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Services Training:
CCW Renewal 2026
For CCW Providers and Case Managers
August 18th, 2026
WYOMING MEDICAID
DEPARTMENT OF HEALTH
HOME & COMMUNITY-BASED SERVICES
WYOMING MEDICAID

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Good afternoon, everyone. Thank you for joining us for this training session on the new services and the updates to older services on the Community Choices Waiver. I am Matt Crandall, the Policy and Communications unit manager for the Home and Community-Based Services Section.

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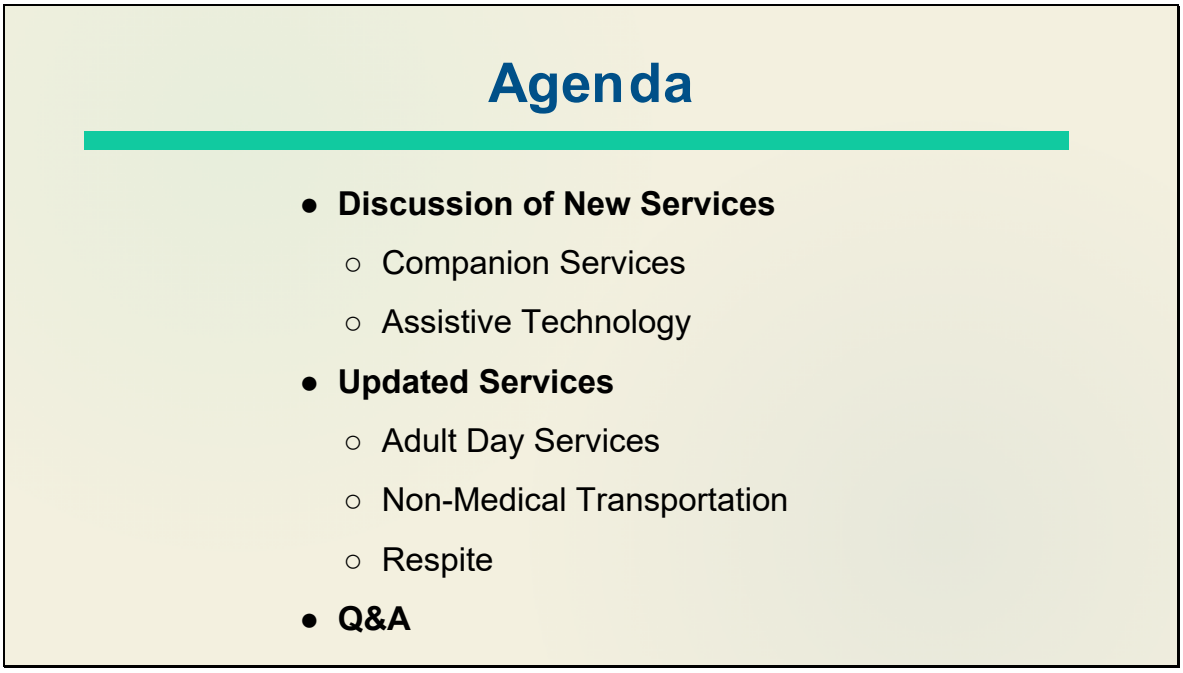

Today, we are going to dive deep into the specific service updates that will affect your daily operations, billing, and participant care. We will first review the new services available on the Community Choices Waiver which includes Companion Services and Assistive Technology. Then we will go into some detail on a few services that were updated during the renewal process. These include Adult Day Services and Non-Medical Transportation. We will have an opportunity at the end of the presentation to answer questions. We will answer all questions in writing and send them via email as well as post them to the HCBS website on the Public Notices, Engagement Groups & Projects page under the Community Choices Waiver Renewal toggle. Our goal is to ensure that by the end of this session, the confusion surrounding new services and service changes is replaced with clear guidance.

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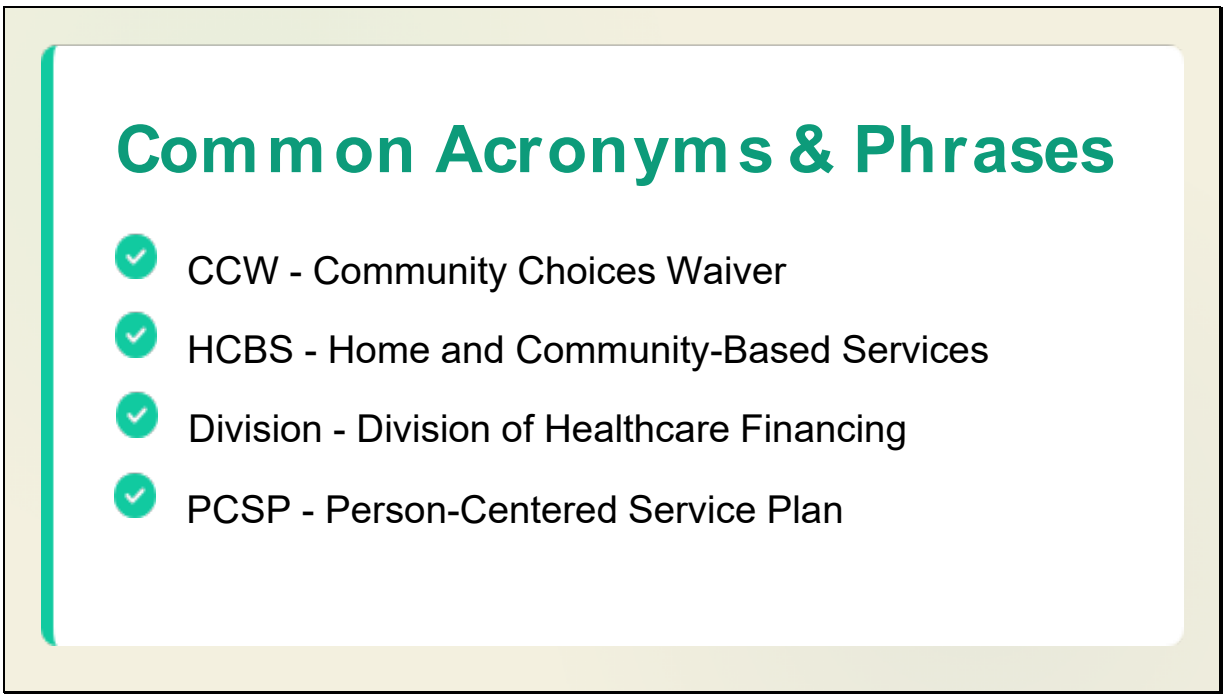

Before we get started, we'd like to go over some of the acronyms and abbreviations we will be using in today's training. The Medicaid system in general, and the Home and Community-Based services program, use a lot of acronyms. Although most of you know these terms, for any new provider, it can be confusing.

CCW refers to the Community Choices Waiver program.
HCBS stands for Home and Community-Based Services.
"The Division" refers to the Department of Health's Division of Healthcare Financing, under which the HCBS section is organized.
PCSP stands for the Person-Centered Service plan, the plan created for each Community Choices Waiver participant that must be followed by providers.

Now, let's start by reviewing a new service on the Community Choices Waiver.

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New Service: Companion Services

- **Core Purpose:** Designed to keep participants connected through direct support and social activity, while helping them safely live more independently at home and in the community.
- **Location:** Provided in both home and community settings.
- **Incidental Tasks:** May include meal prep, laundry, and shopping as long as they are not the sole purpose of the service.

Our first addition to the CCW is Companion Services. This is designed specifically to combat participant isolation and to reduce loneliness. We want to keep participants connected through direct support and social activity, while helping them safely live more independently at home and in the community. Some participants on the Waiver live alone or are alone for long periods during the day. They may not be able to get into the community due to limited mobility or lack of transportation. Companion services offers participants an opportunity for socialization in their home or an opportunity to get out of their home and into the community.

The service provides part-time or intermittent supervision, socialization, and support. Again, this service can be used in the home or the community. Perhaps a participant would like to attend a book club at the local library. A companion could assist by driving them to the library, helping them to safely enter the building, and assisting them with a wheelchair transfer to use the restroom. A participant could attend a farmer's market with their companion to assist them with carrying bags or assist with mobility. Maybe a participant wants company while going on a walk through the neighborhood or someone to play cards with. All of these activities are a part of companion services.

Companions can also assist with or supervise meal prep, laundry, shopping, and light housekeeping, provided these tasks are incidental to care and not standalone services. This means that it is not the sole purpose of the service. A companion can help a participant with making lunch before going out into the community. This assistance should also include discussion about favorite meals, questions about where they learned their recipes, or help

creating a grocery list. A companion could assist a participant with organizing a closet, creating a donation box, and taking the box to a donation center with the participant. Engagement with the participant is the central aspect of companion services.

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Companion Services: Scope and Requirements

- **Scope of Care:** Includes assistance with Activities of Daily Living (ADLs), personal care, and medication assistance.
- **Direct Service:** Companion services a direct service and requires the participant to be physically present and awake.
- **Transportation:** Routine transportation is built into the service reimbursement rate.

The service covers personal care, assistance with Activities of Daily Living (ADLs), and medication assistance as needed. Personal care may include assistance with housekeeping, brushing hair or shaving, or assistance with an exercise. Activities of daily living include tasks such as bathing, dressing, toileting, transferring from a wheelchair, or assistance during a meal. A companion may also remind a participant to refill their pillbox or ask if they have taken their medications today. While companions can assist the participant with hygiene activities and medication reminders, they are not nurses and the service does not cover hands-on nursing care. Companions do not provide bedside care, monitor vitals for a participant, or provide other nursing services.

Companion Services is a direct service and requires the participant to be physically present while services are provided. The employee must document how they actively encouraged participant engagement during the services. Because it requires engagement with the participant, companion services cannot be provided while the participant is sleeping.

Routine transportation is included in the service. This means that the provider must provide transportation if the participant want to go somewhere during the service and that transportation is built into the rate that is being paid. It means the person providing the service needs to have a vehicle and insurance. Again, the goal of the service is to reduce participant isolation and going out into the community is important to achieving that goal.

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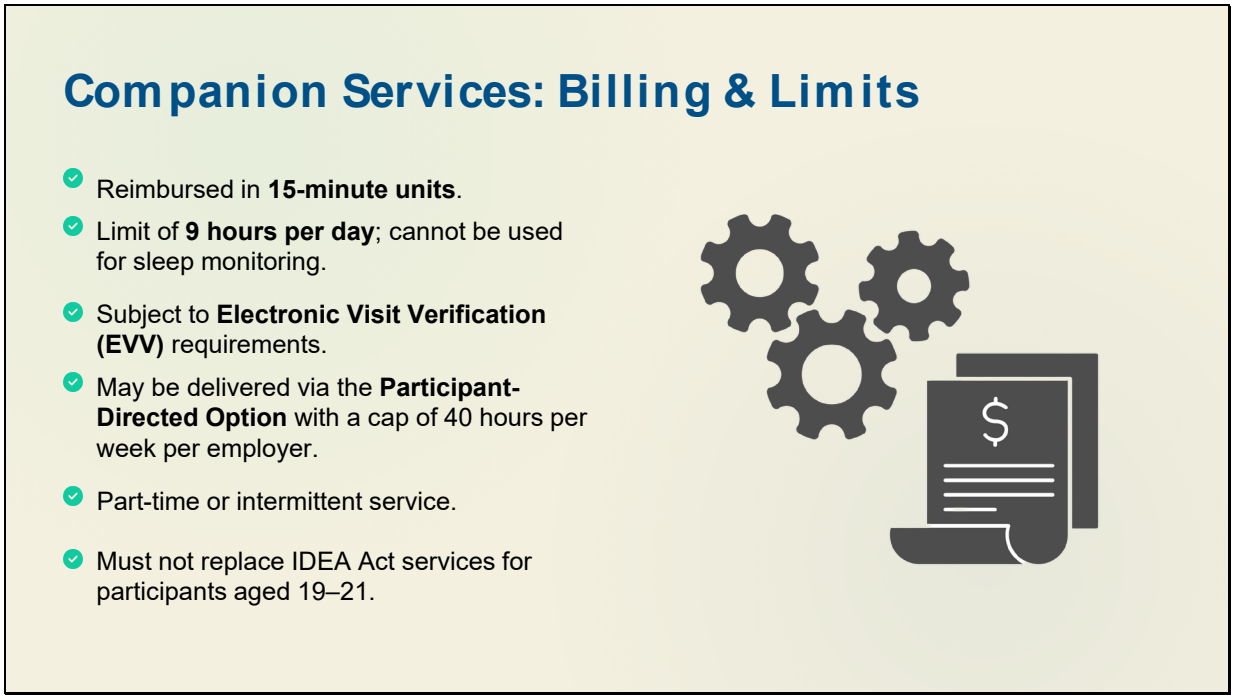

Moving on to billing and details on the limits: Companion services is reimbursed in 15-minute units. Note the daily limit of nine (9) hours per day. As previously discussed, this service cannot be used for monitoring the participant while they are sleeping. The goal of companion services is to reduce loneliness and increase social engagement. It is impossible to comply with the service index and achieve the goals of the service while someone is asleep.

As companion services is a direct care service and is subject to Electronic Visit Verification (EVV). Providers must utilize an EVV solution, like Carebridge, to clock in and out of companion services. Electronic Visit Verification (EVV) is a federal requirement of the 21st Century Cures Act. EVV is used to record and confirm the service, participant, date, location, caregiver, and exact start and end times of the service in real-time by using apps and GPS. The Division has partnered with CareBridge to offer an EVV solution to providers that is free of charge.Providers may use another EVV solution, but they must ensure that the solution is able to interface with CareBridge. As EVV is a federal requirement, provider non-compliance can negatively impact federal funding for the CCW program. If you plan to provide companion services, please ensure you and your staff are familiar with EVV requirements. More information on EVV can be found on the HCBS Current Providers page under the *EVV* tab.

Companion Services is available under the Participant-Direction option, with a cap of 40 hours per week per employer. It is a part-time or intermittent services, which is limited to a maximum of 40 hours per week. A participant should not necessarily be at 40 hours per week for companion services. The CCW is a waiver for part-time and intermittent service, in general.

This service should be used in combination with other services to address the needs of the individual. Participants, their case manager, and their plan of care team need to look at the whole picture of the person's needs and choose services that are appropriate for the participant’s needs. 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.

As the Community Choices Waiver is available to folks 19 and older, we included language that companion services cannot replace services available under the Individuals with Disabilities Education Act, or IDEA act, for participants aged 19-21. The IDEA act covers special education and related services for youth from ages 3 through 21. Medicaid Waiver services are the payor of last resort. If a participant happens to be 19-21 years old, companion services cannot overlap with school hours or school services.

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How to use Companion Services

- **Billing Compliance:** Billing for unneeded, higher-rate services for financial gain is considered fraud and will be reported to Program Integrity.
- **Service Differences:** Personal Support covers part-time help with daily living tasks (eating, bathing) where chores are secondary. Companion Services focus on active supervision and socialization.
- **Companion Limits:** Companions can assist with chores (meals, laundry, shopping) or daily living tasks, but cannot perform them as standalone or full-time services.
- **Case Manager Oversight:** Case managers must coordinate the right service mix, monitor delivery monthly, review all billing, and report issues.
- **Reporting:** If inappropriate billing is suspected, then an official complaint must be submitted via the HCBS website.

Per the Medicaid Provider Agreement signed by all providers and case managers, following Medicaid rules is mandatory. Billing for an unneeded, higher-rate service constitutes a waste of services or over-serving for financial gain. Services must match the needs of the participant. Providers failing to deliver services appropriately may be reported to Program Integrity for a waste, fraud, or abuse investigation. Everyone on the team--the state, the provider, the case manager, and the participant--need to work together to make sure the service is the correct one, and that we are taking care to avoid fraudulent use of taxpayer funds.

We have received comments that Companion Services is similar to Personal Support Services that was previously on the Community Choices Waiver. We'd like to highlight that the differences between these services. Personal Support Services are specifically for tasks that a person would complete on their own if they did not have a disability. For example, a participant would use the toilet on their own if they did not have a disability with a need for assistance. According to the Service Index, Personal Support Services is intended for part-time or intermittent assistance with Activities of Daily Living (ADLs) like eating, bathing grooming, and mobility.

Companion services focus is on active supervision and socialization in the participant's home or community as outlined in the Service Index. Anyone, regardless of disability, may need assistance if they are lonely and need to socialize. Companions may assist or supervise the participant with tasks such as meal preparation, laundry, and shopping, but do not perform these activities as standalone services. Assistance with ADLs can occur during the service, but it cannot comprise the entirety of the service.

The Division relies on case managers to coordinate the most appropriate service mix for each participant, as well as monitor these services on a monthly basis to ensure services are being delivered in alignment with the Service Index. Because case managers receive and review provider documentation and make contact with the participant each month, they are able to gain insight into service delivery. For example, a case manager reviewing service documentation from a provider billing for companion services can see if the majority the service is being used for assistance with activities of daily living and household chores without much engagement with the participant. During the case manager's monthly contact with the participant, they can ask specific questions about the services, like what tasks completed or what activities occurred. Case managers play an important role in ensuring that direct services are not billed during the same time frame, ensuring services are being delivered according to the service index, and that the correct units are being billed. If a case manager knows or suspects that a provider is inappropriately billing for a service, the first step is to advise the provider that they are inappropriately billing. This practice may be considered Medicaid fraud. The case manager is then required to submit a complaint to the HCBS Section via the HCBS website.

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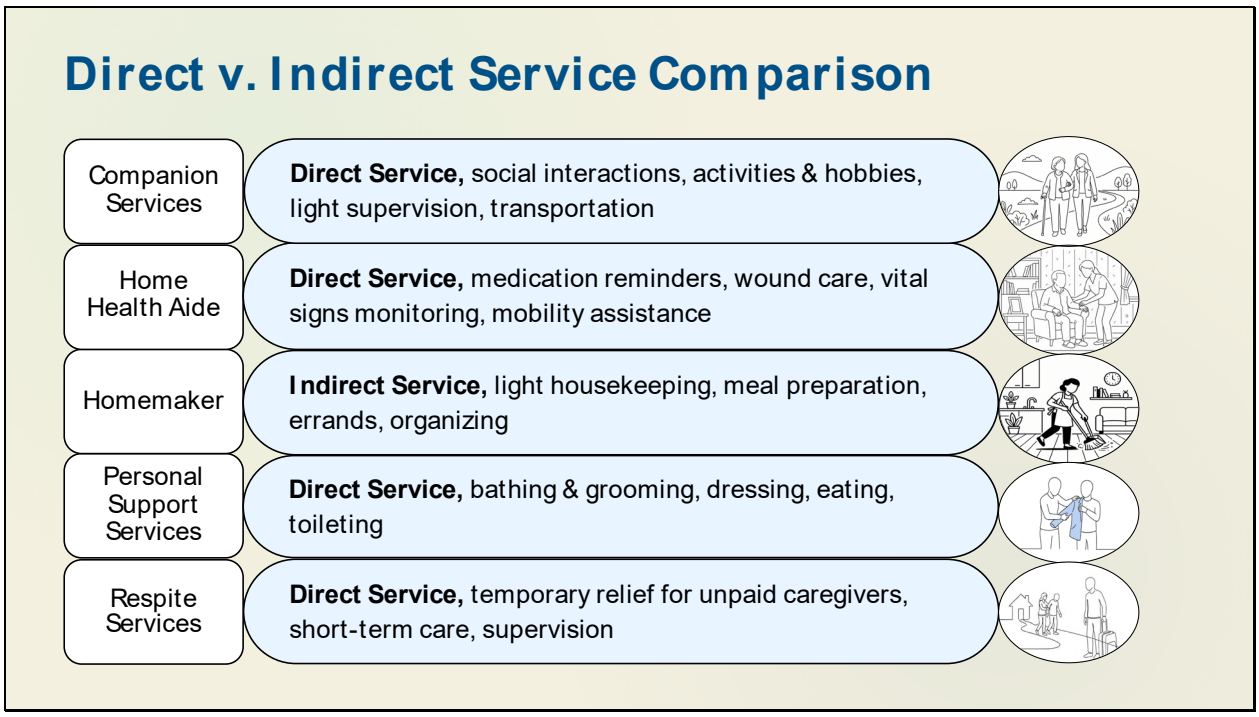

Earlier, we stated that companion services is a direct service. There are two types of services, direct and indirect services. Let's take a closer look at the definition of indirect and direct services and why it is important to know if a service is direct or indirect.

An indirect service is a service that does not require the participant to be present when the service occurs. They consist of chore-type activities and routine household care where providers do not prompt or assist the participant in completing tasks, the provider completes the task independent from the participant. Examples of covered tasks include meal preparation, shopping for groceries and personal items, laundry and ironing, or household cleaning. All tasks must be completed for the benefit of the participant. Because an indirect service does not require the participant to be present for the service, other direct services can be provided by a different provider or provider staff during the same time frame.

A direct care service requires the participant to be present when the service is delivered. It involves providing hands-on assistance, care, prompting, or direct supervision to the participant to assist with tasks, daily living activities, or health needs, rather than consisting solely of routine chore-type activities or household care performed without the participant's direct involvement. Providers directly prompt, assist, or care for the participant during the delivery of the service. Because direct services require the participant to be present and engaged with the provider, no other direct services can be provided during the same time frame.

Companion services is a direct service with a focus on social interactions, activities, participation in hobbies, supervision for health and safety, and transportation.

Home Health Aide is also a direct service with a focus on medication reminders, wound care, monitoring of vital signs, and mobility assistance.

Homemaker is an indirect service that includes light housekeeping, meal preparation, errands, and organization of the participant's home.

Personal support service is another direct service that includes assistance with bathing, grooming, dressing, eating, toileting, and other activities of daily living.

Finally, respite is a direct service that offers temporary relief for the main, unpaid caregiver that includes supervision for health and safety and is intended to be delivered on a short-term basis.

Now, let's discuss the second new service on the Community Choices Waiver.

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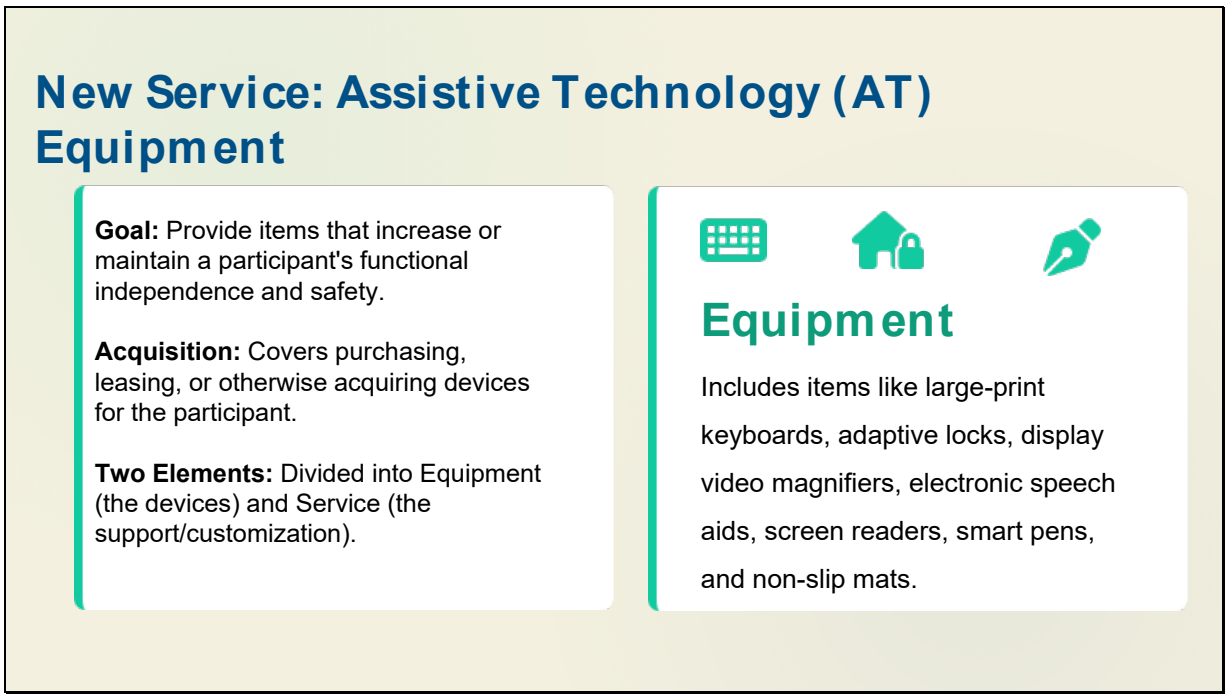

The second new service is Assistive Technology. The Division wants to promote participant independence and support folks to keep living in their homes safely. We have heard the call for the need for tools in order to better support participants. The goal is to provide items that increase or maintain the participant's functional independence and safety. Assistive Technology covers purchasing leasing or otherwise acquiring devices for the participant. Assistive Technology is divided into two service elements, the Equipment and the Service.

Assistive Technology Equipment covers equipment, with prior authorization, that are not currently covered by Durable Medical Equipment (DME) under the Medicaid State Plan. Assistive Technology Equipment includes a range of products, equipment, and systems that enhance learning, working, and daily living for participants. Assistive Technology Equipment includes, but is not limited to devices like screen readers, large keyboards, electronic speech aids, smart pens, adaptive locks, display video magnifiers, or non-slip mats. Assistive Technology Equipment consists of purchasing, leasing, or otherwise providing for the acquisition of Assistive Technology devices by a participant. Case managers should work with participants in identifying items that would support their needs.

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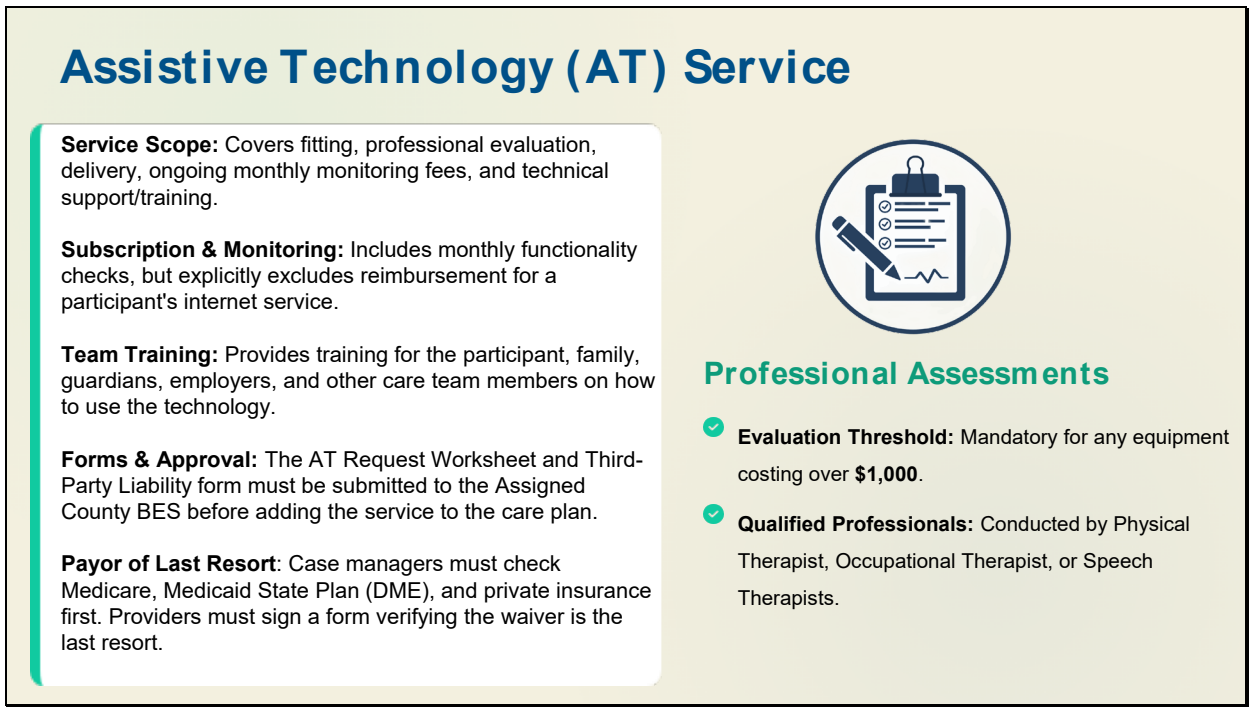

The service doesn't just cover the device; it covers the service aspect too: fitting the device if needed, training the care team on how to use it, and even monthly monitoring fees to ensure the tech is still functioning correctly if needed for complex items. Assistive Technology Service includes a service 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.

For any equipment costing more than $1,000, a professional evaluation is mandatory. This must be conducted by a qualified professional—typically a Physical, Occupational, or Speech Therapist.

For all Assistive Technology requests, the Assistive Technology Request Worksheet and Third-Party Liability form 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. 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.

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Assistive Technology Limits

Component / Policy Category	Standard / Limit
Annual Total Cap	**$4,000 per year** for all components combined.
AT Support	Capped at **8 hours per year**.
Payer of Last Resort	Case Manager must exhaust State Plan (DME), Medicare, and private insurance first.
Internet Costs	Does **not** cover ongoing personal internet service charges.

There are hard limits to keep in mind for AT. The total annual cap for all components—equipment and services combined—is $4,000. Professional evaluations are capped at 8 hours per year. Remember that Medicaid is the payer of last resort. The case manager must assist the participant and provider with ensuring all other resources have been exhausted. They must also take the lead in completing the Assistive Technology Request Worksheet and Third-Party Liability form. These forms document that the participant and their support team has explored and exhausted coverage from the State Plan's Durable Medical Equipment, Medicare, and private insurance before billing this under the CCW. Please note that federal policy does not allow monthly internet bills to be covered by Assistive Technology and continues to be the participant's responsibility.

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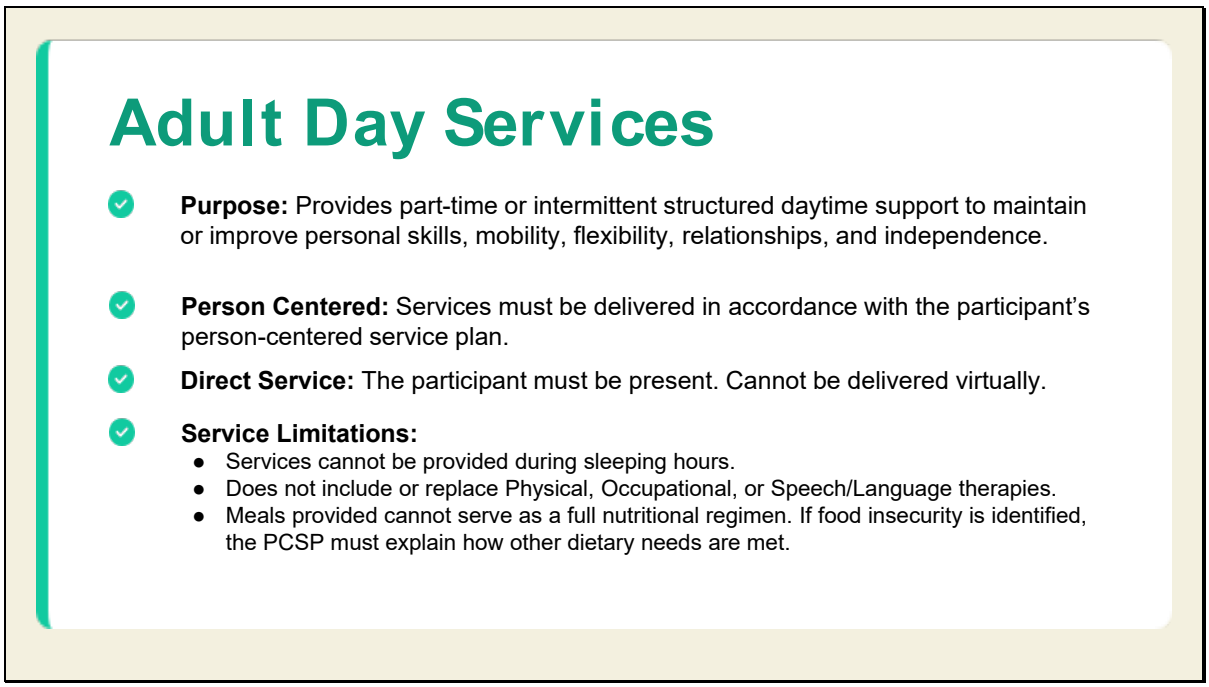

Adult Day Services is not new to the Community Choices Waiver, but we have made significant updates to the service. Adult Day Services (ADS) provides part-time or intermittent structured daytime support to maintain or improve personal skills, mobility, flexibility, relationships, and independence. Transportation to and from the service is built into the provider's reimbursement rate. This means that providers do not have to bill for non-medical transportation separately as the rate being paid for ADS includes transportation. Providers will need to have a vehicle with insurance to cover transporting participants. Services must deliver active, individualized support as outlined in the participant's person-centered service plan. ADS is a direct service, meaning the provider must be physically present with the participant. No other direct service can be billed at the same time as ADS. ADS cannot be provided virtually and cannot be provided during sleeping hours. It does not include or replace Physical, Occupational, or Speech and Language therapies available through the state plan. If meals are provided as part of the service, they cannot serve as a full nutritional regimen. If food insecurity is identified, the PCSP must explain how other dietary needs are met.
Now let's take a look at some of the changes made to ADS during the CCW renewal.

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Adult Day Services Changes

- Consolidated **Health and Social models** into a single, simplified definition.
- **Transportation:** Transportation to and from the ADS location are now bundled directly into the ADS rate.
- **Half-Day Unit Removed:** Replaced by a 15-minute unit and daily unit. Allows for accurate billing based on actual time spent in services and scheduling flexibility..
- **Daily Unit:** Any use of ADS over 4 hours (16 15-minute units) a day must be billed as a daily unit.
- **Part-time/Intermittent Service:** Must be used appropriately to meet the needs of the individual.

We've heard your feedback regarding the complexity of Adult Day Services. To streamline things, we have consolidated the 'Health' and 'Social' models into one single, simplified service. As you may have noticed from the last slide, transportation costs are now bundled. This means ADS providers will no longer submit separate Non-Medical Transportation claims for the trip to and from the ADS location; the cost of that trip is now reflected in the base ADS rate. Half-day units were removed and replaced by 15-minute units and daily units. This allows for more accurate billing based on the actual time the participant spent in services and provides flexibility in scheduling. It also is more in-line with the unit structure of other CCW services. The daily unit must be billed if the participant spends over four (4) hours a day, or 16 15-minute units, in ADS services with a provider. ADS is a part-time or intermittent service. As we stated earlier, the Community Choices Waiver is for part-time or intermittent services, in general. Like all other services, ADS needs to be used appropriately to meet the needs of the individual. Case managers should work with the participant and their service plan team to find the most appropriate array of services to meet the individuals needs.

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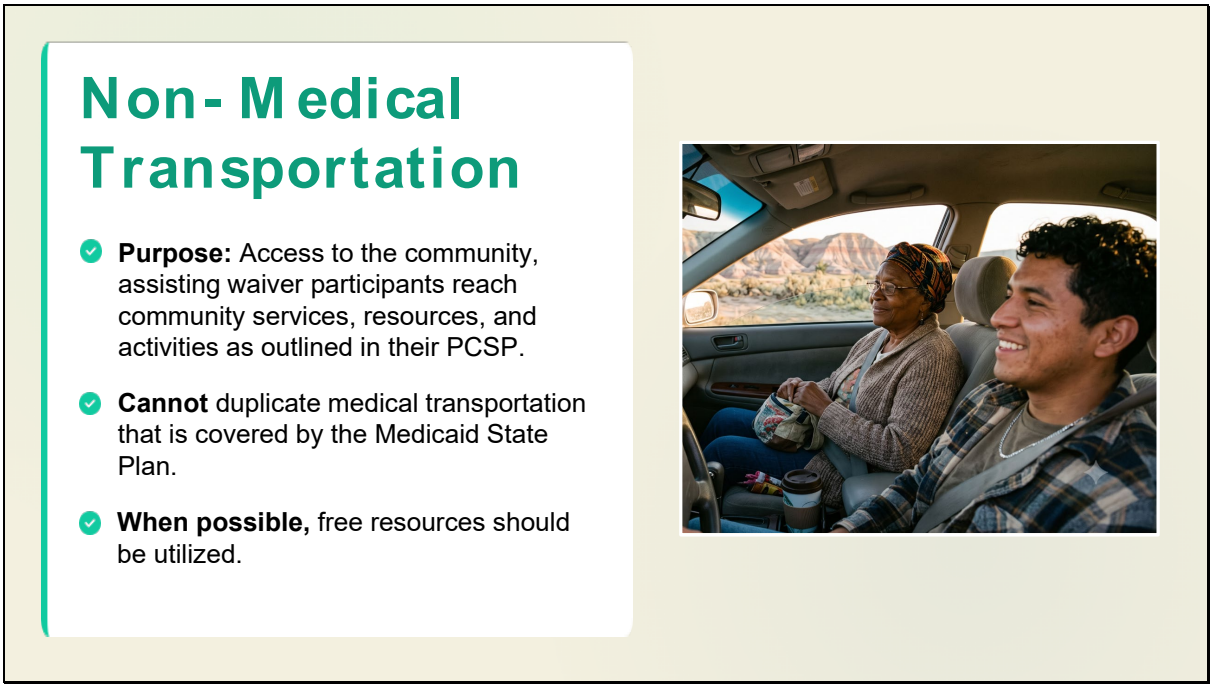

Another service that is not new to the waiver, but has been updated is Non-Medical Transportation. Non-Medical Transportation is offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the person-centered service plan. Non-Medical Transportation serves as an addition to–and does not replace–medical transportation that is covered by the Medicaid State Plan. Remember that waiver services cannot duplicate services covered by the Medicaid State Plan. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge should be utilized.

Now let's review some of the changes to Non-Medical Transportation.

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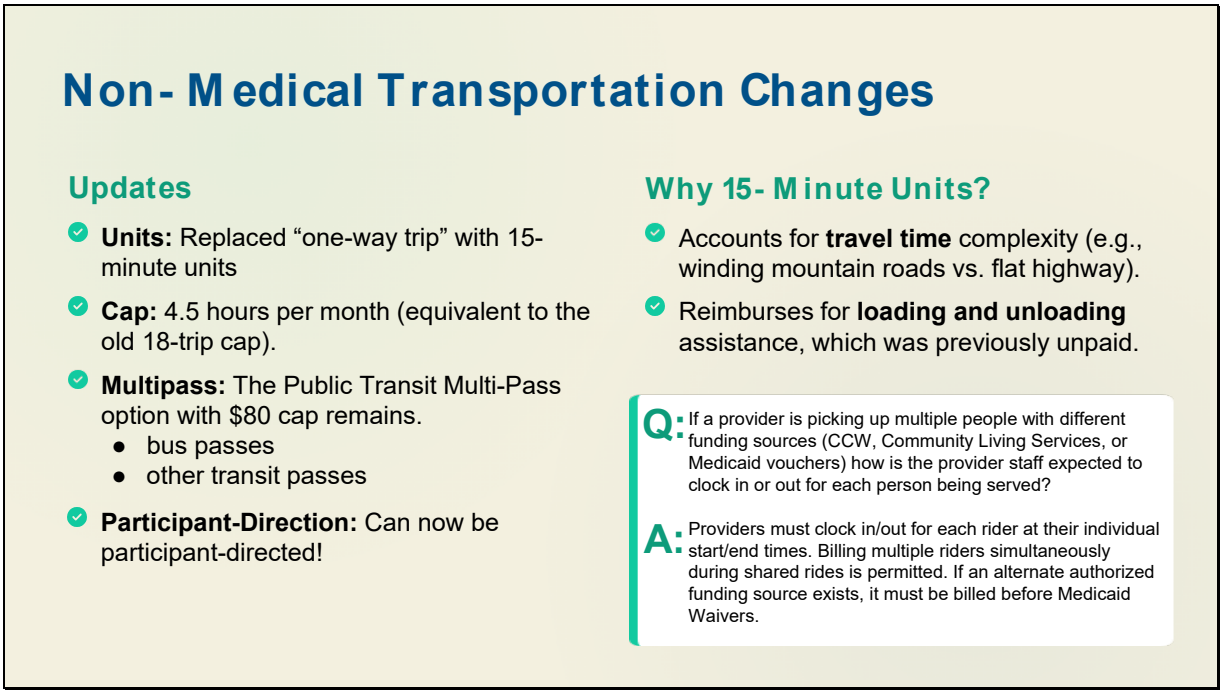

The changes made to Non-Medical Transportation include a unit update. We have shifted the the current cap of 18 one-way trips is being converted into a time-based cap of 4.5 hours per month. The new 4.5 hours per month cap is equivalent to the old 18-trip cap when considering how the rate for the 18-trip cap was calculated. If a participant uses a bus pass or other transit, the 'Public Transit Multi-Pass' option remains available as a separate purchase unit. We are very excited to make Non-Medical Transportation available under the participant-direction service option. Our goal is to expand participants’ options and make services more accessible. Like all participant-directed services, the employee must deliver the service according to the service index.

We received some questions regarding the updates to this service. The most common question is broad: Why shift Non-Medical Transportation to 15-minute units? This transition ensures a consistent billing logic across the waiver and ensures providers are paid for their time. Because distance doesn't always equal time. A five-mile drive on a winding mountain road takes much longer than five miles on a highway. Furthermore, this new logic finally pays providers for the time spent on 'loading and unloading' assistance, which was previously an unpaid.

The next question is a little more specific: If a provider is picking up multiple people with different funding sources (CCW, Community Living Services, or Medicaid vouchers) how is the provider staff expected to clock in or out for each person being served? If this is the case, providers should clock in and out for each person being served, at the time the service began/ended for that individual. CCW allows providers to bill for multiple riders at the same time, so staff can be clocked in for multiple individuals simultaneously during a shared ride.

Keep in mind that a participant-directed employee can transport multiple individuals at the same at their discretion, but cannot bill multiple participants at the same time as it is considered a direct service without a “group” option. ~~this is not an option for participant-directed services.~~ If a rider has an alternate funding source authorized for transportation, that source must be billed for their trip instead of Medicaid Waivers.

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The last service we'd like to highlight the updates to is respite services. The primary purpose of respite is to provide short-term care for participants unable to care for themselves, giving the primary unpaid caregivers relief or coverage during an absence. Respite is generally delivered in the home, but can also be provided in the community to assist with Activities of Daily Living (ADLs), like transfers, toileting, or mobility assistance, while accessing community services or activities. Respite is a direct service and requires the participant to be physically present, and employees must document how they actively encouraged participant engagement.

Travel costs are ***not*** included in the reimbursement rate for this service. If the provider is transporting a participant during the delivery of respite services, they will need to clock out of respite, and clock into non-medical transportation for reimbursement.

Respite is still capped at the prorated equivalent of thirty (30) days per service plan year. Respite services are added to the person-centered service plan by the case manager based on the participant's assessed need. Again, we'd like to remind case managers to work with participants to find the most appropriate services to fit their needs. Respite should not be used to provide regular companionship for the participant. A variety of services can be added to the participant's person-centered service plan in order to fit their needs.

Let's review the changes made to respite.

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Respite Services Changes

Updates

- **Units:** 15-minute and daily units. Any use over 9 hours must be billed as a daily unit.
- Removed the facility provider type.
- **DD-Qualified Providers:** Can become certified to provide respite on CCW.
  - Interested providers should email wdh-hcbs-credentialing@wyo.gov
- **Participant-Direction:** Can now be participant-directed!

We added a daily unit to respite that can be used by traditional providers. Any use of respite over 9 hours (36 units) must be billed as a daily unit. Respite still requires Electronic Visit Verification (EVV), so please ensure to familiarize yourself and train your staff on EVV compliance before delivering this service. Information on EVV can be found on the HCBS Current Providers page under the *EVV* tab.

We removed the "out-of-home" option and facility provider types for respite. This option was not widely utilized. Facilities often did not have extra space for a temporary respite placement. Furthermore, the out-of-home option did not align with the Home and Community-Based Services goal of providing services to participants in their homes, without disrupting their daily lives. We'd like to remind everyone that respite can still be delivered in the community for things like mobility assistance when taking a walk in the neighborhood or assistance in the restroom when participating in a book club.

In order to broaden the pool of providers of respite, the Division has created a simplified pathway for providers who are qualified to provide respite on the DD waivers to provide respite on the Community Choices Waiver. The provider must complete the Medicaid application process for taxonomy 251B00000X. DD waiver providers who are interested in providing respite services on the CCW should reach out to the HCBS Credentialing Unit through their email, wdh-hcbs-credentialing@wyo.gov.

To further expand participant options, respite can now be participant-directed! Like all other providers, the participant-directed employee must comply with the service index. All participant-

directed services must be billed in 15-minute units and employees under participant-direction cannot exceed 40 hours per week per employer. We will hold a CCW participant-direction specific training on Tuesday, September 1st, 2026 at 1PM. The information for that training can be found on the HCBS Public Notices, Engagement Groups & Projects page under the *Community Choices Waiver Renewal* tab. The meeting information will also be posted in the chat. Please join us to learn more about the updates made to participant-direction during the renewal.

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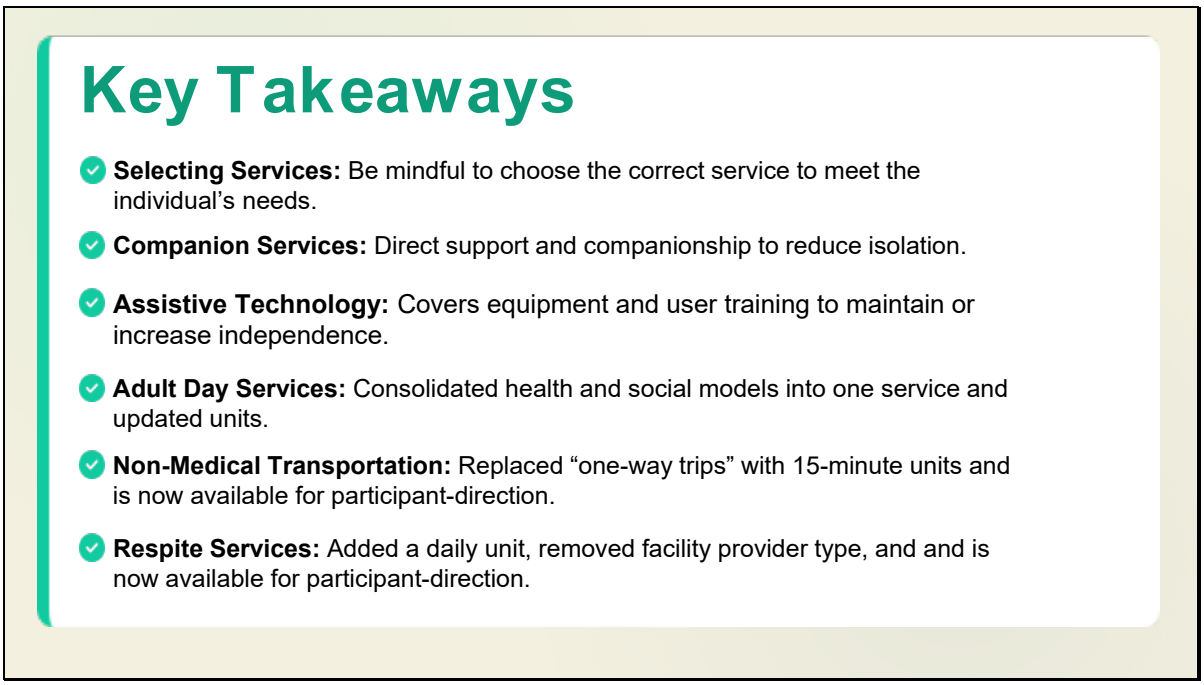

As we wrap up today's presentation, we want to leave you with a few key takeaways.

The first big takeaway that we'd like you to take home is the importance of selecting the most appropriate services to meet the needs of the participant. The Community Choices Waiver is designed to assist participants with part-time or intermittent support. It is not designed for full-time or around the clock services. Case managers should assist participants with choosing the correct services to meet their needs.

Companion Services is new to the CCW waiver. This service is designed to reduce participant isolation through active supervision, socialization, and community engagement.
It differs from other services on the waiver, like Personal Support Services that focus on Activities of Daily Living, like bathing and dressing, and assistance with incidental chores. Companion Services focus on active supervision and engagement. While companions can assist with chores and ADLs, these cannot be standalone services.

Assistive Technology, the other new service on the waiver, as the primary goal of supporting the participant to maintain or increase their independence. It is split into two components: Equipment, devices like screen readers, adaptive locks, and services, like evaluation, fitting, support, and training.

Adult Day Services was updated during the waiver renewal to consolidate the previous Health and Social models under a single definition, updated the units to 15-minute and daily units, and

included transportation in the rate for the service. These updates were made to reduce the complexity of delivering and billing for the service.

We replaced Non-Medical Transportation “one-way trip” unit with 15-minute units and made the service available under the participant-direction option.

Finally, Respite Services had a daily unit added, we removed the facility provider type, and made it available for participant- direction.

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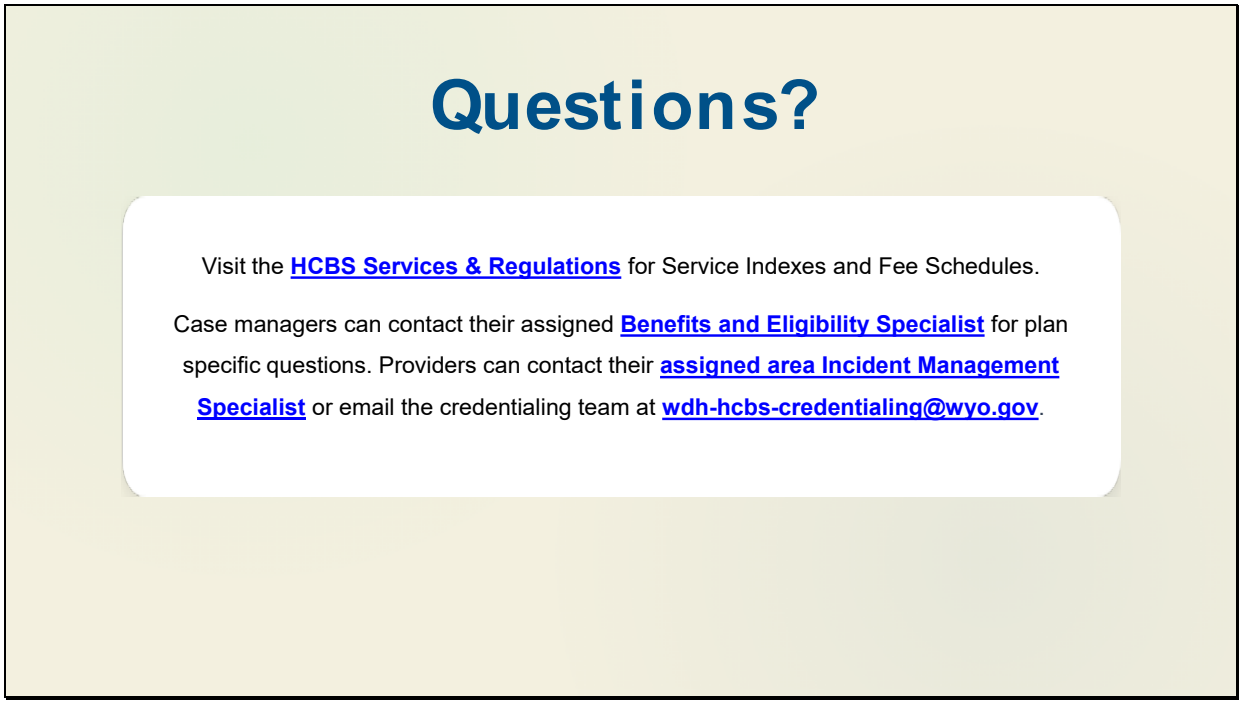

We know this is a lot of information. Please remember that the updated Service Index and Fee Schedule on the HCBS Services & Regulations page. If case managers have specific questions about a participant's plan of care or how to calculate these new units, please reach out to your assigned County Benefits and Eligibility Specialist. Providers can reach out with questions to their assigned area Incident Management Specialist or email the credentialing team at wdh-hcbs-credentialing@wyo.gov. We are here to support you through these changes. Before we begin the question and answer session, we want to remind everyone that the questions during this session need be relevant to today's training. Does anyone have any questions about the services we covered today?