Wyoming Department of Health
Behavioral Health Division

New Comprehensive and Supports Waiver Services

NOTE: These services are subject to approval by CMS and will be effective on the new waivers when they are approved to begin.

Self-directed services available!

- Independent Support Brokerage
- Supported Living
- Individual Habilitation Training
- Self-Directed Goods and Services
- Homemaker *New!*
- Companion Services
- Respite
- Residential Habilitation-Shared Living *New! Comp waiver only*
- Personal Care
- Supported Employment
- Child Habilitation Services

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** Items in red highlight areas of change since the definitions were last posted.*

Service	Programs	Code(s)		Rate(s)	Unit
Adult Day Care	Comprehensive Waiver Supports Waiver	S5100 S5100 TF S5100 TG	Basic Care Intermediate Care High level of care	$2.70 $3.51 $5.40	15 minute unit

Adult Day Care services are available to individuals who are 21 years of age or older who have chosen not to be employed or are unable to be employed or are unable to participate in community integrated services due to physical disabilities or stamina. Adult Day Care services are structures services consisting of day activities that maximize or maintain skills and abilities, keep participants engaged in their environment and community through optimal care and support; actively stimulate, encourage, develop, maintain, personal skills; introduce new leisure pursuits, establish new relationships, improve or maintain flexibility, mobility, and strength; or to build on previously learned skills.

Adult Day Care services provide active supports which foster independence, are person centered to the maximum extent possible, as identified in the participant's plan of care. Adult Day Care services also include personal care, protective oversight, and health maintenance activities such as medication assistance and routine activities that may be provided by unlicensed direct support professionals identified in the plan of care.

Adult Day Care services are provided for usually four to nine hours per day and delivered in a congregate community setting. When provided in congregate community setting, there must be staff on-site within immediate proximity to allow staff to provide support and supervision, safety and security, and provide activities to keep the person engaged in their environment.

Transportation into the community to shop, attend recreational and civic events, or other community activities and resources, is a component of Adult Day Care services and is included in the rate to providers.

A Participant receives a tiered service approved in the plan of care based upon need, according to the following tiers descriptions:

Basic Level of Care
Levels 1 and 2 on the Level of Service Need Grid will generally be in this tier. Service tier requires limited staff supports and personal attention to a participant daily due to a moderately high level of independence and functioning. Behavioral needs, if any, can be met with medication or informal direction by staff. The person may have periods of time with indirect staff supervision where staff are onsite and available through hearing distance of a request.

Intermediate Level of Care
Levels 3 and 4 on the Level of Service Need Grid will generally be in this tier. Service tier requires full-time supervision with staff available on-site within line of sight due to significant functional limitations, medical and/or behavioral needs. Behavioral and medical supports are not generally intense and can be provided in a shared staffing setting. Maximum ratio is limited to 1:6 with *regular* personal attention given throughout the day for training, personal care, reinforcement, community or social activities.

High Level of Care
Levels 5 and 6 on the Level of Service Need Grid will generally be in this tier. Service tier requires full-time supervision with staff available on-site within absolute line of sight and frequent staff interaction and personal attention for significant functional limitations, medical and/or behavioral needs. Support and supervision needs are moderately intense, but can still generally be provided in a shared setting unless otherwise specified in the plan of care. Maximum staffing ratio flexibility is limited to 1:4 during sedentary activities only, with *frequent* personal attention given throughout the day for training, reinforcement, positive behavior support, personal care, community or social activities.

Scope and Limitations
No unit cap on Supports Waiver.
On Comprehensive Waiver, approved units will be based on individual level of support need and must fit

within the assigned budget. Services may be provided up to five (5) days a week.

- Adult Day Care services focus on enabling the participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the service plan. Services may serve to reinforce skills or lessons taught in other settings.
- Individuals in Adult Day Care may not be paid for work activities performed during this service.
- Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).
- Personal care needed is a component part of the service as necessary to meet the needs of a participant, but may not comprise the entirety of the service nor can personal care services be billed in conjunction with this service during the same time.
- Participants who receive this service may also receive Community Integration services, Supported Employment and Prevocational services. A participant's service plan may include two or more types of non-residential habilitation services as long as service times do not overlap.

Behavioral Support Services	Comprehensive Waiver Supports Waiver	T2025	Prior Authorization number (PA#)	Per event

Behavioral Support Service includes training, supervision, or assistance in appropriate expression of emotions and desires, compliance, assertiveness, acquisition of socially appropriate behaviors, and the reduction of inappropriate behaviors through the implementation of positive behavior support and interventions. Behavioral Support service can also be accessed for the intent purpose of reducing the use of restrictions and restraints within a participant's current plan of care or service environment.

Reimbursable activities:

- Observation of the person and environment for purposes of development of a plan and to determine baseline
- Development of a behavioral support plan and subsequent revisions utilizing positive behavior supports and interventions.
- Obtain consensus of the Individualized Support Team that the behavioral support plan is feasible for implementation.
- Training in assertiveness
- Training in stress reduction techniques
- Training in the acquisition of socially accepted behaviors
- Training staff, family members, roommates, and other appropriate individuals on the implementation of the behavioral support plan
- Consultation with team members

Scope and Limitations:

Behavioral Support services provided must not be covered under any billable service through the Medicaid State Plan. All billable activities will follow the Division policy for cost and must be prior authorized.

Other Activities that are not allowed under this service:

- Aversive techniques – Any techniques not approved by the individual's person centered planning team and the provider's human rights committee.
- Therapy services furnished to the participant within the educational/school setting or as a component of the participant's school day.
- Services furnished to a minor by a parent(s), step-parent(s), or legal guardian.
- Services furnished to a participant by the participant's spouse.
- Simultaneous receipt of facility-based support services or other Medicaid-billable services and intensive behavior supports.

Case Management	Comprehensive Waiver Supports Waiver	T2022	$268.86	Month

This service will be phased out in year 2 of the waiver cycle as Targeted Case Management is implemented on the Medicaid State Plan to provide case management services to participants on this waiver.

Case management is a service 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 to which access is gained.

(Traditional case management) Case managers are responsible for the following functions for participants choosing NOT to self-direct services:

- Assessment and/or reassessment of the need for waiver services;
- Initiating the process to evaluate and/or re-evaluate the individual's level of care
- Linking waiver participants to other Federal, state and local programs;
- Development of the plan of care adhering to the Division's policies and procedures;
- Coordination of multiple services and/or among multiple providers;
- Ongoing monitoring of the implementation of the plans of care;
- Ongoing monitoring of participants' health and welfare;
- Addressing problems in service provision, including problems found during the ongoing monitoring of the implementation of the plan of care or concerns with a participant's health and welfare;
- Responding to participant crises;
- Reviewing service utilization and documentation of all services provided on a monthly basis to assure the amount, frequency, and duration of services are appropriate.

The case manager is required to complete the following responsibilities monthly in these cases:

- A home visit with the participant present to monitor the participant's health and welfare, as well as to discuss satisfaction with services and needed changes to the plan of care with the participant.
- Direct contact each month with participant and/or guardian, which must include the home visit but may also include observation of services to assess implementation of the plan of care, telephone contact with participant or guardian and/or meeting with the participant and/or guardian to complete follow up on concerns identified through incident reports, complaints or identified through other means.
- Follow-up on all concerns or questions raised by the participant, guardian or plan of care team or identified through incident reports, complaints or through observation of services.
- Reviewing service utilization and provider documentation of service, identify significant health changes, trends through incident reports, evaluate the use of restraints and restrictive interventions, interview participant and/or guardian on satisfaction with services, and complete follow-up on concerns identified in any of these processes.

***Subsequent assessments**:* These assessments are provided as part of ongoing case management and will include the necessary collaboration of professionals to assess the needs, characteristics, preferences and desires of the waiver participant. Case managers shall initiate and oversee subsequent assessments, regardless of payment source. These include the psychological assessment, if needed for continued eligibility and any other assessments that are necessary to determine the participant's needs and are not available through the Medicaid State plan. All assessments shall be prior authorized by the Division.

(For services self-directed) Case Managers are responsible for the following functions for participants who choose to self-direct services:

- Assessment and/or reassessment of the need for waiver services;
- Initiating the process to evaluate and/or re-evaluate the individual's level of care
- Working with the participant, Support Broker and other team members on development of the plan of care that addresses the participant's needs, and submission of the plan of care to the Division adhering to the Division's policies and procedures;
- Ongoing monitoring of the implementation of the plan of care, including monitoring self-directed services and traditional services;
- Ongoing monitoring of participants' health and welfare;
- Addressing problems in service provision, including problems found during the ongoing monitoring

of the implementation of the plan of care or concerns with a participant's health and welfare, working with the participant, Support Broker and plan of care team members as appropriate;

- Responding to participant crises;
- Reviewing service utilization and documentation of all services provided on a monthly basis, including all self-directed services, to assure the amount, frequency, and duration of services are appropriate.

The role of the Case Manager is to monitor the implementation of the individual plan of care and provide coordination and oversight of supports but not "hands on" involvement in identifying and securing supports. Those are duties of the Support Broker.

The case manager is required to complete the following monthly on these cases:

- A home visit with the participant present to monitor the participant's health and welfare, as well as to discuss satisfaction with services and needed changes to the plan of care with the participant.
- Direct contact each month with participant and/or guardian, which must include the home visit but may also include observation of services to assess implementation of the plan of care, telephone contact with participant or guardian and/or meeting with the participant and/or guardian to complete follow up on concerns identified through incident reports, complaints or identified through other means.
- Follow-up on all concerns or questions raised by the participant, guardian or plan of care team or identified through incident reports, complaints or through observation of services.
- Reviewing service utilization and provider documentation of service, identify significant health changes, trends through incident reports, evaluate the use of restraints and restrictive interventions, interview participant and/or guardian on satisfaction with services, and complete follow-up on concerns identified in any of these processes.

Some participants self-directing services may choose not to have a Support Broker. This may be because they are skilled enough to complete those tasks themselves (as determined through assessment) or they have natural supports that can assist them. In these cases, the general oversight responsibilities of the case manager are sufficient to monitor the participant's self-direction efforts.

Scope and Limitations:

Case Managers shall be reimbursed up to 1 unit per month and shall provide a minimum of 2 hours of documented case management service and have completed a home visit each month in order to bill. Service time may consist of direct participant contact, guardian contact, phone calls to the participant or guardian, monitoring the participant in services, following up on concerns or questions regarding the participant, team meetings, plan of care development or updating, the monthly home visit, and service documentation review.

A relative, parent, legally responsible person, or guardian may provide case management services to their ward/related participant if they meet all the provider requirements and complete the process to become a certified Medicaid Waiver case manager, including signing a Medicaid provider agreement. NOTE: The parent, legally responsible person, or guardian may not receive reimbursement for providing case management services. However, they can be reimbursed for case management services they provide to other Waiver participants, who have chosen them to provide these services.

The parent/stepparent acting as an unpaid case manager shall not have a conflict of interest, which means that he/she cannot be a provider of any other service on the plan of care.

If a relative provides services to a related waiver participant as a service provider, an employee of a service provider, or a self-directed employee, then the case manager on the participant's plan of care shall not have a conflict of interest to the relative provider or the participant, which means the case manager shall not be employed by or related to the relative provider or the participant (i.e. Sibling, child, grandparent, aunt, uncle, or other parent/step-parent, cousin, step family, or the participant's guardian).

If hiring a relative through self-direction, the participant's case manager shall not have a conflict of interest with the relative or participant, which means the case manager shall not be a relative of the employee, participant, or the participant's legal representative.

If a parent/stepparent is hired by a participant age 18 and over, whereas the Parent/stepparent is not operating as the Employer of Record, then the participant shall have an actively involved support broker

to ensure that the s/he has engaged in recruitment activities and that there is a responsible person other than the paid family member, who, in addition to the participant, assumes employer responsibilities. In this arrangement, the participant cannot opt out of support brokerage.

Case management services on the waiver can only be billed and reimbursed after the plan of care is approved by the Division. Prior to entrance to the waiver, targeted case management services are reimbursed through the Medicaid State Plan.

Child Habilitation Services	Comprehensive Waiver Supports Waiver	T2027 *(ages 13 to 17)* T2027 HA *(ages 0-12)*	$3.49 $2.72	15 minute unit

Child Habilitation Services provide children with regularly scheduled activities (and/or supervision) for part of the day. Services include training, coordination and intervention directed at skill development and maintenance, physical health promotion and maintenance, language development, cognitive development, socialization, social and community integration and domestic and economic management. This includes services not otherwise available through public education programs in the participant's local school district, including after school supervision, daytime services when school is not in session, and services to preschool age children.

Services may be provided at various times of the day in multiple settings, when other waiver services would not be more appropriate, such as Respite or Personal Care. Service may occur in a single physical environment or in multiple environments, including natural settings in the community. Training activities may involve children and their families.

Child Habilitation Services also includes the provision of supplementary staffing necessary to meet the child's exceptional care needs in a daycare setting. Coordination activities may involve the implementation of components of the child's family-centered and individualized service plans and may involve family, professionals, and others involved with the child as directed by the child's plan.

Transportation is included in the reimbursement rate.

Providers are responsible for both formal and informal training opportunities. The schedule must be individualized and the training objective must be meaningful. Progress on objectives shall be reported to the case manager monthly.

Scope and Limitations:
This service is limited to children under age 18.

There is no cap on the Supports Waiver. On the Comprehensive waiver, there is annual cap of 9400 units per year. Services approved must be based on assessed need and fit within the person's assigned budget.

This service is a 15-minute unit. A provider can receive reimbursement for up to two (2) participants at one time, with a limit of three (3) persons being supervised by a provider or provider staff at one time. The rate for this service, for children through age 12, does not include the basic cost of childcare unrelated to a child's disability that may be needed by parents or regular caregivers to allow them to work or participate in educational or vocational training programs. The "basic cost of child care" means the rate charged by and paid to a childcare center or worker for children who do not have special needs. The basic cost of childcare does not include the provision of supplementary staffing and environmental modifications necessary to provide accessibility at regular child care settings; these costs can be covered by this service. For children ages 13 through 17, the rate for the service has a modifier "add in" component to cover the amount of the child care cost, which is no longer required after age 12.

This service shall exclude any services available through public education programs funded under the Individuals with Disabilities Education Act (IDEA). Child Habilitation Services include personal care services, so providers cannot be reimbursed for providing both services at the same time.

Child Habilitation Services cannot be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the Single State Medicaid Agency. Units shall be limited based upon the participant's need during non-school times and during summer & breaks.

Relative providers (excluding parents/stepparents) may provide this service.

Community Integration Services	Comprehensive Waiver Supports Waiver • May be self-directed	T2021 T2021 TF T2021 TG	Basic care Intermediate Care High Level of Care	$2.97 $3.86 $5.94	15 minute unit

Community Integration Services *(formerly Day Habilitation)* services offer assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that takes place in a non-residential setting, separate from the participant's private residence or other residential living arrangement.

Services should be furnished in any of a variety of settings in the community and are not limited to fixed-site facilities. Services may be provided up to five days a week. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, community networking, and personal choice. Making connections with community members is a strong component of this service provision.

- Community Integration services focus on enabling the participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the service plan. Services may serve to reinforce skills or lessons taught in other settings.
- Services must be furnished consistent with the participant's person-centered plan and include options and opportunities for community integration, relationship-building, and an increased presence in one's community.
- This service must be delivered differently from Adult Day Care services. This service requires a mixture of staff time helping a participant plan, access, participate, and interact with community members, businesses, volunteer activities, libraries, cultural, religious, or art centers, and build and maintain social connections at least half of the time each week during the provision of services.
- Individuals in Community Integration Services may not be paid for work activities performed during this service.
- Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).
- Personal care needed is a component part of the service as necessary to meet the needs of a participant, but may not comprise the entirety of the service nor can personal care services be billed in conjunction with this service during the same time.
- Participants who receive this service may also receive Adult Day Care, Supported Employment and Prevocational services. A participant's service plan may include two or more types of non-residential habilitation services as long as service times do not overlap.

A Participant receives a tiered service approved in the plan of care based upon need, according to the following tiers descriptions:

Basic Level of Care

Levels 1 and 2 on the Level of Service Need Grid will generally be in this tier. Service tier requires limited staff supports and personal attention to a participant daily due to a moderately high level of independence and functioning. Behavioral needs, if any, can be met with medication or informal direction by staff. The person may have periods of time with indirect staff supervision where staff are onsite and available through hearing distance of a request.

Intermediate Level of Care

Levels 3 and 4 on the Level of Service Need Grid will generally be in this tier. Service tier requires full-time supervision with staff available on-site within line of sight due to significant functional limitations, medical and/or behavioral needs. Behavioral and medical supports are not generally intense and can be provided in a shared staffing setting. Maximum ratio is limited to 1:6 with *regular* personal attention given throughout the day for training, personal care, reinforcement, community or social activities.

High Level of Care

Levels 5 and 6 on the Level of Service Need Grid will generally be in this tier. Service tier requires full-time supervision with staff available on-site within absolute line of sight and frequent staff interaction and personal attention for significant functional limitations, medical and/or behavioral needs. Support

and supervision needs are moderately intense, but can still generally be provided in a shared setting unless otherwise specified in the plan of care. Maximum staffing ratio flexibility is limited to 1:4 during sedentary activities only, with *frequent* personal attention given throughout the day for training, reinforcement, positive behavior support, personal care, community or social activities.

Scope and Limitations

Service is available for participants ages 21 and older who are no longer receiving school services.

There is no cap on the Supports Waiver. On the Comprehensive waiver, approved units will be based on individual level of support need and must fit within the person's assigned budget.

Any relative providers may provide this service. Community Integration Habilitation services cannot be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the Single State Medicaid Agency.

Transportation into the community to shop, attend recreational and civic events, or other community activities and resources, is a component of Community Integration Habilitation services and is included in the rate to providers.

Companion Services	Comprehensive Waiver Supports Waiver • May be self-directed	S5135 Individual S5165 HQ Group	$3.85 $1.93	15 minute unit

Companion services include non-medical care, supervision, socialization and assisting a waiver participant in maintaining safety in the home and community and enhancing independence. Companions may assist or supervise the individual with such tasks as meal preparation, laundry, and shopping, but do not perform these activities as discrete services. Companions may also perform light housekeeping tasks that are incidental to the care and supervision of the participant. Companion services include informal training goals in areas specified in the individual plan of care. The provision of companion services does not entail hands-on nursing care, but does include personal care assistance with activities of daily living as needed during the provision of services.

Routine transportation is included in the reimbursement rate.

Scope and Limitations:

This service is available to participants ages 18 and up. It is a 15-minute unit and is available as a 1:1 service or as a group rate serving 2 people or 3 people. Service may be provided up to nine (9) hours a day.

There is no cap on the Supports Waiver. On the Comprehensive Waiver, there is an annual cap of 1664 if the person is in residential habilitation services and does not want to attend a day service program periodically but still requires supervision. This service may not be used in conjunction with residential habilitation, so service times may not overlap.

Companion Services provided to participants ages 18 through 21 may not duplicate or replace services that are covered under IDEA and cannot be provided during school hours.

With the group rate, providers can provide companion services for two participants or three participants at the same time but must document at the rate for the specific group. Providers cannot serve children and adults at the same time unless authorized in advance by the Division.

Relative providers (excluding parents/stepparents) may provide this service.

Companion services cannot be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the Single State Medicaid Agency.

Crisis Intervention Support	Comprehensive Waiver Supports Waiver	H2011	$6.18	15 minute unit

Crisis Intervention services may be added to a plan for situations where a participant's tier level may not provide sufficient support for specific activities, medical conditions or occurrences of behaviors or crisis, but the extensive supervision is not needed at all times. The service may only be provided to a participant age 18 years or older in habilitative residential or day services.

Crisis Intervention provides funding for extra support from another staff to supervise a participant in the habilitation service during times of periodic behavioral episodes where the person is a danger to oneself or others, or if the participant has an occasional or temporary medically fragile situation and is at risk of imminent harm without the extra staff support.

Intervention for behavioral purposes is not intended for watching the person should the behavior occur, but for the purpose of supporting the participant when the need arises, using positive behavior supports and non-violent, non-physical crisis intervention services to de-escalate a situation, teach appropriate behaviors and keep the participant safe until the participant is stable.

Quantity of caps approved by the Division's Clinical Review Team and shall be based on verified need, evidence of the diagnosis or condition requiring this service. Documentation of progress and data on behaviors and the outcome of the intervention services must be submitted to the case manager and Division at the frequency specified in the approved plan of care. Service must be used in conjunction with another habilitation service for those over 18.

Crisis Respite	Supports Waiver only	T2034	$180.00	daily

Crisis Respite provides short-term care to a waiver participant living with an unpaid primary caregiver. Crisis Respite is for participants who have chronic, terminal or acute medical or mental health illnesses, or who are in imminent danger of abuse or neglect in their current living environment. For caregivers in stressful situations, Crisis Respite also provides temporary relief from the ongoing responsibilities for caring for children in the home.

Crisis Respite is available in response to a family emergency or crisis, or may be used on a regular basis to provide relieve to a caregiver in cases where an individual's behavioral or medical needs have exhausted the family support structure. Respite provided on a regular basis cannot exceed 72 hours a month, or at the discretion of the Division. Respite may be provided in the participant's home, the private home of a respite provider, a developmental disabilities agency, or in community settings.

Crisis Respite providers assist with providing support with activities of daily living, accessing community resources and supports, transportation to and from appointments or school, meals, social activities, medication assistance as needed, and community networking.

Crisis Respite is reimbursed on a 24-hour daily rate and includes transportation. Providers currently certified to provide respite, residential habilitation, supported living, or special family habilitation home may provide this service. Service is not available to persons in the custody of Department of Family Services.

Dietician	Comprehensive Waiver Supports Waiver	S9470	$28.66	Session

Dietician Services provided by a registered dietician include menu planning, consultation with and training for caregivers, and education for the individual served. The service does not include the cost of meals. Dietician Services are not available under the State Plan. Without this service certain individuals would receive inadequate nourishment and would require institutionalization. The Dietician services are those services designated in the participant's Individual Plan of Care. The clientele served by this service show a pattern of chronic and unusual need requiring Dietician Services, which are not provided by the State Plan. Chronic needs encompass conditions such as severe obesity, poor food choices that compromise health, special diets approved by a physician for specific diagnoses or severe allergies. Service is limited to services not provided under the Medicaid State Plan. Relative providers shall not provide this service. At least 30 minutes of service must be provided per session in order to bill.

Environmental Modification	Comprehensive Waiver Supports Waiver	S5165 NU New SF165 Repair	PA#	Per event

Environmental modifications include those functionally necessary physical adaptations to the private residence of the participant or the participant's family, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant.

Scope and Limitations:

Lifetime cap of $20,000 per family, regardless of waiver. Cap begins for purchases made after July 1, 2013 on previous Wyoming Waivers. A critical health or safety service requests that exceeds the lifetime cap is subject to available funding and approval by ECC.

As stated in Wyoming Medicaid Rules, Chapter 44, Section 6: Environmental Modifications shall meet at least two of the following criteria for approval by the Division:

1. Be functionally necessary, and
2. Contribute to a person's ability to remain in or return to his or her home and out of an ICF/ID setting, or
3. Be necessary to ensure the person's health, welfare, and safety.

Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

- Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant. Scope and Limitations of this service are found in Medicaid Rule Chapter 44. Participants cannot have both Individual Goods and Services and Environmental Modifications on the plan.
- Any adaptations that are covered by Medicaid, a state independent living center, vocational rehabilitation are excluded.
- Home accessibility adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.

All services shall be provided in accordance with applicable State or local building codes.

The case manager will follow the process identified in Chapter 44, Section 7. The case manager should not obtain quotes until the overall scope of the project is approved by the Division.

The Division may schedule an on-site assessment of the environmental concern including an evaluation of functional necessity with appropriate professionals under contract with the Division. The Division may use a third party assess the proposed modification and need for the modification to ensure cost effectiveness.

Sale of environmental modifications must not profit the participant or family.

Case Manager shall not give copies of the individual plan of care to the environmental modification provider. The environmental modification provider shall receive a copy of the approved service authorization printout.

Relative providers (including parents/stepparents) may provide this service in accordance with Chapter 45, adhering to the following requirements:

- They are a certified Medicaid Waiver Environmental Modification Provider; and
- The Division receives at least one other bid from another provider to ensure cost effectiveness.

Employment Discovery and Customization	Comprehensive Waiver Supports Waiver	H2025	$6.50	15 minute unit

Employment Discovery and Customization is the individualized determination of the strengths, needs, and interests of the participant and is designed to meet the specific needs of the employee and employer relationship. Employment discovery and customization includes employment developed through job carving, self-employment or entrepreneurial initiative, or other job development or restructuring strategies that result in job responsibilities being customized and individually negotiated to fit the needs of participants. Employment discovery and customization presumes the provision of reasonable accommodations and supports necessary to perform functions of a job that is individually negotiated and developed.

Employment discovery and customization is a 1:1 support service and has a limited time frame of 12 months. This service is reimbursed at a 15 minute unit rate. An additional 12 months may be approved by the Division upon review of the progress made the prior year. There is annual cap of 400 units, where 100 units will be authorized initially in order to develop a strengths, needs, and interest assessment and an employment plan. After submitting the employment plan, an additional 300 units may be approved to explore various types of job customization, self-employment, or entrepreneurial opportunities. Service is available for any participant ages 18 and older. Documentation for any supported employment service must be maintained in the provider and case manager's file for each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 (Vocational Rehabilitation or Workforce Services) or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq./school district). Services cannot be provided during the school hours set by the local school district.

Homemaker	Comprehensive Waiver Supports Waiver • May be self-directed	S5130	$3.85	15 minute unit

Services consisting of general household activities such as meal preparation and routine household care, which are provided by a trained homemaker when the individual regularly responsible for these activities is unable to manage the home and care for himself/herself or others in the home or when the person who usually does these things is temporarily unavailable or unable to perform the tasks. This service does not include direct care/supervision of the waiver participant.

There is no cap on the Supports Waiver. Comprehensive Waiver cap per year is a maximum of 3 hours per week per household or 624 units. Service is not available to participants who receive residential habilitation or special family habilitation home services on the waiver. Relative providers (excluding parents/stepparents) may provide this service.

Independent Support Broker	Comprehensive Waiver Supports Waiver • May be self-directed	T2041	$9.44	15 minute unit

Independent Support Brokerage assists the participant (or the participant's legal representative, as appropriate) in arranging for, directing and managing services. Serving as the agent of the participant or legal representative, the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services. The Support Broker offers practical skills training to participants and their legal representatives to enable them to independently direct and manage waiver services. Support Brokers serve at the discretion of the participant and/or their legal representative. Examples of skills training include providing information on recruiting and hiring direct care workers, managing workers and providing information on effective communication and problem-solving. The service includes providing information to ensure that participants understand the responsibilities involved with directing their services. The extent of the assistance furnished to the participant or family is specified in the individual plan of care. This service does not duplicate other waiver services, including case management. Other functions include assisting the participant in:

1. Identifying immediate and long-term needs, preferences, goals and objectives of the participant for developing the individual plan of care.
2. Making decisions about the individual budget.
3. Developing options to meet the identified needs and access community services and supports specified in the individual plan of care.
4. Negotiating rates of payments and written agreements with service providers.
5. Selecting, hiring and training service providers, as applicable.
6. Developing and implementing risk management agreements and emergency back-up plans.
7. Conducting self-advocacy and assisting with employee grievances and complaints.
8. Assisting with filing grievances and complaints to outside entities, including the appropriate Financial Management Service provider and/or Division.
9. Providing information and practical skills training to the participant in the following areas:
   a. Person-centered planning and its application.
   b. The range and scope of individual choices and options.
   c. The process for changing the individual plan of care and individual budget.
   d. Recruitment and hiring of service workers.
   e. Management of service workers, including effectively directing, communicating, and problem-solving.
   f. Participant responsibilities in self-directed services, including the appeal process.
   g. Recognition and reporting of abuse, neglect, and exploitation.

Support Brokers have responsibility for training all of the participant's employees on the Policy on Reportable Incidents and ensuring that all incidents meeting the criteria of the Division's Notification of Incident Process are reported. Support Brokers must review employee time sheets and monthly Fiscal Management Service (FMS) reports to ensure that the individualized budget is being spent in accordance with the approved Individual Plan and Budget, and coordinate follow-up on concerns with the participant's case manager. Support Brokerage is a waiver service that is funded through the participant's individual budget.

Support Brokerage is an optional service for a participant or legally authorized representative who self-directs services. If an EOR is struggling with self-directing responsibilities, the Division may require a Support Broker to be added to the person's plan of care in order to continue to self-direct. After a year of required support brokerage, the participant or representative may opt out of support broker services if he/she meets one of the criteria below and submits a formal request to opt out of Support Broker Services.

Criteria for Opting out of Support Broker Services includes the following, which is captured on an assessment tool completed by the case manager and approved by the Division:

1. Participants or their legal representatives who are self-directing through the Financial Management Service who demonstrate the ability to choose workers, coordinate the hiring of workers through the Financial Management Service provider, and coordinate the delivery of services with the FMS provider.
2. Participants or their legal representatives who have successfully self-directed services for one year with no concerns, including hiring, firing, training, scheduling workers and reviewing timesheets in a timely manner.

Scope and Limitations:

Service is a 15-minute unit. There is annual cap of 320 units for both the Comprehensive and Supports Waivers. IBAs will not be increased to add this service.

Relatives can be a support broker to their related waiver participant, if they are a certified support provider and provide no other service to the participant on their plan. However, a parent/stepparent/legal guardian acting as a support broker cannot be reimbursed. They can be an unpaid support broker for the participant and are subject to the same qualification and monitoring requirements as paid support brokers.

All paid Support Brokers shall be free of any conflict of interest including employment with a certified waiver provider or provision of any other Waiver service to the same participant. An Individual Support

Broker hired by the participant shall only serve one participant, unless he/she is chosen to serve one additional sibling in the same household.

If a participant is hiring a parent/stepparent/legal guardian as an employee of a direct care services, such as respite or personal care, then the participant shall not opt out of support brokerage and must have an actively involved unrelated support broker to ensure that the s/he has engaged in recruitment activities and that there is a responsible person other than the paid parent, who, in addition to the participant, assumes employer responsibilities.

Individual Habilitation Training	Comprehensive Waiver Supports Waiver • May be self-directed	T2013	$29.66	hour

Individual Habilitation Training *(formerly Residential Habilitation Training)* is a specialized 1:1 intensive training service to assist a participant with the acquisition or improvement in skills not yet mastered that will lead to more independence and a higher level of functioning. Individual Habilitation Training services are for participants who live with unpaid caregivers or who need less than 24-hour paid supervision and support.

- Supports and training objectives are required and may include: adaptive skill development; assistance and training on activities of daily living; transportation safety and navigation; and building social capital and connections and hobby skill development for work on fine or gross motor skills.
- Objectives must be specific and measureable, and data must be tracked and analyzed for trends. Summary reports on progress or lack of progress must be given to the case manager and participant or guardian monthly. Objectives shall be re-written as needed when skills are learned or the objective is not yielding any progress.
- Services may be provided in the person's home or in integrated settings with persons who do not have disabilities.
- Community access services cross the lifespan from childhood to adulthood. Supports may include facilitation of inclusion of the individual within a community group or volunteer organization; opportunities for the participant to join formal/informal associations and community groups; opportunities for inclusion in a broad range of community settings including opportunities to pursue social and cultural interests, choice making, and volunteer time.
- Transportation relating to the participant's training objective, such as trips into the community, shall be provided by the service provider and is included in the rate for the service.
- This service includes services not otherwise available through public education programs in the participant's local school district, including after school supervision, daytime services when school is not in session, and services to preschool age children.

Scope and Limitations:

- Individual Habilitation Training is a 1:1 service with an hourly unit, which can be provided in 15-minute increments throughout the day but cannot be rounded to the nearest hour to bill. It is available to participants ages 0 through 21 on the waiver. Individual Habilitation Training services have a 2 hour a day limit and units shall be approved based upon the participant's need and budget limit.
- Training can be done in a sixty (60) minute block of time, or a number of programs with specific time frames for each program, so a total 60 minutes in one day can be completed.
- Providers are responsible for both formal and informal training opportunities. The schedule must be individualized and the training objective must be meaningful. Progress on objectives shall be reported to the case manager and participant or guardian monthly.
- Relative providers (excluding parents/stepparents) may provide this service.
- For participants through age 21, Individual Habilitation Training services cannot duplicate or replace services covered under IDEA and services cannot be provided during school hours.
- Individual Habilitation Training cannot be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the Single State Medicaid Agency.

Occupational Therapy	Comprehensive Waiver Supports Waiver	97532 Individual 97150 Group	$17.02 $15.96	15 minute Session

Occupational Therapy services consist of the full range of activities provided by a licensed occupational therapist. Services include assessing needs, development a treatment plan, determining therapeutic intervention, training and assisting with adaptive aids. Occupational Services through the waiver can be used for maintenance and the prevention of regression of skills. The units must be prior authorized and must be prescribed by a physician. State Plan Occupational Services are limited to restorative therapy. Services are available for a participant age 21 and older. Services are provided under the state plan when they are restorative. Maintenance therapy may be provided under the waiver. These services are uniquely coded. Edits to MMIS prohibit both restorative and maintenance therapy from being billed on the same day. Relative providers shall not provide this service.

Service is available as an individual 15 minute unit or as a group session unit which requires a minimum of 30 minutes in service in order to bill.

Personal Care	Comprehensive Waiver Supports Waiver • May be self-directed	T1019	$3.85	15 minute unit

A range of assistance to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the participant to perform a task. Personal care services may be provided on an episodic or on a continuing basis. Health-related services that are provided may include nursing care and medication administration to the extent permitted by State law.

Such assistance may include assistance in performing activities of daily living (ADLs-bathing dressing, toileting, transferring, maintaining continence) and instrumental activities of daily living on the person's property (IADLs-more complex life activities, e.g. personal hygiene, light housework, laundry, meal preparation exclusive of the cost of the meal, using the telephone, medication and money management). Transportation costs are not included as part of this service.

The participant must be physically present. Personal care shall be provided in the participant's home or on their property. If the individual providing this service is not employed and supervised by an agency, then the participant is responsible for supervising the individual and may coordinate monitoring of the service with his/her case manager.

Scope and Limitations:

This service is available to all ages and is a 1:1 service.

There is no cap on the Supports Waiver. On the Comprehensive Waiver, units shall be approved based upon need, fit within the person's assigned budget, with a maximum annual cap of 6000 units for persons in a non-residential service setting.

For participants in a residential service, personal care units may be approved up to 7280 units a year when the participant needs ongoing supervision but cannot attend a day service due to a medical or health condition that prohibits or limits attendance at a congregate day program upon verification of need and approval of the Division.

Personal care services are included in Companion, Child Habilitation, Individual Habilitation Training, Supported Living, Adult Day Care, Community Integration Habilitation, Prevocational, Supported Employment, Special Family Habilitation Home, and Residential Habilitation services; therefore, Personal Care cannot be provided in conjunction with those services and if provided on the same day, service times must not overlap.

Personal care cannot be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the Single State Medicaid Agency. The amount of personal care services prior authorized by the Division for the legally responsible individual will be based upon individual extraordinary care needs as specified in the individualized plan of care and other assessments.

Personal care is not covered as a stand-alone service through the state plan. It can be provided through

home health only. A home health provider typically provides services from 8 am to 5 pm. Being a rural state, many Wyoming communities do not have home health providers to serve their community. Those that do, often do not have enough employees to meet the extensive needs of some waiver participants. Waiver participants who need personal care services must utilize providers that can provide the type, amount and flexible hours of services deemed most appropriate for the participant. The waiver service allows the team to find and utilize providers who can best meet the participant's needs.

Any relative providers may provide this service. For relative providers residing in the same household as the waiver participant, personal care provided by the relative provider in the home shall be for extraordinary care only, as defined by the Division, and cannot exceed four (4) hours per day per participant. Legally Responsible Individuals (parent/stepparent/guardian) of minor children may be a provider of personal care for extraordinary care needs with the same limit of 4 hours a day per participant. It is expected that for those participants living with their families, that the family members will contribute natural support and supervision, similar to how families function. Additional units needed beyond 4 hours a day require additional documentation and shall only be approved by the Division's Extraordinary Care Committee.

For personal care provided to participants under age 18 by a legally responsible individual, payment shall only be authorized for extraordinary care services provided by the legally responsible individual provider as documented in the plan of care and align with the assessed needs of the participant which show the need for extraordinary care.

Extraordinary care cases shall meet the following criteria:

1. The participant's Adaptive Behavior Quotient is 0.35 or lower on the Inventory for Client and Agency Planning (ICAP) assessment; and either b or c
2. The participant needs assistance with Activities of Daily living (ADLs) or Instrumental Activities of Daily Living (IADLs) exceeding the range of expected activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization. (Example: a 12 year old needing assistance with dressing and bathing, whereas the average 12 year old does not.); or
3. The participant requires care from a person with specialized medical skills relating to the participant's diagnosis or medical condition as determined appropriate by the participant's medical professional and the Behavioral Health Division.

If a legally responsible individual is providing personal care to his/her ward, the plan of care shall be developed and monitored by a case manager without a conflict of interest to the legally responsible individual provider or to the participant, which means the case manager shall not be employed by or related to the provider or the participant (i.e. sibling, child, grandparent, aunt, uncle, or other parent/step-parent, cousin, step family, or the participant's guardian), to ensure the provision of services is in the best interest of the participant.

The plan shall document that services do not duplicate similar services, natural supports, or services otherwise available to the participant.

Physical Therapy	Comprehensive Waiver Supports Waiver	97110 Individual 97150 Group	$20.83 $15.96	15 minute Session

Physical Therapy services consist of the full range of activities provided by a licensed physical therapist. This service assists individuals to preserve and improve their abilities for independent function such as range of motion, strength, tolerance, and coordination. It may also prevent, insofar as possible, irreducible or progressive disabilities through the use of assistive and adaptive devices, positioning, and sensory stimulation. Services are available for a participant age 21 and older. Services through the waiver can be used for maintenance and the prevention of regression of skills. The units must be prior authorized and must be prescribed by a physician. State Plan Physical Services are limited to restorative therapy. Services provided under the state plan must be utilized to the extent they are allowed. The state plan covers some visits each year and the cap can be exceed with justification from a qualifying medical professional when they are restorative. These services are uniquely coded. Edits to MMIS prohibit both

restorative and maintenance therapy from being billed on the same day. Relative providers shall not provide this service.

Service is available as an individual 15 minute unit or as a group session unit which requires a minimum of 30 minutes in service in order to bill.

Prevocational	Comprehensive Waiver Supports Waiver	T2015 T2015 TF T2015 TG	Basic Care Intermediate Care High level of care	$2.70 $3.51 $5.40	15 minute unit

Prevocational services are services designed to create a path to integrated community based employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Prevocational services should enable each individual to attain the highest level of work in the most integrated setting and with the job matched to the individual's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines. Services provide learning and work experiences, including volunteer work, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings.

- Services include teaching concepts such as compliance, attendance, task completion, problem solving, interpersonal relationships, and safety. Services are not job-task oriented, but aimed at generalized results.
- Service activities must be reflected in the participant's plan of care and are directed to habilitative, rather than employment objectives.
- Services may be furnished in a variety of locations in the community and are not limited to provider facilities.
- Prevocational services may be provided at a volunteer worksite or mentorship locations for the purpose of helping someone obtain competitive employment.
- Participation in prevocational services is not a required pre-requisite for individual or small group supported employment services provided under the waiver furnished under the waiver.
- Prevocational services are time-limited, not to exceed 12 consecutive months and cannot be repeated during the subsequent plan year.
- Services are reimbursed based upon the participant's level of service need..
- Transportation is included in the reimbursement rate.

A Participant receives a tiered service approved in the plan of care based upon need, according to the following tiers descriptions:

Basic Level of Care

Levels 1 and 2 on the Level of Service Need Grid will generally be in this tier. Service tier requires limited staff supports and personal attention to a participant daily due to a moderately high level of independence and functioning. Behavioral needs, if any, can be met with medication or informal direction by staff. The person may have periods of time with indirect staff supervision where staff are onsite and available through hearing distance of a request.

Intermediate Level of Care

Levels 3 and 4 on the Level of Service Need Grid will generally be in this tier. Service tier requires full-time supervision with staff available on-site within line of sight due to significant functional limitations, medical and/or behavioral needs. Behavioral and medical supports are not generally intense and can be provided in a shared staffing setting. Maximum ratio is limited to 1:6 with regular personal attention given throughout the day for training, personal care, reinforcement, community or social activities.

High Level of Care

Levels 5 and 6 on the Level of Service Need Grid will generally be in this tier. Service tier requires full-time supervision with staff available on-site within absolute line of sight and frequent staff interaction and personal attention for significant functional limitations, medical and/or behavioral needs. Support and supervision needs are moderately intense, but can still generally be provided in a shared setting

unless otherwise specified in the plan of care. Maximum staffing ratio flexibility is limited to 1:4 during sedentary activities only, with frequent personal attention given throughout the day for training, reinforcement, positive behavior support, personal care, community or social activities.

Scope and limitations:

Individuals participating in prevocational services may be compensated in accordance with applicable Federal laws and regulations; however, waiver funding is not available for the provision of vocational services delivered in facility-based or sheltered work settings, where individuals are supervised for the primary purpose of producing goods or performing services. *This part of the definition will be deleted and the waiver amended after year one (1).*

Service is available for participants ages 21 and older who are no longer receiving school services. Documentation must be maintained in the provider and case manager's file for each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Residential Habilitation	Comprehensive Waiver only • Shared Living may be self-directed on Comprehensive Waiver only	T2016 UA level 1 T2016 UC level 2 T2016 U8 level 3 T2016 U7 level 4 T2016 U6 level 5 T2016 U5 level 6	$ 80.65 $ 88.77 $119.31 $142.00 $187.40 $323.59	daily

Residential Habilitation services are individually-tailored supports for a waiver participant that assists with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Residential Habilitation includes personal care, protective oversight and supervision.

- Residential Habilitation services are reimbursed using a daily unit based upon the level of service need of the participant, where the participant needs some level of ongoing 24 hour support by a provider on site.
- Services can be furnished in a group home, shared living arrangement, host home, or in the participant's home.
- Residential Habilitation may be furnished in a home owned or leased by a provider or the participant.
- For Residential Habilitation delivered through self-direction as Shared Living- This service may be self-directed for an individual in a shared living setting, where the participant or participants own or lease the residence from an entity that is not a certified waiver provider. The employee hired through self-direction may serve up to 3 people in shared living, but can serve no other people in a residential habilitation service.
- Residential habilitation services are reimbursed using a daily unit based upon the level of service need of the participant, where the participant needs some level of on-going 24 hour support by a provider employee on site.
- Provider owned or leased facilities where Residential Habilitation services are furnished must be compliant with the Americans with Disabilities Act.
- Transportation between the participant's place of residence, other service sites, or places in the community is included in the rate.
- Residential habilitation services must be furnished in living arrangements subject to §1616(e) of the Social Security Act (the Keys Amendment), and the standards for such services must meet Chapter 45 of the Wyoming Medicaid Rules for facility standards, including assuring that the living arrangement is homelike rather than institutional in character.

Tiered Levels

A Participant receives a tiered service approved in the plan of care based upon need, according to the following tiers descriptions. Tier levels for this service align with the assessed Level of Service Need for the participant and the expectations of the service as specified in the definition. All supervision and

supports delivered must align with the participant's plan of care.

Level 1 –Due to a high level of independence and functioning and no significant behavioral or medical issues, this tier requires staff available on-site and meeting periodically with the participant during awake hours on each day billed to provide general supervision, support, monitoring, training, and on-call 24 hour support.

Level 2- Due to a moderately high level of independence and functioning and few behavioral or medical issues, if any, that require minimal staff support, monitoring, or personal care, this tier requires staff available on-site within close proximity to the person's residence at all times, meeting periodically with the participant during awake hours on each day billed to provide general supervision, support, monitoring, training and on-call 24 hour support.

Level 3- Due to moderate functional limitations in activities of daily living and possible behavioral support needs, this tier requires staff available on-site within hearing distance in the same residence as the participant and meeting periodically with the participant on each day billed for general supervision, support, personal care, positive behavior support, monitoring, training and staff support through the night in the residence or in a near-by office.

Level 4- Due to significant functional limitations, medical and/or behavioral support needs, this tier requires full-time staff to be on-site in the person's residence when the person is in this service, with regular personal attention given throughout the day for training, personal care, reinforcement, positive behavior support, community or social activities. Behavioral and medical supports are not generally intense and can be provided in a shared staffing setting. There must be staff support in the residence through the night.

Level 5-- Due to significant and somewhat intensive functional limitations, medical and/or behavioral support needs, this tier requires 1 or more full-time staff support to be on-site and in line of sight during awake hours when the person is in this service, with frequent personal attention given throughout the day for training, personal care, reinforcement, community or social activities. Behavioral and medical supports or personal care may be somewhat intense but service may be provided in a smaller shared staffing setting.

Level 6-Due to the high medical, behavioral and/or personal care needs, this tier requires frequent personal support and supervision with full-time staff on-site within line of sight during awake hours. The expectation is that the participant shall receive the attention of at least one to two caregiver(s) as specified in the plan of care. Staffing ratios must be kept as approved by BHD in the plan of care.

Scope and limitations

The participant must be age 18 or older to use this service. The provision of Residential Habilitation services includes personal care needs, so plans of care are not approved that include both residential services and personal care services.

Since residential habilitation is paying for support to an individual who needs support 24 hours a day, the provider must be in the residence of the participant providing service during both awake and sleeping time for a minimum of 8 hours in a 24 hour period (from 12:00am-11:59pm) for the provider to be reimbursed.

Family visits and trips are encouraged. The provider will be allowed to be reimbursed on the day the participant returns home from a trip.

Payment is not made, directly or indirectly, to members of the participant's immediate family, except as provided in Appendix C-2 of the waiver application. Payment is not be made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment for Residential Habilitation is specified in Appendix I-5 of the waiver application.

Relative providers may provide all components of this service as defined with the following limitations:

- A relative (excluding parents/stepparents/legal authorized representatives) may provide this service to the participant while residing in the same residence as the participant.
- A relative who is a parent/stepparent, and a certified provider and LLC or a corporation or an employee of a certified provider, may provide this service as defined but shall not live or reside in the same residence as the participant.

Targeting Criteria to receive this service

Waiver participants not receiving 24-hour residential services, who are at significant risk due to extraordinary needs that cannot be met in their current living arrangement, may request 24-hour Residential Habilitation services if the participant meets one of the following targeting criteria:

- A substantial threat to a person's life or health caused by homelessness or abuse/neglect that is either substantiated by Department of Family Services or corroborated by the Behavioral Health Division or Protection & Advocacy Systems, Inc.
- Situations where the person's condition poses a substantial threat to a person's life or health, and is documented in writing by a physician.
- Situations where a person has caused serious physical harm to him or herself or someone else in the home, or the person's condition presents a substantial risk of physical threat to him or herself or others in the home.
- Situations where there are significant and frequently occurring behavior challenges resulting in danger to the person's health and safety, or the health and safety of others in the home.
- Situations where the person's critical medical condition requires ongoing 24-hour support and supervision to maintain the person's health and safety.
- Loss of primary caregiver due to caregiver's death, incapacitation, critical medical condition, or inability to provide continuous care.

Respite	Comprehensive Waiver Supports Waiver • Maybe self-directed	T1005 S9126	$3.49 $167.52	15 minute Daily

Respite Service is intended to be utilized on a short-term, temporary basis for an unpaid caregiver or non-CARF residential habilitation provider to provide relief from the daily burdens of care. Respite service includes assistance with activities of daily living (ADL), medication assistance if needed, and supervision. Respite cannot be used to substitute for care while the primary caregiver is at work, or during services otherwise available through public education programs including education activities, after school supervision, daytime services when the school is not in session, or services to preschool age children.

It may be provided in the caregiver's home, the provider's home, or in community settings. Respite can only be provided for up to two people at the same time or up to three if members are in the same family and live in the same household (as long as all participants can be safely supported by one provider or unless the participant's plan of care requires an intensive support level).

Scope and Limitations:

Respite is reimbursed as a 15-minute unit or a daily rate.

There is no cap on the Supports waiver. On the Comprehensive Waiver, the total number of 15 minute units available for respite per plan year is 1,664. The combined use of daily and 15-minute service cannot exceed an average of 8 hours a week of service over the plan year, which is equivalent to 416 hours a year.

- Any use of respite over 9 hours a day must be billed as a daily unit.
- Approved amount of service is based upon the participant's need and budget limit, not to exceed 1664 units per plan year on Comprehensive waiver.
- Services provided must be provided as relief of the primary caregiver, should primarily be episodic in nature, and not used when parents or primary caregivers are working.
- Relative providers (excluding parents/stepparents) may provide this service.
- Respite services cannot be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the Single State Medicaid Agency.

A respite service provider or provider staff providing respite services:

- Cannot serve more than two waiver participants or up to three, if participants are in the same family and live in the same household (as long as all participants can be safely supported by one provider or unless the participant's plan of care requires an intensive support level).
- May also provide supervision to other children under the age of 12 or other individuals requiring support and supervision, but
- Must limit the total combined number of persons they are providing services to at a given time (both participants and other children under the age of 12 or other individuals requiring support and supervision) to no more three persons unless approved by the Division
- Must adhere to the supervision levels identified in each participant's plan of care

Respite services cannot not take the place of residential or day habilitation services. Transportation is included in the rate.

Participants who use this service while the primary caregiver is working have to choose a different service or support to provide the supervision need, such as Child Habilitation or Companion services. Respite services shall accommodate the needs of the participant. The respite site and services shall match the identified needs of the participant and family.

A respite provider cannot provide respite services to adults and children at the same time except to participants who are 18 to 20 years of age who may receive respite services with adults. In exceptional cases, such as when participants are members of the same family, respite may be provided to adults and children at the same time with Division approval.

Self-directed Goods and Services	Comprehensive Waiver Supports Waiver • **Only available through self-direction** and only if one direct care service is being self-directed as well	Annual Cap of $2000	Prior approval from Division needed	Cost varies per event

Goods and services are services, equipment, and supplies that provide direct benefit to the participant and support specific outcomes in the individual plan of care. The service, equipment or supply must:

1. Reduce the reliance of the participant on other paid supports, or
2. Be directly related to health or safety of the participant in the home or community, or
3. Be habilitative and contribute to a therapeutic objective, or
4. Increase the participant's ability to be integrated into the community, or
5. Provide resources to expand self-advocacy skills and knowledge.

Subject to approval by the Division, Goods and Services may include:

- Specialized equipment
- Devices, aids, controls, supplies, or household appliances which enable individuals to increase the ability to perform activities of daily living or to perceive, control, or communicate with the environment and/or community in which s/he lives. Service includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. Service includes vehicle modifications but does not include items of direct medical or remedial benefit to the individual. All items must meet applicable standards of manufacture, design, and installation.
- Transportation provided by family members (excluding parents, step-parents, guardians, or spouses per Wyoming State Statute), friends, and other licensed drivers for using non-agency vehicles to transport the person to services and activities specified in the person's individual plan of care unless the service includes transportation. The unit of service is one mile. The rate may not exceed the current state rate for mileage reimbursement and cannot include medical transportation covered by the Medicaid State Plan.
- Home modifications - Physical adaptations which are necessary to ensure the health, welfare, and safety of the individual in the home, enhance the individual's level of independence, or which

enable the individual to function with greater independence in the home.

- Camps - May cover cost of the participant attending a camp, and in some cases, an attendant to accompany the person to a camp that he/she could not attend alone and additional staffing was not available at the camp to ensure the person's health and safety.
- Consultation, evaluation and training, and/or a written document that evaluates and identifies the participant's strengths, needs, current availability and potential capacity of natural supports, and the need for service and financial resources, if appropriate. As appropriate for the participant, a consultation shall include participant preferences, health status, medications, conditions and treatments, functional performance, including Activities of Daily Living (ADLs), level of assistance needed, and assistive devices used and/or needed. Behavior and emotional factors, including pertinent history, coping mechanisms, and stressors. Cognitive functioning, including memory, attention, judgment, and general cognitive measures. Environmental factors, including architectural, transportation, other barriers. Social supports and networks, including natural supports. Financial factors, including guardianship or conservatorships, or entitlements that influence the array of supports and services that are needed.

Consultations and evaluations may be warranted based upon a specific disability, diagnosis, behavior concern, or medical condition relating to the disability. Family members and the person's environment may be involved in the consultation and training, which will help the person increase their health and safety, minimize the use of paid supports, and reduce the likelihood of institutionalization. This consultation and evaluation shall be used by the family and participant's team to better provide both paid and unpaid supports for the participant.

Scope and Limitations:

Self-Directed Goods and Services have a $2,000 annual limit. All goods and services must be prior authorized by the Division and cannot be available through Specialized Equipment or Environmental Modifications on the waiver as specified in Chapter 44 of the Medicaid Rules. The Division may approve requests above the limit if the request meets the specified criteria. Criteria for approving requests above the limit shall include goods or service needs that are due to:

- Unmet needs because of aging out of school
- Documented unavailability of vocational rehabilitation services
- Increasing health concerns that require more services
- Increasing behavioral concerns that require more intervention
- Health needs of unpaid caregivers who cannot continue the historical level of support.

Equipment purchases have a cap of $2,000. If an item needed exceeds that amount, the team may request an exception to the cap through the ECC. The Division may require an assessment for specialized equipment needs by a Certified Specialize Equipment (CSE) professional. Assessment is funded as a part of the $2,000 cap.

Electronic technology devices are only allowed once five (5) years and like items cannot be purchased during those five (5) years. The Division shall limit the purchase of any general item purchase and only allow the purchase of an iPad or other electronic devices, if recommended by CSE professional.

This service is only available for participants self-directing at least one direct care service through the Fiscal Employer Agent FMS option. This service may be provided by a relative (excluding parents/stepparents). This service may not duplicate any Medicaid State Plan service.

Modifications to a residence are not approved when the cost of such modifications exceeds the value of the residence before the modification. Covered modifications of rented or leased homes shall be those extraordinary alterations that are uniquely needed by the individual and for which the property owner would not ordinarily be responsible. Does not include adaptations or improvements to the home, which are of general utility and are not of direct medical or remedial benefit, nor adaptations that add to the total square footage of the home.

Skilled Nursing	Comprehensive Waiver Supports Waiver	T1002	$18.01	15 minute unit

Skilled Nursing services are medical care services delivered to individuals with complex chronic and/or acute medical conditions, which is performed within the Nurses' scope of practice as defined by Wyoming's Nurse Practice Act, for which the care requires a level of expertise that is undeliverable by non-medical trained individuals. The delivery of Skilled Nursing services is limited to those individuals who possess a valid and unencumbered license issued by the Wyoming State Board of Nursing. Skilled Nursing services under the waiver differ in provider type (including provider training and qualifications) from skilled nursing services in the Medicaid State Plan. Services approved in the plan of care that must be within the scope of the State's Nurse Practice Act.

- Skilled nursing may not be used if trained provider staff are able to provide the service, such as medication assistance or support for a medical appointment, unless the participant has a chronic or acute medical condition that requires a skilled nurse's direct support.
- Skilled nursing on the waiver may be provided by provider agencies and independent nurses as long as they meet the provider qualifications. The Wyoming Medicaid State Plan requires that skilled nursing services be provided by home health agencies that provide a minimum of two medically necessary services.
- Relative providers shall not provide this service.
- A billable skilled nursing service unit is considered to be a service that is provided up to 15 minutes and that involves one-on-one direct patient care.
- Providers cannot be reimbursed for skilled nursing services that do not include direct patient care or services that do not include skilled nursing duties. For example, skilled nursing providers cannot be reimbursed for watching television with a participant, transportation to and from doctor appointments, time spent charting, time spent in waiting room with participant, or time spent completing paperwork.
- Skilled nursing services cannot be services provided under the Medicaid State Plan. Skilled nursing services must be prescribed by a physician and listed on the Skilled Nursing form as part of the individual plan of care for the participant.

Special Family Habilitation Home	Comprehensive Waiver only	T2033	$130.40	Daily

Special Family Habilitation Home consists of participant specific, individually designed and coordinated training within a family (other than biological or adoptive parents) host home environment.

- This service is no longer available to children who are not yet receiving this service. The Division will keep the service on the waiver to serve current SFHH placements until another residential option is available to the child, subject to involvement from the Department of Family Services, Department of Education, Office of the Attorney General and the Wyoming Department of Health. These placements will be reviewed by a cross-agency team to determine the appropriate placement for the minor child within the next three (3) years.
- This service is intended for children birth through 20 years of age.
- The provider is the primary caregiver and assumes 24-hour care of the individual.
- This service cannot be used in conjunction with Individual Habilitation Training services.
- The provision of special family habilitation home services includes personal care needs, so plans of care are not approved that include both residential services and personal care services.
- Since this service is paying for support to an individual who needs support 24 hours a day, the provider must be in the residence of the participant providing service during both awake and sleeping time for a minimum of 8 hours in a 24 hour period (from 12:00am-11:59pm) for the provider to be reimbursed. Family visits and trips are encouraged. The provider will be allowed to be reimbursed on the day the participant returns home from a trip.
- Relative providers (excluding parents/stepparents) may provide this service.
- Providers are responsible for both formal and informal training opportunities. The schedule must be individualized and the training objective must be meaningful. Progress on objectives shall be reported to the case manager monthly.
- Transportation is included in the reimbursement rate.

Specialized Equipment	Comprehensive Waiver Supports Waiver	T2029 NU New T2029 Repair	PA#	Per event

Specialized equipment includes:

1. Devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living;
2. Devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live;
3. Items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items;
4. Such other durable and non-durable medical equipment not available under the Medicaid state plan that is necessary to address participant functional limitations; and,
5. Necessary medical supplies not available under the Medicaid state plan or other insurance held by the participant. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the state plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.

If the participant has an IEP or IFSP, the case manager will be required to submit a copy of that document, along with documentation as to why the equipment is not sent home with the participant or a reason why the equipment is necessary at home but not at school.

Scope and Limitations:

Specialized equipment shall meet at least three of the following criteria and is subject to BHD approval:

1. Be functionally necessary, and
2. Be necessary to increase ability to perform activities of daily living or to perceive control, or communicate with the environment in which the person lives, or
3. Be necessary to enable the participant to function with greater independence and without which the person would require institutionalization, or
4. Be necessary to ensure the person's health, welfare, and safety.

Allowable items and limitations of this service are found in Medicaid Rule Chapter 44.

Relative providers (including parents/stepparents) may provide this service with the following requirements:

- They are a certified Medicaid Waiver Specialized Equipment Provider; and
- Do not impose a mark-up to the total cost of the equipment when providing this service to their relative (unless they operate a non-profit corporation); and
- Receive at least one other bid from another provider to ensure cost effectiveness.

The individualized plan of care shall reflect the need for equipment, how the equipment addresses health, safety, or accessibility needs of the participant or allows them to function with greater independence, and specific information on how often the equipment is used and where it is used. Criteria for approval is outlined in Chapter 44 of the Wyoming Medicaid Rules. The case manager shall check with Medicaid, Medicare, and/or a participant's other insurance carrier to see if the requested equipment is covered under their plans. Waiver funds are a payer of last resort. The Medicaid waivers can only pay for what is functionally necessary, in other words, no convenience items.

Service Caps

Equipment purchases have an annual cap of $2,000. If an item needed exceeds that amount, the team may request an exception to the cap through the ECC. The Division may require an assessment for specialized equipment needs by a Certified Specialized Equipment (CSE) professional. Assessment is funded as a part of the $2,000 cap.

Electronic technology devices are only allowed once every five (5) years and like items cannot be purchased during those five (5) years.

Speech, Language and Hearing Services	Comprehensive Waiver Supports Waiver	92507 Individual 92508 Group	$50.34 $19.32	Session

Speech, Hearing and Language services consist of the full range of activities provided by a licensed speech therapist. Services include screening and evaluation of participants with respect to speech function; development of therapeutic treatment plans; direct therapeutic intervention; selection, assistance, and training with augmentative communication devices, and the provision of ongoing therapy. Services are available for a participant age 21 and older. Services through the waiver can be used for maintenance and the prevention of regression of skills. The units must be prior authorized and must be prescribed by a physician. Services are provided under the state plan when they are restorative. Maintenance therapy may be provided under the waiver. These services are uniquely coded. Edits to MMIS prohibit both restorative and maintenance therapy from being billed on the same day. Relative providers shall not provide this service. A minimum of 45 minutes of service per session must be provided in order to bill.

Subsequent Assessment	Comprehensive Waiver Supports Waiver	T2024TS	PA#	Per event

Subsequent assessments are provided as part of ongoing case management and will include the necessary collaboration of professionals to assess the needs, characteristics, preferences and desires of the waiver participant. Case managers shall initiate and oversee subsequent assessments, regardless of payment source. These include the psychological assessment, if needed for continued eligibility and any other approved assessments that are necessary to determine the participant's needs and are not available through the Medicaid State plan. Psychological evaluations for eligibility are no longer required every five years and will only be approved because of a significant change in the participant and with prior approval by the Division. Any assessments must be prior authorized by the Division.

Supported Living	Comprehensive Waiver Supports Waiver • May be self-directed	T2017 Individual T2017 HQ Group of 2 T2017 UP Group of 3 T2031 Day unit (may serve 3)	$8.27 $4.14 $3.17 $88.76	15 minute 15 minute 15 minute Daily

Supported Living services assist a participant to live in a home or apartment leased by the participant or guardian, or in the family home when the participant requires a range of community-based support to live as independently as possible. Supported Living Service provides individually tailored supports to assist with the acquisition, retention, or improvement in skills related to living successfully in the community. Supported Living Services are based on need and include assisting with common use of the community's transportation system; teaching the use of police, fire, and emergency assistance; performing routine household activities to maintain a clean and safe home; assistance with health issues, medications, and medical services; managing personal financial affairs; building and maintaining interpersonal relationships; participating in community life, and 24-hour emergency assistance.

- Supported Living Service includes personal care, therefore personal care services cannot be added as a separate service on the plan of care.
- Participants must be at least 18 years old to receive Supported Living Service.
- Relative providers may provide all components of this service as defined with the following limitations:
  - A relative (excluding parents/stepparents/legal authorized representatives) may provide this service to the participant while residing in the same residence as the participant.
  - A relative, who is a parent/stepparent, and a certified provider and LLC or a corporation or an employee of a certified provider, may provide this service as defined but shall not live or reside in the same residence as the participant.

Scope and limitations

- Supported Living Service daily rate is based on 7 hours of service a day and a provider must provide a minimum of 4 hours of documented service per calendar day for reimbursement. One staff or provider can be reimbursed for up to 3 participants during one period of time.
- Supported Living Service can also be billed at a 15-minute unit rate for a maximum of 5,400 units per plan year for services provided to a group up to two or three participants, or 3,900 15-minute units per plan year provided to an individual participant.
- The plan of care must identify either the daily unit or the individual or group 15-minute unit, based on the participant's need. Both the daily unit and the 15 minute unit may be on the participant's plan of care but cannot be used on the same day.
- Transportation is included in the reimbursement rate for this service.

Supported Employment	Comprehensive Waiver Supports Waiver • Individual Supported Employment may be self-directed	T2019 Individual T2019 UQ Group	$6.78 $2.70	15 minute units

Employment Pathway-Service Overview

This waiver offers various employment support services to support and assist a participant (ages 18+) who, because of their disability, needs intensive support to find and maintain a job in competitive, integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by an individual without a disability. The outcome of using the employment pathway of support services is to help a participant find and maintain a job that meets personal and career goals.

A range of supported employment services are available with varying levels of support and intensity to assist the participant in attaining and maintaining the highest level of paid, community integrated employment. Consistent with the *Olmstead* decision and with person-centered planning, a participant's plan of care regarding employment services shall be constructed in a manner that reflects individual choice and goals relating to employment and ensures provision of services in the most integrated setting appropriate. Pathway services include:

- Prevocational Services
- Employment Discovery and Customization
- Small Group Supported Employment
- Individual Supported Employment
- Supported Employment Follow Along
- Transportation

Small Group Supported Employment

Small group supported employment services may be provided under a group rate for groups ranging from 2 to 9 persons. Group employment for groups larger than 9 people will not be reimbursed by the waiver. Small Group Supported Employment services consist of intensive, ongoing support that enable a participant, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of his/her disability, need supports to perform in a regular work setting, including mobile work crews or enclaves. Services are conducted in a variety of settings, particularly work sites where persons without disabilities are employed. Services include activities needed to sustain paid work by a participant, including supervision and training. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations; supervision and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting.

Objectives must be identified in the participant's plan that supports the need for continued job coaching with a plan to lessen the job coaching over time, if possible. The job coach must be in the immediate vicinity and available for immediate intervention and support. Small group supported employment can include employment in community businesses or businesses that are part of a provider organization.

Individual Supported Employment

Individual Supported Employment services are the 1:1 supports available to a participant who, because of their disability, needs intensive, sometimes on-going support, to obtain and maintain an individual job in competitive or customized employment, self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by an individual without a disability.

Services are conducted in a variety of settings, particularly work sites where persons without disabilities are employed. Services include activities needed to sustain paid work by a participant, including supervision and training. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations; supervision and training required by participants receiving waiver services as a result of their disabilities, but does not include payment for the supervisory activities rendered as a normal part of the business setting.

Objectives must be identified in the participant's plan that supports the need for continued job coaching with a plan to lessen the job coaching over time, if possible. Individual Supported Employment must be provided in a community employment setting, unless the support is to develop customized employment, self-employment, or home-based employment (*subject to prior approval of the Division*).

Supported Employment Scope and Limitations:

Service is available for any participant ages 18 and older. All other services approved must be based on participant need and fit within the person's assigned budget. Documentation for any supported employment service must be maintained in the provider and case manager's file for each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 (Vocational Rehabilitation or Workforce Services) or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) (school district). Services cannot be provided during the school hours set by the local school district.

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for training that is not directly related to a participant's supported employment program.

Relative providers (excluding parents/stepparents) may provide these services.

Transportation is included in the reimbursement rates for this service.

Supported Employment Follow Along	Comprehensive Waiver Supports Waiver	T2019 UB	$6.78	15 minute unit

Services and supports that enable a participant who is paid at or above the federal minimum wage to maintain employment in an integrated community employment setting. Service is provided for or on behalf of a participant through intermittent and occasional job support, communicating with the participant's supervisor or manager, whether in the presence of the participant or not. SEFA may cover support through phone calls between support staff and the participant's managerial staff. SEFA reimburses at a 15 minute rate for up to 100 units annual, with approved units based upon individual need in order to maintain employment.

SEFA does not reimburse for transportation, work crews, public relations, community education, in-service meetings, or individual staff development.

SEFA Reimbursable Activities:

- Time spent at the participant's work site: observation and supervision of the participant, teaching job tasks and monitoring at the work site a minimum of twice a month, to ascertain the success of

the job placement
- Employment services occur at an integrated work setting.
- The provision of skilled job trainers who accompany the participant for short-term job skill training at the work site to help maintain employment.
- Regular contact and/or follow-up with the employer and participant in order to reinforce and stabilize the job placement.
- Facilitation of natural supports at the work site.
- Individual program development, writing tasks analyses, monthly reviews, termination reviews and behavioral intervention programs.
- Advocating for the participant, but only with persons at the employment site (i.e., employers, co-workers, customers) and only for purposes directly related to employment.
- Staff time used in traveling to and from a work site.

SEFA Non-reimbursable Activities:

- Transportation of an individual participant.
- Activities taking place in a group, i.e., work crews or enclaves.
- Public relations.
- Community education.
- In-service meetings, department meetings, individual staff development.
- Incentive payments made to an employer to subsidize the employer's participation in a supported employment program.
- Payments that are passed through to users of supported employment programs.
- Sheltered work observation.
- Payments for vocational training or activities that is not directly related to a participant's employment objective.
- Any other activities that are non-participant specific, such as a job coach working the job instead of the participant.
- Services furnished to a minor by a parent(s), step-parent(s) or legal guardian.
- Services furnished to a participant by the participant's spouse.

Transportation	Comprehensive Waiver Supports Waiver	A0080	$0.56 Annual cap of $2000	mile

Transportation service on the waiver is a gap service to enable participants to gain access to an employment location, community services, activities, and resources as specified by the plan of care when a service provider is not needed at the event. Service is not intended to replace formal or informal transportation options, like the use of natural supports, city transportation services, and travel vouchers. Transportation services under the waiver shall be offered in accordance with an individual's plan of care and whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge or with other resources will be utilized.

This service does not include transportation to medical appointments required under 42 CFR 431.53 and transportation services available under the Medicaid state plan.

Service will be reimbursed based on mileage used. Service is capped at $2,000 per year.

Transportation must be provided by certified waiver providers who are certified for this service.

Transportation services cannot be utilized in conjunction with or to access other waiver services that specify in the service scope that transportation is covered in the rate for that service.