehicle options are billed and paid as one-way trips. The billing codes and rates for these options have changed from the previously available service.

There is still an \$80 a month cap on this service. The Division is aware that this service cap allows for fewer trips for participants who need wheelchair accessible vehicles. We will submit a waiver amendment to rectify this situation as soon as possible.

## **Personal Emergency Response System (PERS)**

- Landline and cellular service delivery options.
- Monthly monitoring includes equipment, response, troubleshooting, and documentation.
- Installation includes delivery, installation, activation, and training - limited to once per lifetime.
- Needs based criteria required.

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Personal emergency response systems (PERS) allow a participant to call for outside help in an emergency. This service includes electronic devices that are programmed to signal a response center when a help button is activated, which enables the participant to secure this help in an emergency. This service is limited to participants who can demonstrate the need for the equipment, such as participants who live alone or are alone a significant portion of the day, or who live with others who are unable to help in an emergency.

The biggest change to this service is that a cellular installation and monthly monitoring option are now available in addition to the landline option. This cellular option allows participants to use the service in locations other than their home, such as when they are shopping or participating in community activities.

The monthly monitoring unit for both landline and cellular services includes equipment rental, 24-hour response to alerts and alarms, equipment testing and troubleshooting, and documentation of communications that the provider has with the participant.

Installation for both service options includes delivery, installation, activation, and participant training on the use of the equipment as necessary. The installation unit is limited to one unit per lifetime per participant unless there are extenuating circumstances or there is a change in the service provider.

## **Personal Support Services**

- Part-time or intermittent support with activities of daily living.
- May include general household tasks.
- May be provided in the participant's home or in the community.
- Does not include services that are diversional or recreational in nature.

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Personal support services are a part-time or intermittent service that provides participants with assistance to accomplish activities of daily living. This assistance may take the form of hands-on assistance or prompting the participant to perform a task. Personal support services may also consist of general household tasks when the participant is unable to perform such tasks and the individual who is regularly responsible for these activities is temporarily absent or unable to conduct these activities.

The only changes that were made to the service were the billing code for the participant-directed option and rates for both billing options.

As a reminder, personal support services may be provided in the participant's home, or in the community when the participant requires assistance with activities of daily living in order to participate in community activities or to access other services. Personal support services may not include companionship or other services which are diversional or recreational in nature.

## Respite



- Rates for in-home and assisted living facility options have changed.
- **Combined** limit of the services is capped at 30 days per service plan year.

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Respite includes short-term services provided to participants who are unable to care for themselves and need support because the individuals who normally provide care are either absent or in need of relief. The billing codes for these services remain the same, but the rates for the in-home and assisted living facility options have changed.

The limit for this service is the prorated equivalent of 30 days per service plan year for all respite service options combined.

## — Skilled Nursing

- RN and LPN service delivery options.
- 15-minute billing unit.
- Referral form must be submitted, and prior authorization must be obtained.



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Skilled nursing services include part-time or intermittent skilled nursing care that is delivered within the scope of practice and required to be delivered by a nurse within their scope of practice as defined under the Wyoming Nurse Practice Act. Skilled Nursing.

Two service delivery options are available for this service - services delivered by a Registered Nurse (RN) and services delivered by a Licensed Practical Nurse (LPN). The service unit has changed from a hourly unit to a 15-minute unit. The billing codes and rates for these delivery options are different from previous skilled nursing services. The skilled nursing assessment is no longer billed separately, and the cost for this service is now built into the service referral.

The case manager is responsible for contacting the skilled nursing provider that the participant chooses to see if they are able to provide services for the participant. If the provider is willing to provide the service, they must conduct an assessment of the participant and complete and submit the Division approved referral form to the Division contractor that approves skilled nursing services no earlier than 60 days before to the start of the service plan. This form can be found on the [HCBS Document Library](#) page of the Division website.

The Division's contractor will send a Skilled Nursing Approval Letter to the provider. The provider must send this approval letter to the case manager, who must upload the letter in the Service Referral section of the service plan. Once this letter is uploaded, the case manager can submit the service referral in EMWS using the information from the approval letter. Please note that the units in EMWS cannot exceed the units listed in the approval letter.

Claims billed for this service must include the provider's NPI number.



## Case Management

# Case Management Services

Case management is the only required waiver service, which means that every participant must have a case manager. The case manager is the key to effectively delivering waiver services. From developing a service plan that clearly addresses the participant's wants and needs to assessing participant satisfaction, the case manager plays a critical role in assuring that the participant receives quality services.

Case management is a lynchpin service. The service plan that the case manager develops can determine the success or failure of participants receiving waiver services, and the excellence or mediocrity of their quality of life.

As indicated in the case management service definition, these services are intended to assist participants in gaining access to needed waiver and other Medicaid State Plan services, as well as medical, social, educational, and other services, regardless of the funding source for the services being accessed.

## **Case Management Services Include:**

- Assessment and reassessment of participant needs.
- Development and revision of service plan.
- Service coordination and referral.
- Service plan implementation, monitoring, and follow-up.
- Assistance related to participant direction.

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Case management is a collaborative process that is characterized by advocacy, communication, and resource management. It promotes quality and cost-effective interventions and outcomes, and covers a variety of tasks.

Case managers are responsible for conducting a comprehensive assessment and periodic reassessment of participant needs in order to support the participant in determining their need for medical, educational, social, or other services.

Case managers facilitate and oversee the development of a person-centered service plan, and make periodic revisions as needed. As a reminder, case managers cannot add or reduce waiver services unless it aligns with the participant's assessed needs and has been chosen by the participant.

Case managers conduct tasks that relate to service coordination and referral, such as scheduling appointments for the participant and linking them with medical, social, and educational providers or programs that may or may not be funded through the CCW.

Case managers must monitor the service plan and conduct identified follow-up activities, including activities and contacts that are necessary to ensure that the service plan is effectively implemented and adequately addresses the needs and desires of the participant. Case managers must spend the time necessary to evaluate the effectiveness of the service plan and ensure providers are delivering services in accordance with the plan. They must identify changes in the participant's condition or circumstances, and periodically screen for potential risks or concerns. They need to assess the participant's satisfaction with their

services and supports, and make adjustments to the plan and with providers, as necessary.

Case managers are responsible for informing participants of participant-directed opportunities, and ensuring that participants who express an interest in participant direction are informed of the potential benefits, liabilities, risks, and responsibilities associated with participant direction. If the participant expresses a desire to pursue participant-directed services, case managers must conduct the assessment for participant direction, assist the participant or designated EOR in obtaining and completing required documents, determine the participant's monthly budget allocation, and coordinate with the Financial Management Services (FMS) agency. The case manager must also monitor the effectiveness and quality of participant-directed services, and review the expenditures to ensure they do not exceed the monthly budget allocation.

## **Case Management Agency Responsibilities**

- Administration
- Employment
- Collaboration
- Documentation and billing

Case management agencies have a number of responsibilities that they must meet. These responsibilities are outlined in the Service Index. Although we aren't going through the entire list, we wanted to broadly address these responsibilities.

Case management agencies have administrative responsibilities. These responsibilities include assigning a primary Division contact and maintaining adequate staffing and back-up resources, including translation services and timely responses to messages and telephone calls received outside of normal business hours. Each participant must be assigned a primary case manager, based on the participant's preferences, as well as a backup case manager who can respond in the event that the primary case manager is unable to provide the services. Agencies must be able to overcome geographic barriers in order to provide timely services, and ensure that services are available, at a minimum, during typical working hours.

Case management agencies have an obligation to their employees who are case managers. Agencies must ensure that case managers meet case manager requirements and take the required trainings. Their employees must be aware of up-to-date information on public and private local and state supports, be knowledgeable of CCW policies and procedures, and have access to federal and state statutes, regulations, and other information relevant to case management services. They must have a mechanism for assessing and managing the performance of the case managers employed by the agency.

Case management agencies must establish and maintain working relationships with community-based resources, supports, organizations, hospitals and service providers, and collaborate with other entities, as needed to ensure that participants have access to available

supports.

Agencies must ensure that they bill in accordance with established billing standards and maintain documentation to substantiate claims for a period of six (6) years after the date of service.

Please remember that case managers are required to submit monthly documentation through EMWS prior to submitting a claim for payment. For more information on required case management documentation, please refer to the Case Manager Monthly Review Form training found on the [Training](#) page of the Division website, under the *CCW Case Manager Support Call Trainings* toggle.

## **Conflict Free Case Management**

- Case managers cannot be:
- ◆ Related by blood or marriage;
  - ◆ Share a residence;
  - ◆ Have financial responsibility;
  - ◆ Make financial or health related decisions; or
  - ◆ Have financial interest in other providers.

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The case management agency and case manager must meet conflict of interest standards.

- They must not be related by blood or marriage to the participant, or to any person paid to provide CCW services to the participant.
- They must not share a residence with the participant or with any person paid to provide CCW services to the participant.
- They must not be financially responsible for, or be empowered to make financial or health-related decisions on behalf of the participant.
- Finally, they must not own, operate, be employed by, or have a financial interest in any entity that is paid to provide CCW services to the participant. Financial interest includes a direct or indirect ownership or investment interest or any direct or indirect compensation arrangement.



# Key Takeaways



1. The Service Index is an important resource, and case managers must be familiar with the information it contains.
2. The Service Index defines the expectations of each service, and should be used as case managers monitor services.
3. Case managers must be familiar with the service changes that became effective July 1, 2021.

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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. The Service Index is a guide that case managers can use to assist participants in determining what services are needed and what can be expected from those services. Case managers should be familiar with the information in the Service Index, and support participants in selecting the services that most appropriately meet their needs.
2. The Service Index defines the expectations of each service. Case managers should refer to the Service Index when they develop the service plan to ensure services are within the scope and limitations of the service definition. They should also use the Service Index when they complete their service monitoring responsibilities.
3. Changes to the Community Choices Waiver went into effect on July 1st. Several changes were made to service options, rates, units, and billing codes. Additionally, changes were made to the case management services definition. It is the responsibility of case managers to know the service definitions, ensure that they meet the requirements of the services they deliver, and use accurate information to submit claims.

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# 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 the CCW Service Index. 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.