Slide 1

HOME & COMMUNITY-BASED SERVICES

WYOMING DEPARTMENT OF HEALTH
DIVISION OF HEALTHCARE FINANCING

Community Choices Waiver Renewal Provider Training

September 28, 2026

Slide 2

Hello everyone and thank you for joining us for today's Community Choices Waiver renewal training for CCW providers. I'm Alice Esquibel, Provider Credentialing Assistant Manager for the Home and Community-Based Services (HCBS) section of the Division of Healthcare Financing (referred to as the Division).

Slide 3

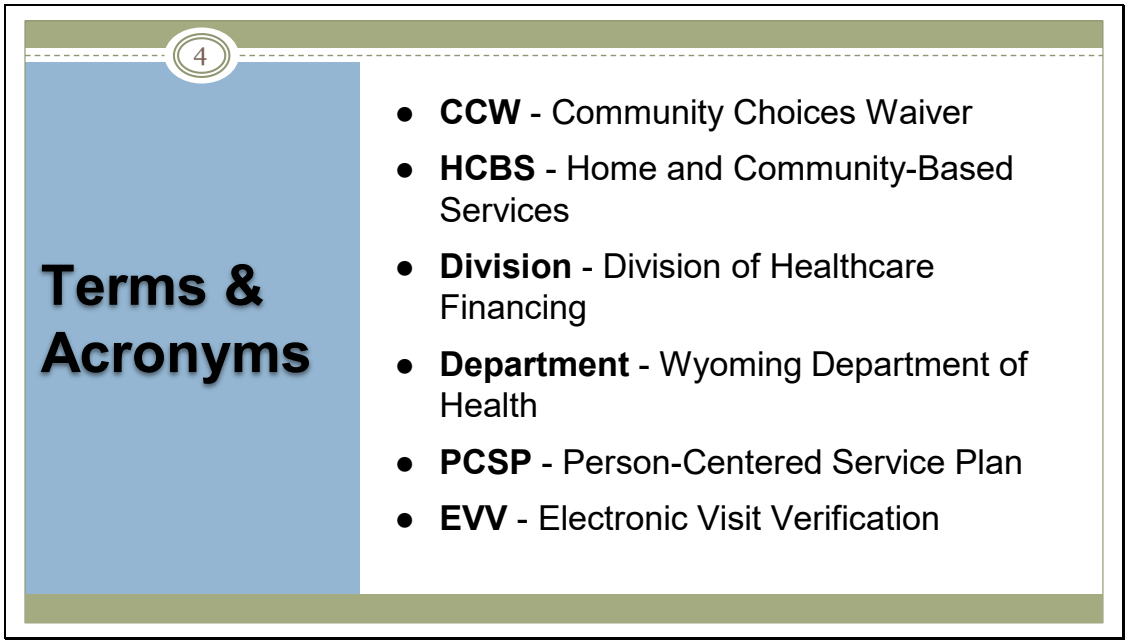
Agenda

3

- Waiver Changes
- New Services
- Updates to ADS & Non-Medical Transportation
- Point-of-Service Documentation
- Provider Verification Requirements
- Critical Incident Language
- DD Certified Providers

Today's training will cover the changes made to Community Choices Waiver (CCW) that are important for providers. We will review where you can find more information on the changes made to the CCW, then we'll take a look at the new services available on CCW, next, we'll discuss some services that were updated during the renewal. We'll then move on to review point-of-service documentation, updates to provider verification requirements, the changes made to the language on critical incidents, and review the process to allow DD certified providers to provide certain services for the CCW program.

Slide 4



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 providers, it can be confusing.

- The Community Choices Waiver is most commonly referred to as the CCW or CCW program.
- We will often refer to the HCBS Section or HCBS program. HCBS stands for Home and Community-Based Services.
- The HCBS Section is organized under the Division of Healthcare Financing, which is a Division of the Wyoming Department of Health. We will sometimes refer to the Division or Department, which means Division of Healthcare Financing, or Department of Health.
- EVV stands for Electronic Visit Verification.
- PCSP refers to the Person-Centered Service Plan that must be completed with each participant and their circle of support to ensure individualized care.

Slide 5

Waiver Changes

5

- Summary of Changes for the CCW renewal can be found on the Public Notices, Engagement Groups & Projects page under the *Community Choices Renewal* toggle.
- Clarified Homemaker, Personal Support, and Home Health Aide limitations to prevent overlap.
- Updated the lists of services requiring criminal background and central registry checks.
  - Adult Day Services, Assisted Living Facility Services, Case Management, Home Health Aide, Homemaker, Personal Support Services, Respite, Skilled Nursing, Transition Intensive Case Management, Companion Services, Non-Medical Transportation

First, we'd like to remind you that the Summary of Changes for the CCW renewal can be found on the Public Notices, Engagement Groups & Projects page under the Community Choices Renewal toggle. It contains a full list of updates made to the waiver.
We will quickly mention that federal requirements mandate that services cannot duplicate each other so we clarified Homemaker, Personal Support, and Home Health Aide limitations to prevent overlapping services. Federal regulations also required us to update the list of services requiring criminal background and central registry checks including:

- Adult Day Services
- Assisted Living Facility Services
- Case Management
- Home Health Aide
- Homemaker
- Personal Support Services
- Respite
- Skilled Nursing
- Transition Intensive Case Management
- Companion Services
- Non-Medical Transportation

Slide 6

Companion Services

6

- **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 to enhance participant independence.
- **Incidental Tasks:** May include meal prep, laundry, and shopping as long as they are not the sole purpose of the service.

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

Our first new addition to the CCW is Companion Services—a key initiative designed directly to tackle participant isolation and loneliness. Many individuals on the waiver spend long hours alone or face mobility and transportation barriers that keep them separated from their community. Companion Services bridges that gap by delivering meaningful socialization both at home and out in the community.

Whether it’s providing transport and physical assistance for a trip to the local library or farmers' market, or simply offering company for a neighborhood stroll or a game of cards, this service centers entirely on connection.

Companions can also assist with or supervise everyday tasks like light meal preparation, laundry, or closet organization—provided these activities are done *alongside* the participant rather than as a standalone chore. The driving principle behind Companion Services is genuine engagement with the participant.

Slide 7

Companion Services Scope and Requirements

7

- **Scope of Care:** Includes assistance with Activities of Daily Living (ADLs), personal care, and medication assistance.
- **1:1 Service:** A provider staff/employee can only bill for one (1) participant during the same timeframe.
- **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.

Looking at the scope, Companion Services covers essential personal care, ADL support, and medication prompts. This ranges from daily grooming and light chores to hands-on help with bathing, dressing, mealtime, and wheelchair transfers. Companions can also help keep medication routines on track with gentle reminders. However, it's vital to draw a clear line here: companions do not deliver clinical or skilled nursing care—meaning no bedside nursing, vital tracking, or medical procedures.

Companion services on the Community Choices Waiver is a 1:1 service. There is currently no billing option for a group. This means that a provider staff or participant-directed employee can only bill for one participant during the same timeframe.

Because the cornerstone of this service is active connection, it is a direct service, that must be delivered while a participant is awake. Participants must be present and awake throughout the service, and staff are required to document specifically how they encouraged participant interaction.

Finally, community integration is central to beating isolation, so routine transportation is integrated into the reimbursement rate. Providers delivering this service must hold valid auto insurance and have a reliable vehicle to help participants get out into the community whenever desired.

Slide 8

Companion Services Billing & Limits

8

- Reimbursed in 15-minute units.
- Strict limit of **9 hours per day**; cannot be used for sleep monitoring.
- Subject to Electronic Visit Verification (EVV) requirements.
- **Part-time or intermittent** service
- Must not replace IDEA Act services for participants aged 19–21.

Moving on to billing and details on the limits of the service: Companion Services is billed in 15-minute units, with a daily cap of 9 hours. To reiterate a key rule, this service cannot be billed while a participant is sleeping, as active engagement is essential to meeting the goal of reducing isolation.

Additionally, Companion Services falls under the federal 21st Century Cures Act requiring Electronic Visit Verification (EVV). Staff must clock in and out of the service via an EVV app in real-time. Providers can utilize CareBridge—which the Division provides free of charge—or an alternative system that links to CareBridge. Maintaining EVV compliance is critical, as failure to do so directly puts federal CCW funding at risk.

The Community Choices Waiver is built on part-time and intermittent care. As such, Companion Services is capped at 40 hours per week, though 40 hours should be viewed as a maximum ceiling rather than a standard allocation. A participant's case manager should work with them to use their budget to select the services that will meet their needs. If a provider recognizes a need that is going unmet, they should discuss it with the participant and their case manager so that the best array of services is added to their person-centered service plan.

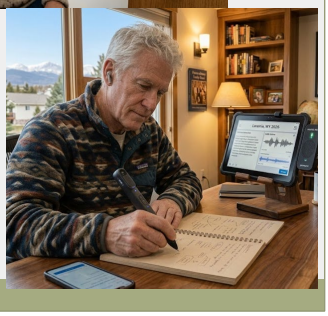
Additionally, for young adults aged 19 to 21, remember that Medicaid is the payor of last resort; Companion Services cannot replace or overlap with school-based services guaranteed under the IDEA Act.

Slide 9

Assistive Technology (AT)

9

- **Goal:** Provide items that increase or maintain a participant's functional independence and safety.
- **Two Elements:** Divided into Equipment (the devices) and Service (the support/customization).
- **Equipment:** Includes large-print keyboards, adaptive locks, display video magnifiers, electronic speech aids, screen readers, and non-slip mats.



Our second new addition to the waiver is Assistive Technology. In response to consistent feedback across the state, the Division is introducing this support to give participants the practical tools they need to live safely and independently in their own homes.
Assistive Technology is structured into two complementary components: the Equipment itself, and the Service required to support the participant in obtaining and maintaining it.
Looking closely at the Equipment side, this service covers items that aren't already available under the Medicaid State Plan Durable Medical Equipment (DME) coverage. With prior authorization, participants can purchase, lease, or acquire specialized products that enhance how they live, work, and learn. This can range from high-tech tools like screen readers, speech aids, smart pens, and video magnifiers to practical adaptive items like oversized keyboards, smart locks, or non-slip mats. We encourage case managers to actively explore these possibilities with participants to identify solutions that best match their daily goals. If a provider knows of equipment that could enhance a participant’s independence, we encourage them to discuss it with the participant and case manager.

Slide 10

Assistive Technology Service

10

- Covers fitting, professional evaluation, delivery, ongoing monthly monitoring fees, and technical support/training.
- Includes monthly functionality checks, but explicitly excludes reimbursement for a participant's internet service.
- Provides training for the participant, family, guardians, employers, and other care team members on how to use the technology.

The service doesn't just cover the equipment; it covers the service aspect too: fitting the equipment, training the care team on how to use it, and monthly monitoring fees to ensure the tech is still functioning correctly. 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 Suppor**t: 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.

Slide 11

AT Request Requirements

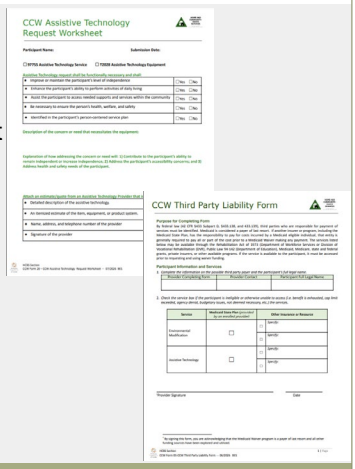
11

All Assistive Technology requests require:

- AT Request Worksheet and Third-Party Liability (TPL) form
- Providers must sign the TPL verifying the waiver is the last resort.
- Providers should work with the case manager to help complete the AT Request Worksheet and Third-Party Liability form.

For Equipment over $1,000:

- Professional assessment is mandatory for any equipment costing over $1,000.
- Conducted by a qualified professional (Physical Therapist, Occupational Therapist, or Speech Therapists)


CCW Assistive Technology Request Worksheet

CCW Third Party Liability Form

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 by the case manager 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. Providers of Assistive Technology need to assist the case manager with completing the required forms, when requested.

Keep in mind that 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.

Slide 12

Assistive Technology Limits

12

- **Annual Total Cap**: $4,000 per year for all components combined
- **AT Support**: Capped at 8 hours per year
- **Internet Costs**: Does not cover ongoing personal internet service charges
- **Payer of Last Resort**: Must exhaust State Plan, Medicare, private insurance, and other resources

There are limits to keep in mind for AT. The total annual cap for all components—equipment and services combined—is $4,000. The AT support component is capped at 8 hours per year. Please note that to remain compliant with federal requirements, monthly internet bills are still the participant's responsibility and are not covered by Assistive Technology.

As we reviewed in the last slide, the Assistive Technology Request Worksheet and Third-Party Liability form must document that all other resources have been exhausted before billing this under the CCW. We would like to remind everyone that WATR (Wyoming Assistive Technology Resources) from the University of Wyoming has a loan library for users to test out equipment before purchase to ensure they are a good fit. WATR can provide case managers and providers with device information and suggestions. The January 27th, 2025 CCW Provider Support Call training materials found in the Support Call Archive, linked in this slide's notes, has a training from WIND (Wyoming Institute for Disabilities) that includes more information on WATR.

Slide 13

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

Slide 14

Adult Day Services Updates

14

- Consolidated Health and Social models into a single 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.
- **Daily Unit:** Any use of ADS over 4 hours (16, 15-minute units) a day must be billed as a daily unit.

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 simplified service definition. 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. 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.
Adult day services is a part-time or intermittent service. As discussed previously, a participant's case manager should work with them to use their budget to select the services that will meet their needs. If a provider recognizes a need that is going unmet, they should discuss it with the participant and their case manager so that the best array of services is added to their person-centered service plan.

Slide 15

Non-Medical Transportation Updates

15

- **Units:** Replaced “one-way trip” with 15-minute units
- **Cap:** 4.5 hours per month (equivalent to the old 18-trip cap).
- **Multipass:** The Public Transit Multi-Pass option with $80 cap remains.
  - bus passes
  - other transit passes
- Providers must document service location, date, times, description, and staff signature or initials.
- Simultaneous clock-ins are allowed for shared rides.

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.

The 15-minute unit of Non-Medical Transportation needs to be documented for like the other services on the Community Choices Waiver. Providers will need to document the beginning and end locations, the date of the service, including the year, month, and day, the beginning and end time of the service, a detailed description of the service provided, and the initial or signature of the staff member performing the service.

Why did we shift Non-Medical Transportation to 15-minute units? This unit change 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.

We’d also like to clarify how to handle providing rides for multiple people. 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. Providers should clock in and out for each person being served, at the time the service began/ended for that individual. If a rider has an alternate funding source authorized for transportation, that source must be billed for their trip instead of Medicaid Waivers.

Slide 16

Respite Services Updates

16

- **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:** They can become certified to provide respite on CCW.
- **Participant-Direction:** Can now be participant-directed.

During the renewal, we also made some updates to respite. 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 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, facility 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.

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 held a CCW participant-direction specific training on Tuesday, September 1st at 1PM. The information from that training can be

found on the HCBS Public Notices, Engagement Groups & Projects page under the *Community Choices Waiver Renewal* tab.

Slide 17

Point of Service Documentation

17

- The practice of documenting the service delivery at the time the services are rendered.
- Ensure staff are completing documentation once the service is complete.
- It is difficult to remember the details of a service that occurred earlier in the week or month.
- Failing to do so may cause discrepancies and inaccurate billing.

While this is not a new expectation, we'd like to remind providers to document for services delivered at the time the services are rendered. Providers should train their staff and ensure they are completing quality documentation once the service is complete. Documentation must include:

- The participant's name
- The location of service, the physical address where the service took place;
- The date of service, including year, month, and day;
- The time services begin and end, using either AM and PM or military time, with documentation for each calendar day, even when services span a period longer than one calendar day;
- An initial or signature of the staff member performing the service; and
- A detailed description of services provided.

Along with these requirements, please remember that quality documentation includes and accurate, detailed description of the service that was provided that is unique from other pieces of service documentation. Notes can be taken during the service to ensure documentation is completed accurately and fully. It is difficult to remember the details of a service that occurred earlier in the week or month.

The Division has seen sub-par documentation and errors in documentation that was completed at a later time. Completing documentation at a later time can lead to inaccurate billing and Medicaid clawing back funds.

Please review the May 5th, 2026 CCW Provider Support Call for more details on Provider Documentation Standards. This training can be found on the CCW Providers & Case Managers page under the Provider Support Calls tab.

Slide 18

Provider Verification

18

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

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

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

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

Slide 19

Critical Incident Language

19

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

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

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

Slide 20

DD Certified Providers

20

- DD certified providers can choose to provide the following services on CCW:
  - Adult Day Services
  - Homemaker
  - Respite
  - Companion Services
- To initiate eligibility for CCW service delivery, contact the HCBS Credentialing unit at their email address wdh-hcbs-credentialing@wyo.gov.

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

In order to begin providing the services on CCW, the provider must complete the Medicaid application process for taxonomy 251B00000X. A provider interested in providing these services on CCW can contact the HCBS Credentialing unit at their email address, wdh-hcbs-credentialing@wyo.gov, for next steps regarding providing the four reciprocal services.

Slide 21

Key Takeaways

21

New Services

➔**Companion Services** provides socialization to prevent isolation.

➔**Assistive Technology** provides technology to help participants stay independent.

Unit & Rate Changes

➔**Adult Day Services:** 15-min units replace half-day; transportation bundled into base rate.
➔**Non-Medical Transport:** Converted "trips" to 15-min units.
➔**Respite:** Added daily units; removed facility option.

Compliance & Admin

➔**Point of Service documentation** - immediately follows service completion
➔**Provider verification** occurs at least every 3 years following the initial 1-year certification.
➔**Abuse, neglect, and exploitation** definitions updated to match Wyoming Statutes.

Contact

➔Providers can reach out to:

- Assigned County IMS
- The credentialing unit at wdh-hcbs-credentialing@wyo.gov

Before we wrap up today's training, we'd like to review and summarize some of the updates and give you some key takeaways. Remember that you can still find the full summary of changes, the CCW FAQ, previous CCW Renewal trainings, and other information on the renewal on the HCBS Public Notices, Engagement Groups & Projects page under the *Community Choices Waiver Renewal* toggle. We highly recommend providers reviewing the full, current CCW agreement.

NEW SERVICES

Some of the most exciting updates include the addition of two new services, Companion Services and Assistive Technology. Companion services is intended to reduce loneliness and prevent isolation by providing companionship to participants. Participants may receive this service in their home or they can choose to get into the community. Assistive Technology is intended to help participants stay independent in their home and community. It will cover technology based on their assessed needs and covers the service and training to obtain and use the equipment.

Unit & Rate Changes

During the renewal, we made some updates to some current services. Federal requirements mandate that services cannot duplicate each other so we clarified the limitations of Homemaker, Personal Support, and Home Health Aide limitations to prevent overlapping services. We merged the Adult Day Services Health and Social Models into one simplified definition and included transportation in the reimbursement rate. We also removed the "half-day" unit and added a 15-minute and daily unit for simplified billing. We changed the "trip" unit for Non-Medical Transportation to 15-minute units to ensure providers are being compensated

accurately for the time they are providing the service and to simplify billing. We also added a daily unit to Respite and removed the facility, out-of-home option.
The Community Choices Waiver is comprised of part-time or intermittent services. A participant's person-centered service plan should include a variety of services to fit the participant's needs. If a provider recognizes a need that is going unmet, they should work with the participant and their case manager to ensure the appropriate array of services are added to their service plan.

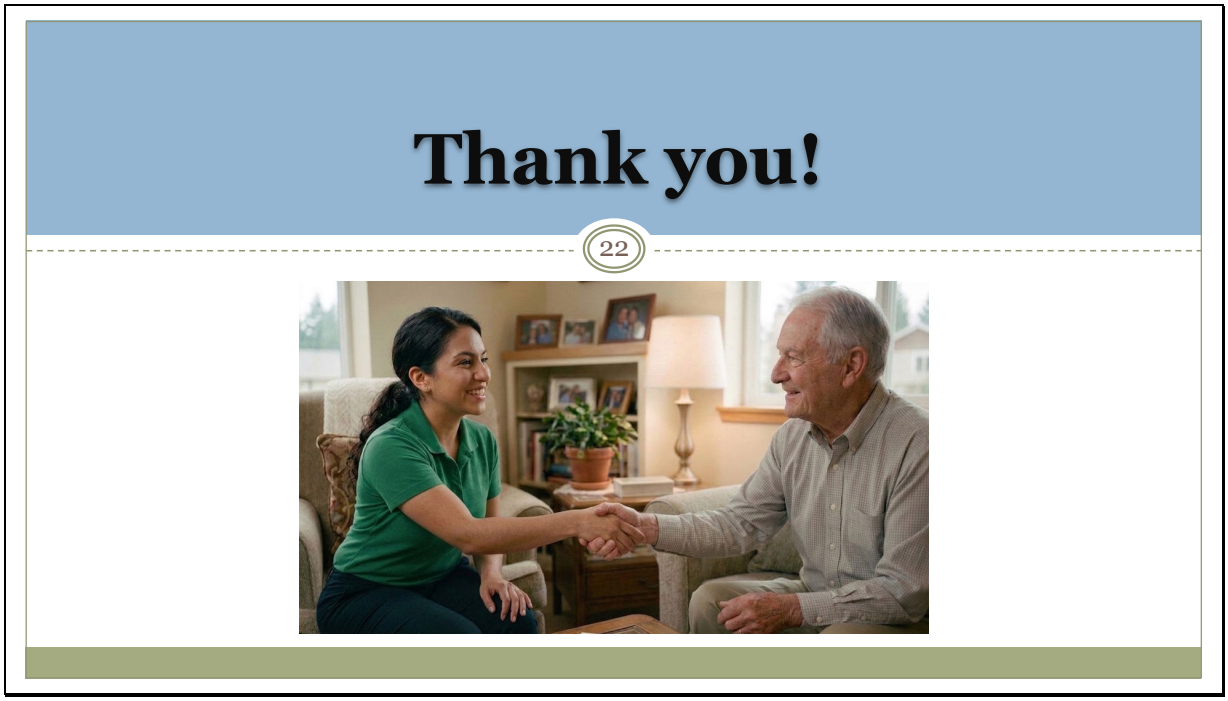
Compliance & Administration

While not a new requirement, we'd like to highlight the importance of completing service documentation at the time the service is delivered. This helps to prevent inaccuracies and billing errors.The language around the frequency of provider verification was updated. The waiver renewal now states that a provider is initially certified for one (1) year, then renewal certifications must occur at least once every 3 years. To remain consistent with Wyoming State Statutes, we have updated the definitions of abuse, neglect, and exploitation to the statues themselves. Finally, we are hoping to expand the CCW provider pool by allowing DD providers of Adult Day Services, Homemaker, Respite, and Companion Services to more easily provide them on the Community Choices Waiver.

Contact

If you have any case-specific questions or questions about credentialing, you can reach out to the assigned County Incident Management Specialist (IMS) or you can reach out to the credentialing unit using their email address **wdh-hcbs-credentialing@wyo.gov**.

Slide 22



At this time if you have any other questions, please post them in the chat. We'll answer as many as we can now, but some may be better answered in writing. We will answer all questions in writing and get those to you by email and post them to the CCW Providers & Case Managers page under the *Provider Support Calls* tab in the next few days. We will also post a recording of this training. Thank you for joining us today!