



**HOME AND
COMMUNITY-
BASED
SERVICES**
WYOMING MEDICAID
DIVISION OF HEALTHCARE FINANCING

WYOMING DEPARTMENT OF HEALTH
DIVISION OF HEALTHCARE FINANCING
HOME AND COMMUNITY BASED SERVICES
(HCBS) SECTION

COMMUNITY CHOICES WAIVER SERVICE INDEX

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Division of Healthcare Financing Service Requirements

The Community Choices Waiver (CCW) services defined in this document shall be performed in the manner described in the service definitions. The CCW program is intended to serve participants on a part-time or intermittent basis. Full-time care is not a part of the waiver. Service plans should be created based on the part-time framework. Services must meet each participant's assessed needs. In accordance with the Wyoming Medicaid Provider Agreement, CCW providers and case managers must be knowledgeable of the Department of Health's Medicaid rules and guidance affecting CCW services, [must meet the provider qualifications established in the CCW Agreement with the Centers for Medicare and Medicaid Services \(CMS\)](#), and [must comply with the provision of the Wyoming Medicaid Provider Agreement](#).

Many CCW service providers are required to have additional licensure or approval through other State of Wyoming entities. Obtaining and maintaining this licensure is essential to providing CCW services; entities without the appropriate licensure will be referred to Program Integrity for potential recovery of funds, and will face additional provider credentialing consequences, up to and including termination of their provider agreement.

Each service, in combination with other services included in a participant's service plan, must be determined necessary by the case manager's assessment of the participant's needs. The participant's service plan must account for services to cover the entire plan year. With the exception of case management services, which participants must receive each month, a minimum number of service units is not required.

Waiver services shall not duplicate services offered through another funding source, such as Section 110 of the Rehabilitation Act of 1973 (Vocational Rehabilitation or Workforce Services), the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.), or the Medicaid State Plan.

Participant-directed services shall be performed in the manner described in the service definitions and meet the participant's assessed needs. Services offered through participant-direction are only billable in 15-minute increments. The participant-direction employer must ensure that all participant-directed services fit within the participant-directed budget. CCW participant-directed services allow for the hiring of any person at least 18 years of age, including relatives who are not legally responsible for the participant.

The CCW program allows spouses to be hired under participant-direction as an employee to provide personal support services.

The following services may be participant-directed:

- Companion Services
- Homemaker
- Non-Medical Transportation
- Personal Support Services
- Respite

The following services are subject to electronic visit verification (EVV):

- Companion Services
- Home Health Aide
- Personal Support Services
- Respite
- Skilled Nursing

A National Provider Identifier (NPI) number is required for all providers.

The Financial Management Service (FMS) contracted to provide support to participants who direct services through participant direction on CCW shall maintain a single NPI that is associated with the Home and Community Based Services (HCBS) within DHCF. The FMS is not required to obtain a second NPI to process CCW claims.

* Please note that Prior Authorization is required for Waiver Services			
Service	Code	Rate	Unit
Adult Day Services	S5100	\$2.37	15-Minute
	S5101	\$56.89	Daily

Adult Days Services include [part-time or intermittent services](#) that consist of meaningful daytime 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, and maintain personal skills; introduce new leisure pursuits; establish new relationships; improve or maintain flexibility, mobility, and strength; or build on previously learned skills. Adult Day Services provide active, person-centered supports which foster independence as identified in the participant's person-centered service plan.

Transportation is a component of Adult Day Services and is included in the rate to providers. Adult Day Services do not include and do not replace or supplant the physical, occupational, and/or speech/language therapies available through the state plan.

Exclusions and Limitations

Services are authorized based on the participant's assessed needs. Adult Day Services cannot be provided during sleeping hours. Services do not include the provision of physical, occupational, or speech, language, and hearing therapies available under the Medicaid State Plan.

ADS is billed at a 15-minute or daily unit. The 15-minute and daily unit cannot be billed on the same day. Any use of ADS over [four \(4\) hours a day \(16 units a day\)](#) must be billed as a daily unit.

[Part-time or intermittent services are limited to 40 hours per week or 8,320 15-minute 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.](#)

Meals provided as part of these services shall not constitute a full nutritional regimen and are not intended to serve as the sole source of nutrition for the participant. If food insecurity is identified as a risk on the participant's assessment, the service plan must address how the participant's additional dietary needs are being met.

Adult Day 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.

Adult day services cannot be provided virtually.

Reimbursement is limited to the following provider types:

- Adult day care facilities licensed by the Wyoming Department of Health, Division of Aging pursuant to W.S. 35-2-901(a)(xxiii).
- Eligible senior centers as established by W.S. 9-2-1201(a)(iii) and overseen by the Wyoming Department of Health, Division of Aging as credible and capable to receive grants for Older

- Americans Act services pursuant to W.S. 9-2-1204(a)(vii).
- Independent providers that maintain a certification for this service from the DHCF.

* Please note that Prior Authorization is required for Waiver Services				
Service		Code	Rate	Unit
Assisted Living	Standard	T2031	\$70.44	Daily
	Memory Care Unit	T2031 U8	\$82.49	

Assisted Living Facility Services include personal care and supportive services, to the extent permitted under state law, that are furnished to waiver participants who reside in a setting that meets the home and community-based setting requirements and includes 24-hour on-site response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security. Services also include social and recreational programming, and medication assistance, to the extent permitted under state law.

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

Participant transportation costs are included in the rate for the Assisted Living Facility services.

Exclusions and Limitations

Reimbursement does not include the costs for room and board, items of comfort or convenience, or facility maintenance, upkeep, and improvement.

Nursing and skilled therapy services are incidental rather than integral to the provision of assisted living services; therefore, reimbursement does not include 24-hour skilled care.

Assisted Living Facility services do not include services which are available through the state plan.

Reimbursement is limited to assisted living facilities licensed by the Wyoming Department of Health, Division of Aging pursuant to W.S. 35-2-901(a)(xxii).

* Please note that Prior Authorization is required for Waiver Services				
Service		Code	Rate	Unit
Assistive Technology	Equipment	T2028	PA#	Per Event
	Service	97755	\$25.17	15-Minute

Assistive Technology (AT) means any item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. AT 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.

AT 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, or non-slip mats. AT 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 AT devices.

AT Service means a service that directly assists a participant in the selection, acquisition, or use of AT Equipment including:

- **AT Professional Evaluation:** the evaluation of the AT needs of a participant, including a functional evaluation of the impact of the provision of appropriate AT Equipment and Services to achieve outcomes in the participant's person-centered service plan.
- **AT Delivery and Subscription:** monthly implementation of service and monitoring for functionality of the technology and equipment, as necessary, by the provider. Reimbursement for an ongoing monthly charge of participant internet services is not covered. The case manager must assist with any reported functionality or equipment repairs, as needed.
- **AT Support:** training or technical assistance beyond that included in initial installation/training and routine service delivery that aids a participant in the use of AT Equipment as well as training for the participant's family members, guardians, advocates, authorized representatives, providers, employers, persons who are otherwise substantially involved in activities being supported by the AT Equipment, or other members of the person-centered care plan team. AT Support may include, when necessary, coordination with complementary therapies, interventions, or devices.

All other reimbursement sources must be explored and utilized, including the Medicaid State Plan services, prior to reimbursement of AT Equipment and AT Services.

AT Equipment and AT Services require prior authorization and approval by WDH. Documentation for prior authorization must describe how the participant's expected use, purpose, and intended place of use have been matched to features of the AT Equipment requested in order to achieve the desired outcome in an efficient and cost-effective manner.

AT Equipment above \$1,000 requires a professional evaluation focused on evaluating the AT needs of a participant. The evaluation may be conducted by a licensed occupational therapist; a speech, hearing, or language therapist; a physical therapist; a certified assistive technology professional; or other professional meeting all applicable WDH standards, including regulations, policies, and procedures relating to provider qualifications. In certain circumstances, WDH may waive the professional evaluation of AT Equipment above \$1,000 and allow the case manager to complete the functional assessment as part of the person-centered planning process to fulfill this evaluation requirement.

The Assistive Technology Request Worksheet found in the [HCBS Document Library](#) must be completed and submitted to the Assigned County BES prior to adding this service to the person-centered plan of care.

Exclusions and Limitations

AT Equipment and Services has a \$4,000 annual limit for all components and is subject to prior authorization through WDH. The cost of the AT Professional Evaluation must be funded as a part of the \$4,000 cap.

AT Professional Evaluation is limited to eight (8) hours per year. AT Support is limited to eight (8) hours per year. WDH may approve additional funding for AT Professional Evaluation and AT Support if the participant has a documented need for new or additional types of AT equipment in the same year.

If a participant's need cannot be met within the limits, WDH may approve exceeding the \$4,000 overall annual limit, if requested by the participant or their case manager, and reviewed by an eligibility specialist. The person-centered service plan must document when the limit for this service is exceeded and results in a decreased need of one or more other waiver services.

Case managers are responsible for checking with Medicaid (including the State Plan DME service), Medicare, and a participant's other insurance carrier, as applicable, to see if the requested equipment is covered under their plans. The provider must then sign a third-party verification form indicating that the Community Choices Waiver is the payor of last resort.

Reimbursement is limited to:

- Case management agencies, which are corporations, limited liability companies (LLC), non-profit organizations, sole proprietorships, or other business entities registered in good standing with the Wyoming Secretary of State.
- County Public Health Nursing agencies
- Independent providers that maintain a certification for this service from the DHCF.
- Assistive Technology Vendors

* Please note that Prior Authorization is required for Waiver Services			
Service	Code	Rate	Unit
Case Management	T2022	\$241.83	Monthly
	T1016	\$12.09	15-Minute

Case Management is a required service that assists participants in gaining access to needed waiver and other state plan services, as well as medical, social, educational and other services, regardless of the funding source. Case management reimbursement rates are determined through the Department's rate study that occurs every two to four years. The rate study includes an assumption of a case manager caseload of 35 participants, which would reflect a full-time position. **Further information on the design of the service can be found on the [HCBS Statistics & Reports](#) in the CCW Rate Study Report.**

Case manager duties include:

- **Service Coordination:** The case manager assists the client in applying for the waiver, monitors the progress of the application, and assists the client in exploring natural supports and community resources to supplement paid services. The case manager conducts a needs assessment as defined by the Department to determine strengths and needs of the individual. **Key activities include, but are not limited to:**
 - **Assessment:** Comprehensive assessment and periodic reassessment of participant's needs to determine the need for waiver services as well as any medical, educational, social, or other services.
 - **Coordination and Referral:** Service coordination, referral, and other related activities (e.g., scheduling appointments for the participant, assisting with the Medicaid financial renewal application, etc.) to help the participant obtain needed services.
 - **Resource Connection:** Activities that help link the participant with medical, social, and educational providers or other programs and services that are capable of providing needed services to address the identified needs and achieve the goals specified in the service plan.
- **Service Plan Development:** After the individual receives a funding opportunity, the case manager coordinates the plan of care team chosen by the client and assists them in developing a plan for services and supports that builds on strengths and addresses needs of the client. This plan includes identifying the providers who will deliver the services, and the frequency, scope, and duration of services. **Key activities include, but are not limited to:**
 - **Plan oversight:** Facilitation and oversight of the development (and periodic revision) of a person-centered service plan in accordance with DHCF policies and procedures.
 - **Participant-Direction Support:** Information and assistance in support of participant-direction as necessary:
 - Inform participants of participant-direction opportunities;
 - Ensure participants who express an interest in participant-direction are informed of the potential benefits, liabilities, risks, and responsibilities associated with each service delivery option;

- Assist the participant/designated employer in obtaining and completing required documents as determined by the Department;
 - Coordinate with the Department to verify the participant's budget allocation in accordance with the Department's methodology;
 - Coordinate with the Financial Management Services (FMS) agency
- **Service Plan Implementation Oversight:** The case manager conducts oversight of the service plan to ensure the client's needs are met, the client is satisfied with services provided, and any new or upcoming needs are addressed. Additionally, the case manager monitors the unit utilization to ensure appropriate budget usage, and adjusts unit usage accordingly. This oversight is documented in the Case Management Monthly Review (CMMR) form uploaded into the Electronic Medicaid Waiver System (EMWS). **Key activities include, but are not limited to:**
 - **General Implementation:** Service plan implementation, monitoring, and follow-up activities, including activities and contacts that are necessary to ensure that the service plan is effectively implemented and adequately addresses the needs of the participant.
 - **Direct Contact:** Maintain direct contact with the participant and/or legal representative (if applicable), which must include a monthly in person visit to the participant's place of residence with the participant present. At least one hour of person-to-person contact with the participant or legally authorized representative is required monthly. Additional service observations, and virtual or in-person interactions may also be required.
 - **Ongoing Monitoring Activities:** Contacts may be with the participant, legal representative, as appropriate, family members, service providers, or other entities or individuals and are conducted at minimum monthly but more often as necessary in order to:
 - Ensure services are being furnished in accordance with the participant's service plan;
 - Evaluate the effectiveness of the service plan in meeting the participant's needs;
 - Identify any changes in the participant's condition or circumstances;
 - Screen for any potential risks or concerns;
 - Assess the participant's satisfaction with services and supports;
 - Make any necessary adjustments in the service plan and service arrangements with providers;
 - Report and follow-up on all critical and non-critical incidents in accordance with DHCF policies;
 - Monitor for compliance with HCBS settings criteria.
 - Coordinate quarterly meetings with the back-up case manager to ensure they remain updated on the participant.
 - **Budget and Utilization Review:** Review service utilization and documentation of traditional and participant-directed services to assure the amount, frequency, and duration of services is appropriate.
 - Follow-up on concerns or questions raised by the participant, legally authorized representative, or plan of care team, or identified through incident reports, complaints, or service observations.
 - Monitor participant-directed service effectiveness, quality, and expenditures against the monthly budget allocation.
 - **Participant-Direction Usage:** When a participant chooses the participant-directed service delivery model, use the FMS portal to review service delivery information, determine budget usage, provide ongoing monitoring of the participant's budget, and report improper budget usage to the assigned DHCF staff member.

Case Management Agency Responsibilities

Case management agencies are responsible for the following:

- Ensure all case managers meet the requirements outlined in the approved Community Choices Waiver and the CCW Case Manager Manual, including all training required to deliver case management services;
- Have internal mechanisms for assessing and managing the performance of each case manager. If the agency does not address case manager performance concerns to the Division's satisfaction, the Division may require case manager retraining or other progressive disciplinary actions, up to and including termination of the case manager's status as a CCW program case manager.
- Maintain adequate administrative and staffing resources and emergency backup systems to deliver case management services in accordance with all federal and state requirements;
- Assign one (1) person to serve as the participant's case manager based on the participant's preferences;
- Ensure all participants have a backup case manager in the event that the primary case manager not be able to provide case management services for any reason;
- Provide up-to-date information about public and private state and local services, supports, and resources to participants or individuals inquiring on their behalf;
- Establish and maintain working relationships with community-based resources, supports, organizations, hospitals, service providers, and other organizations that assist in meeting the participant's needs;
- Collaborate with other entities, as needed to support participants;
- Ensure that case managers have access to federal and state statutes, regulations, and other documents and information relevant to the provision of case management services;
- Ensure that case managers maintain a working knowledge of CCW policies and procedures;
- Overcome any geographic barriers, including distance to the participant, to provide timely case management services;
- Ensure that case management services are, at minimum, available during normal business hours (Monday through Friday, 9:00 AM to 5:00 PM, excluding state holidays);
- Provide access to a telephone system and trained staff to ensure timely responses to messages and telephone calls received outside of normal business hours;
- Ensure the agency meets established billing standards;
- Submit information and reports as required by the Division;
- Maintain sufficient documentation to substantiate claims for reimbursement of case management services for six (6) years after the date of service, including all documents, records, communications, notes, case manager qualifications, and other materials related to services provided and work performed; and
- Facilitate access to telecommunication devices and interpreters for participants with hearing or vocal impairments, and access to foreign language interpreters as necessary to conduct all required case management activities. If a participant needs translation services, the case manager should contact the area's Benefits and Eligibility Specialist for further information.

Non-billable activities include:

- Ancillary, supervisory, or administrative activities, such as mailing, coping, filing, and activities associated with provider certification renewal.

- Time spent with the participant or legally authorized representative for social reasons, unless billable case management activities are also occurring. The Centers for Medicare and Medicaid Services does not consider incidental contact and social exchanges to be case management activity.
- Travel time, which has already been included as part of the rate for this service.

Exclusions and Limitations

The participant's service plan must be reviewed and updated annually. Reimbursement includes the development of the person-centered service plan, any periodic service plan modification activities as necessary to ensure that the service plan is effectively implemented and adequately addresses the needs and desires of the participant.

The monthly unit may only be billed on or after the last day of the month.

The 15-minute unit can be billed at a maximum of 16 units per month, 192 units per service plan year. A minimum of four (4) units monthly must be documented to comply with the one (1) hour of person to person contact requirement.

Reimbursement is limited to the following provider types:

- Case Management agencies, which are corporations, limited liability companies (LLC), non-profit organizations, sole proprietorships, or other business entities registered in good standing with the Wyoming Secretary of State.
- Independent providers that maintain a certification for this service from the DHCF.

Conflict Free Case Management

The case management agency and case manager responsible for the development of the participant's service plan must meet the following conflict of interest standards:

- The case manager must not be related by blood or marriage to the participant, or to any person paid to provide CCW services to the participant;
- The case manager must not share a residence with the participant or with any person paid to provide CCW services to the participant;
- The case manager or case management agency must not be financially responsible for the participant;
- The case manager or case management agency must not be empowered to make financial or health-related decisions on behalf of the participant; and
- The case manager or case management agency must not own, operate, be employed by, or have a financial interest in any entity that is paid to provide CCW services to the participant. Financial interest includes a direct or indirect ownership or investment interest or any direct or indirect compensation arrangement.
- A case management agency or individual case manager cannot provide CCW Case Management and Targeted Case Management to the same individual on the DD waiting list.

* Please note that Prior Authorization is required for Waiver Services			
Service	Code	Rate	Unit
Companion Services	S5135	\$7.35	15-Minute

Companion Services include [part-time or intermittent](#) services that consist of supervision, socialization, and assistance for a participant to maintain safety in the home and community, and to enhance independence. Companions may assist or supervise the participant with tasks such 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. 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.

This service may be participant-directed.

Exclusions and Limitations

Companion Services are reimbursed at a 15-minute unit. Service can be provided for no more than nine (9) hours a day except for special events or out of town trips. This service cannot be used to provide monitoring while a participant sleeps.

[Part-time or intermittent services are limited to 40 hours per week or 8,320 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.](#)

Services cannot be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit.

Companion services provided to participants ages 19 through 21 must not duplicate or replace services that are covered under IDEA. Services cannot be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit.

Companion Services may be participant-directed, [but a participant-directed employee cannot work more than 40 hours per week per employer](#). Services offered through participant-direction are only billable in 15-minute increments.

This service is subject to electronic visit verification.

Reimbursement is limited to the following provider types:

- Agencies certified by DHCF to provide the service;
- Participant-directed employees hired under the participant-direction service delivery option and;
- Independent providers that attain and maintain a certification for this service from DHCF.

* Please note that Prior Authorization is required for Waiver Services				
Service		Code	Rate	Unit
Environmental Modifications	Assessment	T1028	PA#	Per Event
	New	S5165 NU		
	Repair	S5165		

Environmental Modification services include the installation or repair of functionally necessary physical adaptations to the private residence of the participant or the participant's family, as outlined in the person-centered service plan, that are necessary to ensure the health, welfare, and safety of the participant in order for them to remain in their home instead of an institutional setting or to transition from an institutional setting. If transitioning from an institutional setting, this service may be authorized up to 180 calendar days in advance of the transition date. 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.

If this service is provided to a participant transitioning into the community from an institutional setting, the modification will not be considered complete and cannot be billed for until the individual leaves the institution and is accepted onto the waiver.

An occupational or physical therapy assessment in the amount established in the Medicaid State Plan may be included in the service if the individual is transitioning to the community from an institution; assessments for participants who are currently living in the community must be paid through the Medicaid State Plan and are not allowable charges under this service.

All services shall be provided in accordance with applicable state and local building codes.

This service requires a completed Third-Party Liability form.

Exclusions and Limitations

A lifetime cap of \$20,000 per family applies to this service.

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 the entrance or egress of a residence or to configure a bathroom to accommodate a wheelchair). Adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the participant are excluded.

Modifications of rented or leased homes shall be extraordinary alterations that are uniquely needed by the individual, and for which the property owner would not ordinarily be responsible.

Adaptations that are covered by the Medicaid State Plan, a state independent living center, or Division of Vocational Rehabilitation are excluded. Case managers are required to contact Wyoming Medicaid to determine if the requested modification is covered under the Medicaid State Plan. The provider must

then sign a third-party verification form indicating that the Community Choices Waiver is the payer of last resort. Environmental Modifications shall not be furnished to modify settings that are owned or leased by providers of waiver services.

The case manager shall not obtain quotes until the overall scope of the project is approved by the Division.

The Division may use a third party to conduct an on-site visit to assess the proposed modification and need for the modification to ensure cost effectiveness.

Reimbursement is limited to the following provider types:

- Agency providers certified by the DHCF to provide the service and;
- Individual providers certified by the DHCF to provide the service.

* Please note that Prior Authorization is required for Waiver Services				
Service		Code	Rate	Unit
Home Delivered Meals	Hot	S5170 SE	\$10.65	1 Meal
	Frozen	S5170	\$7.88	

Meal delivery service includes home or mail delivered meals to the home of the participant when the participant is unable to prepare a meal for him or herself and the individual regularly responsible for these activities is temporarily absent or unable to conduct these activities. Meals must meet the standards for the nutritional services delivered under Title III of the Older Americans Act.

Hot meals are defined as ready-to-eat meals that are delivered on a daily or semi-daily basis by the meal provider. Hot meals can be provided to the participant at the location of their choosing, like a senior center. If, during the course of delivering the meal the provider notes concerns with the participant's well-being, the provider must report the concerns to the participant's case manager and, if necessary, the Division as an incident.

Frozen meals are defined as meals that are prepared and packaged on a commercial basis, and delivered in bulk through a mail or delivery service.

Exclusions and Limitations

This service is limited to two meals per day. Meals provided as part of these services shall not constitute a full nutritional regimen and are not intended to serve as the sole source of nutrition for the participant. If food insecurity is identified as a risk on the participant's assessment, the service plan must address how the participant's additional dietary needs are being met. Hot meals cannot replace or duplicate meals provided as part of another waiver service or meals for which the participant has already paid as part of the room and board paid to a residential provider.

Providers must meet the standards established in the Community Choices Waiver agreement.

Reimbursement is limited to the following provider types:

- Commercial food service operators licensed or permitted by the state in which the commercial food service preparation facility is located.
- An agency overseen by the Wyoming Department of Health, Division of Aging as credible and capable to receive grants for Older Americans Act nutritional services pursuant to W.S. 9-2-1204(a)(vii).

* Please note that Prior Authorization is required for Waiver Services			
Service	Code	Rate	Unit
Home Health Aide	T1004	\$10.36	15 Minute

Home Health Aide services include [part-time or intermittent](#) assistance with personal care and other daily living needs that is within the scope of practice and required to be delivered by a Certified Nurse Aide (CNA) under the Wyoming Nurse Practice Act.

HCBS Home Health Aide services differ in nature and scope from Medicaid State Plan Home Health Aide services. HCBS Home health Aide services are not limited to rehabilitative services, may be provided on a long-term basis, are not subject to a physician's review every 60 days, and may include general household tasks, such as meal preparation, grocery or personal needs shopping, and light housekeeping [when those tasks are incidental to the personal care provided during the visit](#), the participant is unable to complete these tasks, and the individual regularly responsible for these activities is temporarily absent or unable to conduct these activities.

Home Health Aide Services may be provided in the home or in the community when the participant requires assistance in order to participate in community activities or to access other services. [The participant must be present during the delivery of Home Health Aide Services, and the provider must be able to demonstrate how they encouraged participant engagement during service delivery.](#)

Exclusions and Limitations

Home Health Aide services do not include companionship or other services which are diversional or recreational in nature. Home Health Aide services cannot be provided during sleeping hours.

[Part-time or intermittent services are limited to 40 hours per week or 8,320 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.](#)

Waiver services shall not duplicate services offered through another funding source, such as Section 110 of the Rehabilitation Act of 1973 (Vocational Rehabilitation or Workforce Services), the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.), third-party insurance, or the Medicaid State Plan. Participant transportation costs are not associated with the provision of home health aide services and must be billed separately.

Medically necessary Home Health Aide services for individuals under the age of 21 are provided under the state plan in accordance with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) coverage requirements.

If Home Health Aide and Homemaker are listed on the participant's plan, the case manager must indicate how the chore services associated with Home Health Aide will be different from Homemaker Services. There is a higher chance that the case management information system will trigger a Quality Improvement Review (QIR) of the person-centered service plan when Homemaker is added to a plan that includes Home Health Aide or Personal Support Services. The Benefits and Eligibility Specialist (BES) will

review the information included in the person-centered service plan and work with the case manager if additional clarification is needed or concerns are noted.

Home Health Aide Services and Personal Support Services may be included on the same service plan, but the services cannot be billed for during the same time frame.

This service is subject to electronic visit verification.

Reimbursement is limited to home health agencies licensed by the Wyoming Department of Health, Division of Aging pursuant to W.S. 35-2-901(a)(xi). The individual providing the service must be a Nursing Assistant or Nurse Aide certified by the Wyoming State Board of Nursing in accordance with the Wyoming Nurse Practice Act [W.S. 33-21-120 et seq.].

* Please note that Prior Authorization is required for Waiver Services			
Service	Code	Rate	Unit
Homemaker Services	S5130	\$6.49	15-Minute

Homemaker Services consist of chore-type activities and routine household care that is not covered by Personal Support Services, and is considered a non-direct service. Homemaker is an indirect service as providers do not prompt or assist the participant in the completion of a task, and the participant is not required to be present when the service occurs.

Examples of covered tasks include but are not limited to meal preparation, shopping for groceries and personal items, laundry and ironing, and household cleaning to include regular home maintenance and more involved cleaning tasks such as cleaning appliances and washing windows. All tasks must be completed for the benefit of the participant.

As Homemaker is an indirect service, this service can be provided at the same time that direct services are being provided to the participant by a different provider or provider staff.

This service may be participant-directed.

Exclusions and Limitations

A maximum of three (3) hours per week per household (624 units per year) is allowed.

A provider of Homemaker Services shall not bill for two participants during the same time frame. Transportation costs are not associated with the provision Homemaker Services.

If Homemaker and Personal Support Services or Home Health Aide are listed on the participant's plan, the case manager must indicate how Homemaker services will be different from the chore services associated with Personal Support Services or Home Health Aide. There is a higher chance that the case management information system will trigger a Quality Improvement Review (QIR) of the person-centered service plan when Homemaker is added to a plan that includes Personal Support Services or Home Health Aide. The Benefits and Eligibility Specialist (BES) will review the information included in the person-centered service plan and work with the case manager if additional clarification is needed or concerns are noted.

Homemaker Services may be participant-directed, but [a participant-directed employee cannot work more than 40 hours per week per employer](#). Services offered through participant-direction are only billable in 15-minute increments.

Reimbursement is limited to the following provider types:

- Agency providers that attain and maintain certification for this service from the DHCF. If the Agency is a Home Health Agency, it shall be fully licensed in the state of Wyoming.
- Participant-directed employees hired under the participant-direction service delivery option.

* Please note that Prior Authorization is required for Waiver Services				
Service		Code	Rate	Unit
Non-Medical Transportation	Public Transit Multi-Pass	T2003	Variable	Per Purchase
	15-Minute	A0130	\$7.59	15-Minute

Non-Medical Transportation is offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the service plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the Medicaid State Plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them. Transportation services under the waiver are offered in accordance with the participant's service plan. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge should be utilized.

- The Public Transit Multi-Pass unit can be used to purchase multi-passes, one-way passes, and bus passes.

This service may be participant-directed.

Exclusions and Limitations

The reimbursement for this service is limited to a total of \$80.00 per month for the Public Transit Multi-Pass unit. The 15-minute unit is limited to a total of 4.5 hours (18 units) per month.

Non-Medical Transportation may be participant-directed, [but a participant-directed employee cannot work more than 40 hours per week per employer](#). Services offered through participant-direction are only billable in 15-minute increments.

Reimbursement is limited to the following provider types:

- Public transit agencies determined by the Wyoming Department of Transportation as eligible to receive public transit funds in accordance with W.S. 24-15-101(a)(iii).
- Eligible senior centers as established by W.S. 9-2-1201(a)(iii) and overseen by the Wyoming Department of Health, Division of Aging as credible and capable to receive grants for Older Americans Act services pursuant to W.S. 9-2-1204(a)(vii).
- Contract motor carriers, which must be corporations, limited liability companies (LLC), non-profit organizations, sole proprietorships, or other business entities registered in good standing with the Wyoming Secretary of State and authorized as intrastate operating authorities through the Wyoming Department of Transportation, pursuant to W.S. 31-18-101(ii).
- Participant-directed employees hired under the participant-direction service delivery option.

* Please note that Prior Authorization is required for Waiver Services				
Service		Code	Rate	Unit
Personal Emergency Response System (PERS)	Landline installation	S5160	\$63.09	Per installation
	Cellular installation	S5160 CG	\$63.73	
	Landline monitoring	S5161	\$32.01	Monthly
	Cellular monitoring	S5161 U4	\$41.73	

Personal Emergency Response Systems (PERS) include electronic devices that are programmed to signal a response center once a help button is activated and enable the participant to secure help in an emergency. PERS are limited to participants who demonstrate needs based on their person-centered service plan.

The monthly monitoring service includes equipment rental and maintenance; access to a 24-hour response center monitored by live, professional staff; equipment testing and troubleshooting; responses to alerts and alarms; and documentation of communications with participants, caregivers, case managers, and first responders.

The installation service is billed separately and includes the delivery, installation, and activation of all necessary equipment, as well as participant and caregiver education and training on equipment use.

Exclusions and Limitations

PERS is limited to participants who demonstrate needs based on their person-centered service plan.

A provider can only be reimbursed for one installation per participant unless otherwise warranted by extenuating circumstances (e.g. the participant moves or a lost or stolen device). [Monthly monitoring will only be reimbursed for systems that are operational.](#) Reimbursement for installation fees for the repair or replacement of equipment may not be granted if there has been abuse or misuse of the equipment or if the repair or replacement is sought before the equipment's ordinary life cycle.

Reimbursement is limited to PERS vendors.

* Please note that Prior Authorization is required for Waiver Services				
Service		Code	Rate	Unit
Personal Support Services	Agency Based	S5125	\$8.91	15-Minute
	Participant Directed	S5125 U5	\$3.80	

Personal Support Services include [part-time or intermittent](#) assistance to enable participants to accomplish activities of daily living such as eating, bathing, grooming, dressing, using the restroom, and functional mobility tasks that they would normally do for themselves if they did not have a disability. Personal support assistance may take the form of hands-on assistance (actually performing a task for the person) or prompting the participant to perform a task.

Personal Support Services may also consist of general household tasks [when those tasks are incidental to the Personal Support Service being provided during the visit](#), when the participant is unable to [manage the home and care for themselves](#), and the individual regularly responsible for these activities is temporarily absent or unable to conduct these activities. [However, incidental chore type tasks shall not comprise the entirety of this service.](#)

Personal Support Services may be provided in the home or in the community when the participant requires assistance with activities of daily living in order to participate in community activities or to access other services in the community. [The participant must be present during the delivery of Personal Support Services](#), and must be able to demonstrate how they encouraged participant engagement during service delivery.

This service may be participant-directed.

Exclusions and Limitations

Personal Support Services may not include companionship or other services which are diversional or recreational in nature. Personal Support Services cannot be provided during sleeping hours. Participant transportation costs are not associated with the provision of personal support services and must be billed separately.

[Part-time or intermittent services are limited to 40 hours per week or 8,320 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.](#)

If Personal Support Services and Homemaker are listed on the participant's plan, the case manager must indicate how the chore services associated with Personal Support Services will be different from Homemaker Services. There is a higher chance that the case management information system will trigger a Quality Improvement Review (QIR) of the person-centered service plan when Homemaker is added to a plan that includes Personal Support Services or Home Health Aide. The Benefits and Eligibility Specialist (BES) will review the information included in the person-centered service plan and work with the case manager if additional clarification is needed or concerns are noted.

Personal Support Services and Home Health Aide Services may be included on the same service plan, but these services cannot be billed for during the same time frame.

Personal Support Services may be participant-directed, [but a participant-directed employee cannot work more than 40 hours per week per employer](#). Services offered through participant-direction are only billable in 15-minute increments.

Tasks requiring a license can only be completed by licensed individuals.

[Waiver services shall not duplicate services offered through another funding source](#), such as Section 110 of the Rehabilitation Act of 1973 (Vocational Rehabilitation or Workforce Services), the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.), third-party insurance, or the Medicaid State Plan. Medically necessary personal care services for individuals under the age of 21 are provided under the Medicaid State Plan in accordance with Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) coverage requirements.

This service is subject to electronic visit verification.

Reimbursement is limited to the following provider types:

- Home health agencies licensed by the Wyoming Department of Health, Division of Aging pursuant to W.S. 35-2-901(a)(xi). The individual providing the service must meet the training requirements established by the Aging Division's Rules and Regulations for Home Health Agency Administration.
- Participant-directed employees hired under the participant-directed service delivery option.

* Please note that Prior Authorization is required for Waiver Services			
Service	Code	Rate	Unit
Respite	T1005	\$10.36	15-Minute
	S5151	\$372.96	Daily

Respite Services are provided to participants unable to care for themselves and are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant.

Respite Services may be delivered in the participant's home or in the community when the participant requires assistance with activities of daily living in order to participate in community activities or to access other services in the community.

Respite Services may not be authorized based on the participant's needs for companionship or those which are diversional/recreational in nature. Participant transportation costs are not associated with the provision of respite services and must be billed separately.

This service may be participant-directed.

Exclusions and Limitations

Services are authorized by a case manager based on the participant's assessed need and are limited to the prorated equivalent of thirty (30) days per service plan year.

Respite is billed at a 15-minute or daily unit. The 15-minute and daily unit cannot be billed on the same day. [Any use of respite over nine \(9\) hours a day \(36 units\) must be billed as a daily unit.](#)

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.

Respite may be participant-directed, but [a participant-directed employee cannot work more than 40 hours per week per employer](#). Services offered through participant-direction are only billable in 15-minute increments.

This service is subject to electronic visit verification

Reimbursement is limited to the following provider types:

- Home health agencies licensed by the Wyoming Department of Health, Division of Aging pursuant to W.S. 35-2-901(a)(xi). The individual providing the service must be a Nursing Assistant or Nurse Aide certified by the Wyoming State Board of Nursing in accordance with the Wyoming Nurse Practice Act [W.S. 33-21-120 et seq.].
- Agency providers that maintain a certification for this service from DHCF.
- Participant-directed employees hired under the participant-directed service delivery option.

* Please note that Prior Authorization is required for Waiver Services				
Service		Code	Rate	Unit
Skilled Nursing	Registered Nurse (RN)	T1002	\$26.12	15 Minute
	Licensed Practical Nurse (LPN)	T1003	\$18.86	

Skilled Nursing services include part-time or intermittent skilled nursing care which is within the scope of practice and required to be delivered by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) under the Wyoming Nurse Practice Act. Waiver Skilled Nursing services are provided in addition to the Skilled Nursing Services as defined by 42 CFR §440.70 and furnished under the Wyoming Medicaid State Plan.

Skilled Nursing services under the Waiver differ in nature and scope from State plan Skilled Nursing services in that the Waiver services are not limited to rehabilitative services as defined by 42 CFR §440.130, may be provided on a long-term basis, and are not subject to a physician's review every 60 days.

Skilled Nursing services may be provided in the home or in the community when the participant requires assistance in order to participate in community activities or to access other services in the community. Skilled Nursing may not include companionship or other services which are diversional/recreational in nature. Participant transportation costs are not associated with the provision of Skilled Nursing services and must be billed separately.

Exclusions and Limitations

Skilled Nursing services may not duplicate those available through the state plan or those included in the participant's Individualized Education Plan (IEP) and are authorized by a contracted Quality Improvement Organization (QIO) in accordance with the participant's assessed needs. Medically necessary Skilled Nursing services for individuals under the age of 21 are provided under the state plan in accordance with Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) coverage requirements.

The service is limited to the amount of time determined by the Skilled Nursing assessment and letter from the Division's Utilization Management vendor.

This service is subject to electronic visit verification.

Reimbursement is limited to home health agencies licensed by the Wyoming Department of Health, Division of Aging pursuant to W.S. 35-2-901(a)(xi). The individual providing the service must be a Registered Nurse or Licensed Practical Nurse with the Wyoming State Board of Nursing in accordance with the Wyoming Nurse Practice Act [W.S. 33-21-120 et seq.].

* Please note that Prior Authorization is required for Waiver Services

Service	Code	Rate	Unit
Transition Intensive Case Management	T2025	\$12.25	15-Minute

Transition Intensive Case Management is intended to assist individuals who are currently residing in nursing facilities who want to transition into the community. Transition intensive case managers must perform activities necessary to arrange for the individual to live in the community, and support participants in coordinating and facilitating the purchase of one-time, non-recurring expenses necessary for the participant to establish a basic household upon transitioning from an institutional setting to a community living arrangement. Activities must be documented and not overlap the scope of case management annual service planning or monthly monitoring services.

The payment for this service is only payable upon the participant's discharge from an institution and their proper enrollment in the CCW program. The TICM Service Plan form and TICM Documentation form can be found in the HCBS Document Library. These forms are required for reimbursement.

Exclusions and Limitations

This service is only available to participants during their transition to the community from an extended nursing facility stay, which is defined as ninety (90) or more consecutive calendar days. It is available to a participant once during their lifetime. Case managers may assist individuals with their community transition for no more than 180 consecutive calendar days while the individual is still residing in a nursing home.

Transition Intensive Case Management shall not overlap with the scope of other case management services; therefore, duplicate billing is not allowed. This service is billed in 15-minute unit increments and must not exceed 160 units (40 hours) per participant.

Reimbursement is limited to the following provider types:

- Case management agencies, which are corporations, limited liability companies (LLC), non-profit organizations, sole proprietorships, or other business entities registered in good standing with the Wyoming Secretary of State.
- County Public Health Nursing agencies.
- Independent providers that maintain a certification for this service from the DHCF.

* Please note that Prior Authorization is required for Waiver Services			
Service	Code	Rate	Unit
Transition Setup Expenses	T2038	PA#	Per Event

Transition Setup expenses are one-time, non-recurring expenses necessary for a participant to establish a basic household, and support the participant to transition to a community living arrangement from an extended nursing facility placement, which is defined as ninety (90) or more consecutive calendar days.

To access the Transition Setup, a participant must demonstrate:

- A need for the coordination and purchase of one-time, non-recurring expenses necessary for them to establish a basic household in the community;
- A health, safety, or institutional risk; and
- Verification that other services or resources are not available to meet the need.

Allowable setup expenses include:

- Security deposits that are required to obtain a lease on an apartment or home.
- Setup fees or deposits to access basic utilities or services (telephone, electricity, heat, and water).
- Services necessary for the individual's health and safety such as pest eradication or one-time cleaning prior to occupancy.
- Essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, or bed or bath linens.
- Expenses incurred directly from the moving, transport, provision, or assembly of household furnishings.

Transition Setup services are available to individuals up to 180 consecutive calendar days in advance of the transition date and are to be billed after an individual transitions into the community and is enrolled in the CCW program.

Transition Setup Services are to be furnished only to the extent they are reasonable and necessary as determined through the Transition Intensive Case Management (TICM) service plan development process. The service plan must clearly identify the need for the service by identifying that the person is unable to meet such an expense and the service cannot be obtained through other sources. The Transition Setup Expenses Request form can be found in the HCBS Document Library. This form is required for reimbursement.

Exclusions and Limitations

Transition Setup does not cover rental or mortgage expenses, ongoing food costs, regular utility charges, or items that are intended for purely diversional, recreational, or entertainment purposes. Transition Setup does not include payment for room and board. Equipment or other markups shall not be paid through this service.

Transition Setup must not exceed a total of \$2,500 per participant, unless otherwise authorized by the Division, and must be prior approved in the participant's service plan. The Division may authorize additional funds above the \$2,500 limit, not to exceed a total value of \$3,000, when it is demonstrated

as a necessary expense to ensure the health, safety, and welfare of the participant.

Community transition services are to be furnished only to the extent they are reasonable and necessary as determined through the service plan development process. The service plan must clearly identify the need for the service by identifying that the person is unable to meet such an expense and the service cannot be obtained through other sources.

This service is only available to participants during their transition from an extended nursing facility stay to the community, and is available to a participant once during their lifetime. Transition Setup Services are not available to a participant who is transitioning to a provider owned or controlled setting.

Reimbursement is limited to the following provider types:

- Case management agencies, which are corporations, limited liability companies (LLC), non-profit organizations, sole proprietorships, or other business entities registered in good standing with the Wyoming Secretary of State.
- County Public Health Nursing agencies.
- Independent providers that maintain a certification for this service from the DHC