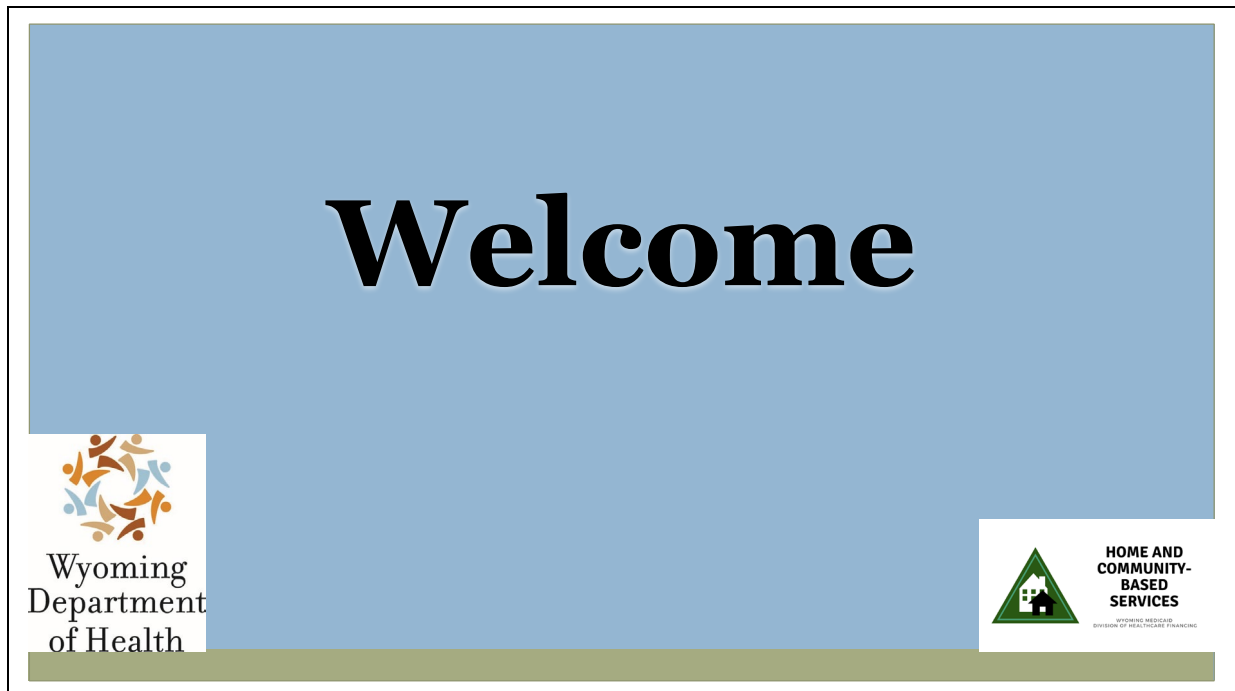




HOME & COMMUNITY- BASED SERVICES

WYOMING DEPARTMENT OF HEALTH
DIVISION OF HEALTHCARE FINANCING

Community Choices Waiver Renewal Training
Effective July 1st, 2026

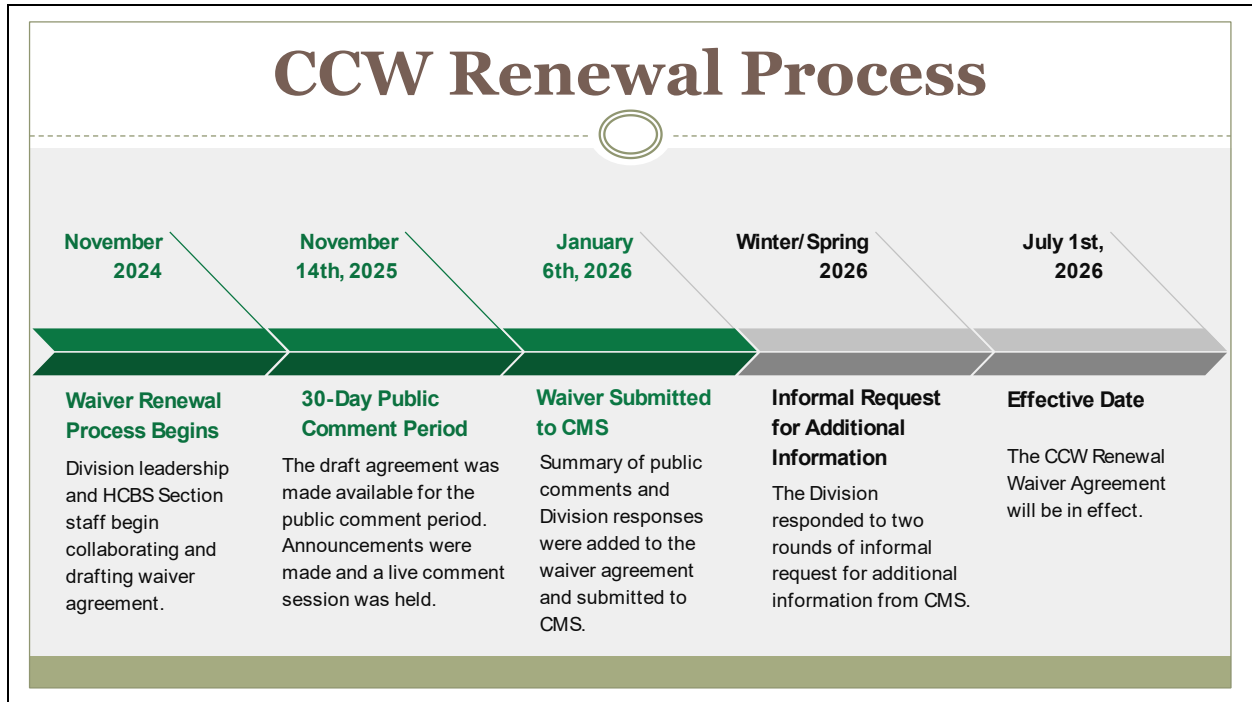


Hello everyone and thank you for joining us for today's Community Choices Waiver renewal training. I'm Adrienne Rosenberg, policy analyst for the Home and Community-Based Services (HCBS) section of the Division of Healthcare Financing (referred to as the Division). I'm joined by Jenifer Adams, HCBS Benefits and Eligibility Unit Manager, and Hannah Ostheimer, HCBS Provider Support Unit Manager. As we review the updates to the Community Choices Waiver, please post questions that you have in the chat box. We will answer what we can live and answer questions in an updated [Frequently Asked Questions](#) document that will be emailed and posted to the [Public Notices, Engagement Groups & Projects](#) page.

Agenda

- CCW Renewal Process
- CCW Waiver Changes
 - General Changes
 - New Services
 - Rates & Units
 - Participant-Direction
 - Case Management Responsibilities
 - Verification Requirements
 - DD Certified Providers

Today's training will cover the Community Choices Waiver (CCW) renewal process and the changes that will be effective July 1st, 2026. We will review some general changes, then the new services available, next, we'll discuss unit updates and participant-direction, and finally we'll cover new case management responsibilities, updated provider verification requirements, critical incident definitions, and review the process to allow DD certified providers to provide certain services for the CCW program.



The Centers for Medicare and Medicaid (CMS) requires states to submit renewal waiver agreements on a five (5) year cycle. Amendments can be made during the five-year cycle, if updates are warranted. The waiver agreement is a contract the state makes with the federal government. The state must adhere to and enforce the active Waiver Agreement. While we are reviewing the changes during this training, we encourage providers and case managers to review the Community Choices Waiver Renewal agreement.

The current Community Choices Waiver began on July 1st, 2021. As we approached end of that cycle, we began the waiver renewal process. In November 2024, the Division began drafting the Community Choices Waiver renewal agreement. Division Leadership and HCBS Section staff collaborated on updates and changes to the waiver.

Once the draft was ready, the Division made a draft version of the renewal available to the public for a 30 day public comment period that began on November 14th, 2025. A live, online public comment session was held on December 4th, 2025 where Division staff took comments. The public comment period officially ended on December 19th, 2025.

The Division reviewed, summarized, and responded to the public comments. The summary of comments with Division responses were included in the waiver application and submitted to the Centers for Medicare and Medicaid, or CMS, on January 6th, 2026. The summary with the responses were also posted to the [HCBS Public Notices, Engagement Groups & Projects webpage](#).

CMS reviews the renewal waiver agreement to ensure the State is adhering to all Federal law and subregulatory requirements. During their review process, the Division received two rounds of informal requests for additional information, or IRAI, during the winter and spring of 2026. The Division provided clarification and made updates as requested by CMS, but nothing impacted the overall intent of the waiver renewal.

The CCW renewal will be effective on July 1st, 2026. We will upload a new Service Index, Fee Schedule, Case Manager Manual, Provider Manual, and other documents and forms ahead of the July 1st effective date.

Now, let's dig in and review the updates found in the CCW renewal agreement.

General Changes

- Cleaned up the wording in all appendices and performance measures to better reflect the Division's current practices.
- Adjusted participant estimates, cost-neutrality tables, and average length of stay figures.
- Added rate methodologies in Appendix I for new services.
- Formalized the MOU with the Department of Family Services in Appendix G.
- Clarified Homemaker, Personal Support, and Home Health Aide limitations to prevent overlap.
- Updated the lists of services requiring criminal background and central registry checks.

When drafting the CCW Waiver renewal, we made some general changes. We cleaned up language throughout the application and, although we didn't change the intent of the wording, we did make changes to help clarify current practices. We updated the language of several of our performance measures to reflect current Division practices. Updates were made to the Division's estimates for total unduplicated number of participants as well as the Demonstration of Cost-Neutrality table and Average Length of Stay estimates. These updates were made based on the data available to the Division at the time. A rate methodology was added in appendix I for Companion Services. Additionally, language was added to state that the Division maintains a memorandum of understanding (MOU) with the Department of Family Services. Federal requirements mandate that services cannot duplicate each other so we clarified Homemaker, Personal Support, and Home Health Aide limitations to prevent overlapping services.

For compliance with federal regulations, we have updated the list of services requiring criminal background and central registry checks including:

- Adult Day Services
- Assisted Living Facility Services
- Case Management
- Home Health Aide
- Homemaker
- Personal Support Services
- Respite

- Skilled Nursing
- Transition Intensive Case Management
- Companion Services
- Non-Medical Transportation

New Services



Now let's take a look at the two new services that have been added to the Community Choices Waiver.

Companion Services

- Provides active supervision and social interaction in both home and community settings. Includes assistance or supervision with meal preparation, laundry, shopping, and light housekeeping, provided these are incidental to the overall care and not the entirety of the service.
- 15-minute units
- May be participant-directed
- Subject to electronic visit verification
- Generally limited to 9 hours per day
- Part-time or intermittent service; not for 24-hour support

The first new service is Companion Services. Those who are familiar with the DD waivers may be familiar with Companion Services. Companion Services is intended to reduce participant isolation. Companion Services provides active supervision, socialization, and assistance for a participant to maintain safety in both home and community settings, and to enhance independence. Companions may assist or supervise the participant with tasks such as meal preparation, laundry, and shopping, as long as these activities do not make up the entirety of the service. Companions may also perform light housekeeping tasks that are incidental to the care and supervision of the participant. The provision of Companion Services does not entail hands-on nursing care, but does include personal care, such as medication assistance, and assistance with activities of daily living, as needed, during the provision of services. Routine transportation is included in the reimbursement rate.

Companion services is reimbursed in 15-minute increments. It may be participant-directed and is subject to Electronic Visit Verification.

The service is generally limited to 9 hours per day. This service cannot be used to provide monitoring while a participant sleeps.

It is a part-time or intermittent services, which is limited to 40 hours per week or 8320 units for the plan year. If multiple part-time or intermittent services are added to the service plan, the person-centered service plan must clearly outline the necessity for each service.

It cannot be billed at the same time as other waiver services. For participants aged 19–21, it must not replace services covered under the Individuals with Disabilities Education Act (IDEA).

Assistive Technology

- Assistive Technology (AT) is designed to provide items, equipment, or product systems that increase, maintain, or improve a participant's functional capabilities. The service must be based on assessed needs and aimed at improving independence, safety, and the ability to perform daily activities.
- The service is limited to \$4,000 per year for all components, including the professional evaluation.
- AT Equipment: Includes a range of products such as screen readers, adaptive locks, electronic speech aids, smart pens, large keyboards, and non-slip mats.
- AT Service: direct assistance with selecting, acquiring, or using equipment.

Assistive Technology (AT) is the second new service designed to provide items, equipment, or product systems that increase, maintain, or improve a participant's functional capabilities. The assistive technology must improve or maintain the participant's level of independence, ability to perform activities of daily living, ability to access needed supports and services in the community, or be required to ensure a participant's health and welfare, and must be based on assessed needs and identified in the participant's person-centered service plan.

There are two components of Assistive Technology including Assistive Technology Equipment and Assistive Technology Services.

Assistive Technology Equipment includes a range of products, equipment, and systems that enhance learning, working, and daily living for participants. AT includes, but is not limited to, devices like screen readers, large keyboards, electronic speech aids, smart pens, adaptive locks, display video magnifiers, speech amplifiers, and non-slip mats. Assistive Technology equipment consists of purchasing, leasing, or otherwise providing for the acquisition of AT devices by a participant, including selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing Assistive Technology devices.

Assistive Technology Services includes direct assistance with selecting, acquiring, or using equipment. Assistive Technology Services will cover:

- Professional Evaluations
 - Assessing specific needs, which is mandatory for equipment costing over \$1,000.
- Delivery and Subscription: Which includes monthly monitoring for functionality.
- Support: Technical assistance and training for the participant, family, or care team.

The service is limited to \$4,000 per year for all components, including the professional evaluation.

Professional evaluations and Assistive Technology services are limited to 8 hours per year.

Case manager must work with the participant's person-centered planning team to complete the Assistive Technology Worksheet and the Provider must sign the Third Party Liability form stating all other funding sources, including Medicaid State Plan, Medicare, and private insurance, were explored and utilized first.

The service does not cover ongoing monthly charges for a participant's personal internet services.

Specific Changes



Next, we'll review some specific changes to the CCW program that we would like to highlight.

Rates & Units

- Transportation bundled into the rates for Adult Day Services and Assisted Living
- Consolidated Adult Day Health and Social models
- Removed the half-day unit, added a 15-minute unit for Adult Day.
- Removed out of home Respite option and added a daily unit
- Updated Non-Medical Transportation units from one-way trips to 15-minute units and kept the multi-pass option

We have added new units to some services and included transportation in the rates for others. These changes were made in an effort to make billing more streamlined for providers.

- **Transportation** will now be bundled into the rates for **Adult Day Services** and **Assisted Living Facility Services**.
- We also consolidated Adult Day Health and Social models into a single service, removed the half-day unit, and added a **15-minute unit** for Adult Day Services.
- We have removed out of home Respite option as it was not widely utilized and added a daily unit for Respite.
- Non-Medical Transportation units were updated to 15-minute units and kept the **public transit multipass**. The 15-minute unit cap of 4.5 hours is the equivalent of the current cap of 18 one-way trips. The Public Transit Multi-Pass unit can be used to purchase multi-passes, one-way passes, and bus passes.

Participant-Direction

- Expanded the options to Companion Services, Homemaker, Personal Support Services, Respite, and Non-Medical Transportation.
- Updated to allow participants to hire a spouse as a provider (as long as they do not have financial decision-making authority).
- Guidance on modifying plans that currently have Personal Support Services through participant-direction.
- Additional guidance on participant-directed Non-Medical Transportation.

We are excited to expand participant-direction options for participants. As of July 1st, Companion Services, Homemaker, Non-Medical Transportation, Personal Support Services, and Respite will all be available under the participant-direction option. We also made an update in the waiver agreement to allow participants to hire a spouse as a provider if they do not have financial decision-making authority. These changes will provide more choice and flexibility for participants who want to self-direct their services.

We would like to remind case managers of guidance that was communicated on June 2nd. It is critical for CCW case managers to modify plans that currently have Personal Support Services through Self Direction. This needs done before June 30th. Please only add Personal Support Services and no other services. Signatures and new forms are not required with this change. If Personal Support Services is not added back to the plan after June 30th, employees will not be paid for services.

We also want to note that if participant-directed non-medical transportation is added to the plan of care paperwork is needed in order for the services to be paid. After adding this service, reach out to ACES\$ at supportwy@mycil.org to request documentation be sent so services can be provided and paid accordingly. It is best to add transportation services on the 1st of the month due to the wage revisions. Transportation will not be paid retroactively.

You can contact your assigned county [Benefits and Eligibility Specialist](#) if you have any questions.

I'll hand the presentation over to Jenifer Adams, the Benefits and Eligibility Unit Manager, to review some of the case management changes.

Case Management

- The description in the Service Index effective July 1st has been reorganized to clarify the three key components of Case Management services
- Monthly Home Visit Requirement
- One hour of person-to-person contact
- Unit updates
 - Monthly
 - 15-minute
- Caseload Assumptions

To better outline and clarify the Case Management Service and all of its components, we have rearranged the definition in the service index. All of the wording from the waiver agreement is present, but the case manager duties have been moved into three key components of case management, including *Service Coordination*, *Service Plan Development*, and *Service Plan Implementation Oversight*.

The Division has included a monthly home visit requirement to the waiver agreement. This new requirement directly supports the three key components of case management, specifically our focus on *Service Plan Implementation Oversight*. The intent is to ensure participants' needs are met, they are satisfied with their services, and to review the health and safety of the individual. As stated in the CCW Case Management Manual, this review of health and safety extends beyond briefly interacting with the individual. It can also include evaluating the physical condition of the home, if the individual can safely navigate the home, and other key observations. The monthly home visit gives participants an opportunity to let their case manager know their needs directly and work together to find appropriate services and solutions. A Monthly Home Visit Verification form is currently available in the [HCBS Document Library](#).

During the public comment period, we received input that the Division should clarify expectations regarding direct contact with the participant. Clarification has been added to the upcoming service index to state that the case manager must have at least one

hour of person-to-person contact with the participant or legally authorized representative. This requirement can be met by completing the required monthly home visit, phone calls, or other means of direct contact with participant or their legally authorized representative. The person-to-person contacts will need to be detailed in the case manager monthly review (CMMR). This change reinforces the three key components of case management by ensuring consistent, meaningful Service Coordination, Service Plan Development, and Service Plan Implementation Oversight. Again, the intent is to ensure the participant has opportunities to connect with their case manager and make any needed updates to their person-centered service plan.

The Division has removed the “Initial Service Plan Development/Annual Update” unit, but this is not a rate decrease. The reimbursement for the Initial/Annual Update unit has been rolled into the Monthly and the new 15-Minute units. This adjustment ensures that reimbursement is more evenly distributed across the three key components of case management that you perform every month.

The intent for creating the 15-Minute unit is to assist with the times where a case manager change needs to occur mid-month. Currently, only one case manager can bill per month, making the mid-month transitions very difficult. The Division still encourages case manager transitions to occur on the first of the month. If the case manager transition is happening mid-month, the case manager will need to outline the reason on the updated CCW Change of Case Management Form. The form will be available on the [HCBS Document Library](#) page on July 1st.

We would also like to note that the Case Management rate includes a baseline assumption that a case manager would be working 40 hours per week with a caseload of 35 clients. This is based off of the rate study and can be used as a reference as to where the Division obtained their facts and figures.

Now I’m going to pass the presentation to Hannah Ostheimer to discuss provider updates.

Provider Verification

- Explicitly notes collaboration with the Aging Division to conduct initial and periodic reviews.
- List of Excluded Individuals/Entities (LEIE) and Data Exchange (DEX) are searched monthly for active providers.
- Updated frequency of verification of provider qualifications.
 - *DHCF shall initially certify a new agency providing a service for one year. Renewal of that certification shall be conducted at least once every three (3) years. DHCF has the authority to conduct an on-site visit when a concern is identified during a complaint, incident report, internal referral, or at DHCFs discretion.*

The renewal explicitly notes collaboration with the Aging Division to conduct initial and periodic provider qualification reviews.

We have also added that the Division contracts with a private corporation to act as its Medicaid Provider Enrollment Vendor. Our vendor searches the list of Excluded Individuals/Entities (LEIE) and Data Exchange (DEX). The searches occur during initial screening and are monitored monthly for active providers.

We have updated the frequency of verification of provider qualifications. Starting July 1st, the Division shall initially certify a new agency providing a service for one year. Renewal of that certification shall be conducted at least once every three (3) years. The Division of Healthcare Financing (DHCF) has the authority to conduct an on-site visit when a concern is identified during a complaint, incident report, internal referral, or at the discretion of the Division of Healthcare Financing. Previously, this verification was required annually.

Critical Incident Language

- Replaced our definition with the Wyoming Statutes that define abuse, neglect, and exploitation.
 - Abuse as defined by Wyo. Stat. Ann. § 35-20-102 or Wyo. Stat. Ann. § 14-3-202;
 - Neglect and self-neglect as defined in Wyo. Stat. Ann. § 35-20-102 or Wyo. Stat. Ann. § 4-3-202;
 - Exploitation as defined in Wyo. Stat. Ann. § 35-20-102;

In Appendix G-1-b, we have updated the language around critical incidents and replaced our definitions of abuse, neglect, and exploitation with the Wyoming Statutes that define abuse, neglect, and exploitation. This is to help us maintain consistency within the State.

- Abuse as defined by [Wyo. Stat. Ann. § 35-20-102](#) or [Wyo. Stat. Ann. § 14-3-202](#);
- Neglect and self-neglect as defined by [Wyo. Stat. Ann. § 35-20-102](#) or [Wyo. Stat. Ann. § 4-3-202](#);
- And Exploitation as defined by [Wyo. Stat. Ann. § 35-20-102](#).

DD Certified Providers

- DD certified providers can choose to provide the following services on CCW:
 - Adult Day Services
 - Homemaker
 - Respite
 - Companion Services
- To initiate eligibility for CCW service delivery, contact your county Credentialing Specialist.

To help broaden the pool of potential providers, the Division has updated Adult Day Services, Homemaker, and Respite Services to allow providers who are certified to provide the service on the Comprehensive and Supports Waivers to provide the service on the Community Choices Waiver. DD-qualified providers of Companion Services will also have the opportunity to provide the service on the CCW.

In order to begin providing the services on CCW, the provider must complete the Medicaid application process for taxonomy 251B00000X. The prospective provider can contact the [HCBS Credentialing Specialist](#) for their area for next steps regarding providing the four reciprocal services.

To wrap up, I will hand it back to Adrienne to review some of the key takeaways.

Key Takeaways

- The HCBS Section must adhere to CMS requirements & waiver agreements. We highly recommend reviewing the full agreement.
- Specific services now feature updated units; transportation costs have been bundled into the rates for select services to streamline claims.
- Increasing flexibility for participants using the participant-direction service option
- The service menu has been expanded to better meet participant needs.
- DD certified providers may now seek certification to provide specific CCW services.
- Case Managers are now required to conduct one monthly home visit consisting of at least one hour of person-to-person contact.
- New requirements for provider verification and updated definitions for Critical Incidents have been established.

Thank you. As we end this training, we'd like to review some of the key items that providers need to remember:

The Division operates under a direct contract with the Centers for Medicare & Medicaid Services (CMS). Because CMS funds **50% of our budget**, strict adherence to the federal assurances outlined in the waiver agreement is non-negotiable.

- Failure to meet performance measures or adhere to the agreement means CMS can halt our funding.
- Providers are expected to have a foundational understanding of the waiver documents; reviewing the full agreement is highly recommended to understand the CCW program.

To simplify the billing process and reduce administrative friction, the following updates have been implemented:

- Specific services now feature updated units and transportation costs have been bundled into rates for select services to streamline claims.

We are increasing flexibility for participants using the participant-direction service option:

- This option is now available across a broader range of services and spouses now have the opportunity to be hired as employees for service delivery.

The service menu and provider options has been expanded to better meet participant needs:

- Assistive Technology and Companion Services have been added to the waiver and DD-certified providers may now seek certification to provide specific CCW services.

We have made updates regarding oversight to ensure participant safety and program integrity:

- Case Managers are now required to conduct **a monthly home visit** along with at least one hour of person-to-person contact. This new requirement is designed to strengthen the three components of case management—Service Coordination, Plan Development, and Implementation Oversight.
- We'd also like providers to keep in mind the new requirements for provider verification and the updated definitions for **Critical Incidents** that have been established.

Thank you!



At this time if you have any other questions, please post them in the chat. We'll answer as many as we can now, but some may be better answered in writing. We will answer all questions in writing and get those to you by email and post them to the [Public Notices, Engagement Groups & Projects](#) page in the next few days. We will also post the recording of this training. Thank you for joining us today!