Frequently Asked Questions (FAQ)

Service Utilization

1. **Q: Will a separate training session be scheduled to address updates to the service index?**

   A: Yes. The Division is excited about the new and revised offerings within the Service Index and plans to provide a number of trainings, including training on new services such as Assistive Technology and Companion Services. In the meantime, the Division encourages case managers and providers to thoroughly review the Service Index regarding these changes.

2. **Q: Please provide guidance on when and how the Case Management T1016 (15-minute) code should be utilized.**

   A: The intent of the 15-minute Case Management Unit (T1016) is to allow some flexibility and support both to program participants and to case managers. The appropriate uses of T1016 may include:

   - The participant wishes to change case managers mid-month: T1016 allows for a participant to leave the outgoing case manager mid-month, and receive services from the incoming case manager, without either case manager sacrificing payment for their work. Both case managers can bill for the time during the transition month.
   - The case management agency has unanticipated staff changes: Occasionally case management agencies have unanticipated staff changes that may require the transfer of the case. Again, T1016 allows for each appropriate case manager to bill for services rendered.

   Please note that this 15-minute unit usage is aimed at supporting clients during transitional periods. A monthly visit must still be performed. Please contact the Division for further guidance in these situations on who has or will perform the home visit to support the client's well-being during this transition.

3. **Q: Will there be additional training on how to implement new services, add them to plans, and complete the necessary documentation? Will a new naming convention be sent out?**

   A: Yes, the Division will provide additional training on the new services. While the core workflow for adding services to a Plan of Care will remain highly similar to current processes, detailed guidance is forthcoming. New naming convention guidance will be posted to the HCBS Document Library July 1st.

4. **According to IMPROV there are only two Adult Day Services (Daily) Providers. Is this correct or will it be updated?**

   A: Yes, all of the available providers certified to deliver Adult Day on the Community Choices Waiver are on the provider list. This waiver renewal has only

been in effect since July 1st, 2026. The Division is supporting providers in exploring this service option, and also supporting DD waivers in delivering this service. Improvements in provider coverage is an ongoing challenge, and the Division welcomes suggestions and assistance in recruitment of providers for CCW services.

5. **Is it possible to input services correctly for Adult Day Services in EMWS? (Generally, are the issues with EMWS and other systems resolved?)**

   A: There are some known issues in EMWS with new services, and a few errors were identified after implementation. The Division's technology team is working diligently with contractors to fix known issues and address any new issues brought to our attention.

6. **Does Respite hours take away from the 40 hour cap budget for the other services or are they their own entity? If my client's caregiver leaves once a month, 24 hrs - does that take away from the 40 hour cap for the other services.**

   A: For traditional services, there is not a 40 hour cap for all services on the person-centered service plan (PCSP). Multiple part-time or intermittent services can be added to the PCSP. The need for each service should be clearly outlined in the PCSP. The limitations of the CCW are such that an individual is not able to receive services on a full time or 24-hour basis.

   For participant-directed services, an employee can only work 40 hours per week per employer due to federal labor laws.

7. **How will services delivered in the community relate to EVV compliance?**

   A: The intent of EVV is that the service is delivered in the appropriate service location. At this time, CCW EVV services include Companion Services, Home Health Aide, Personal Support Services, Respite, and Skilled Nursing. These services are required to be delivered in the participant's home or designated service location.

   However, in a broader sense, any service that requires the use of EVV is treated the same. An EVV visit is compliant when it contains all required EVV elements and was properly captured through the EVV system. For services that allow delivery in the community, it's allowable for that GPS location to be in the community. You would still need to meet the six required components of a compliant EVV visit. This includes documenting in the EVV app the type of service performed, the participant receiving the service, the caregiver providing the service, the date of the service, the location of the service delivery, and the time the service begins and ends. The Division recommends that providers review the EVV resources on the HCBS Current Providers page, under the *EVV* tab, where we explicitly define what the required components are of a compliant EVV visit, and how that visit must be recorded to be compliant.

8. **Q: Are there currently any Assistive Technology or Companion providers listed in Laramie County? How can a participant utilize these services?**

   A: Because these waiver updates do not take effect until July 1, 2026, new service providers will not appear in the IMPROV system prior to that date. Providers may begin the certification process for these new services starting July 1, 2026.

9. **Q: If companionship and transportation are added, overall plan costs will rise. Will this be assumed during plan approvals?**

   A: The Division is tasked with being good stewards of taxpayer funds, while also supporting the needs of CCW participants. The Division monitors and intends to continue monitoring plan costs closely as the renewal takes effect. Please keep in mind that the CCW is not a full-time residential-type waiver, and services are instead intended to be part-time and intermittent, provided in the individual's home. The Division plans for a more diverse offering of services to meet needs, not to create the expectation of 24-hour care and support.

Assistive Technology (AT)

10. **Q: Must Assistive Technology (AT) services professionals be Medicaid providers?**

    A: Yes, that is correct.

11. **Q: Who conducts the professional evaluation for AT, and how do we initiate it?**

    A: The professional evaluation can be completed by a physical therapist, occupational therapist, speech therapist, etc. The Division acknowledged this is an important area and noted that more in-depth training will be provided on this topic in the future.

12. **Q: Will participants need to provide proof of exhaustion of all other resources when adding in AT, and who can provide this service?**

    A: Yes, you must exhaust all other resources. Medicaid is the payer of last resort, meaning alternative funding sources (such as private insurance) must be explored and utilized first. More detailed guidance on AT providers is forthcoming.

13. **Q: What is the difference between companionship and respite services?**

    A: As outlined in the Service Index, Respite Services provides relief for an unpaid caregiver. If an individual is delivering unpaid care, Respite Services allows for an occasional break from that care. Respite is the only service on the waivers for the direct benefit of the unpaid caregiver.

On the other hand, Companion Services are intended to reduce isolation and provide assistance in the home and community to the participant. The case manager must work with the participant to find the service that best meets their needs.

14. **Q: Can Homemaker and Companion services be provided at the same time?**

    A: Yes. Because Homemaker is categorized as an indirect service, it can be provided concurrently with direct waiver services (like Companion services), provided they are delivered by different staff or providers. Please be sure to review the Service Index to determine what services are direct and indirect.

15. **Will the Occupational Therapist or Physical Therapist need to bill the State Plan for the Assistive Technology evaluation?**

    A: When determining if a service should be billed through the State Plan or through HCBS AT Services, the provider and case manager should evaluate the individual's plan and utilization. The State Plan is utilized first. For services such as Physical Therapy, a set number of appointments are covered through the State Plan. Appointments beyond the number covered annually by the State Plan should be billed through the CCW.

16. **Q: Under companion services transportation, can the provider transport the participant to medical appointments?**

    A: If companion services are being used for supervision, personal assistance, or support during the appointment, companion could be used to cover the transportation to the appointment. However, companion can not be billed if the provider is simply providing a ride to the appointment. Talk to your local city transit to see what services are offered to individuals for free.

    If the service is being used only as a ride to and from a medical appointment then the state plan benefit should be utilized instead of companion services.

Companion Services

17. **Q: If companionship covers meal prep, laundry, shopping, and housekeeping, what prevents everyone from billing under Companionship for the higher rate instead of Personal Support Services (PSS)?**

    A: Providers are required to bill for the most appropriate service rather than the most profitable one. According to the Service Index, PSS is intended for part-time or intermittent assistance with Activities of Daily Living (ADLs) like eating, bathing, grooming, and mobility. For PSS, chores and meal prep are merely incidental, whereas Companion services focus on active supervision and socialization as outlined in the Service Index. The Division relies on case

managers to coordinate the most appropriate service mix for each participant, as well as to monitor these services on a monthly basis to ensure services are being delivered in alignment with the Service Index.

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. 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 overserving for financial gain. Providers failing to deliver services appropriately may be reported to Program Integrity for a waste, fraud, or abuse investigation. Ultimately, case managers are responsible for reviewing all services and promptly reporting concerns.

Non-Medical Transportation & Billing Code Changes

18. **Q: Do we need to modify existing plans to reflect the new 15-minute units for non-medical transportation prior to July 1st?**

    A: Please review the needs of the client and what type of transportation they require. If they are utilizing the multipass option, changes may not need to occur. If the client is utilizing a discontinued service code, then the plan will need to be modified.

19. **Q: As a provider, what steps do we need to take regarding the new billing code for Non-Medical Transportation?**

    A: Providers will need to add the new billing code through a Provider Change Request in the Wyoming Health Provider (WHP) portal.

20. **Q: Why was transportation shifted from flat units to 15-minute increments? It complicates plan of care calculations**.

    A: The new rate takes into account the time spent on travel, not simply the mileage. A participant may only need to go 10 miles, but if it is through a winding mountain road, the five miles would take longer than 20 flat highway miles. Similarly, a participant may need assistance safely loading and unloading from the vehicle. This time was previously not paid to the provider. Please contact your assigned BES for assistance with plan of care calculations.

21. **Q: 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?**

A: 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 (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.

22. **How would a provider become a Non-Medical Transportation provider?**

    A: Providers who would like to provide Non-Medical Transportation should reach out to our credentialing team, who can give guidance on specific application steps or processes to either add a service if you are an existing provider or apply for services if you are a new provider. The credentialing email is wdh-hcbs-credentialing@wyo.gov, or you can reach out to the county-specific Credentialing Specialist listed on our website under the HCBS Contact Staff page.

23. **What is the difference between the pass and regular non-medical transportation?**

    A: Non-Medical Transportation providers are the individuals or provider agencies who've gone through the process of being certified as a provider for Non-Medical Transportation. The Non-Medical Transportation pass option would cover a city bus pass or similar types of transportation passes.

Case Management

24. **Q: Regarding the one-hour minimum service requirement, must the "one hour of direct contact" be 60 minutes of face-to-face contact? Specifically, would a 30-minute face-to-face visit supplemented by 30 minutes of contact via phone, text, or email with the participant fulfill this requirement?**

    A: The one hour requirement includes face-to-face interactions as well as other direct contact. We expect the case manager to maintain regular contact, which is now required monthly, and can be done by home visit, phone calls or other means of direct contact with the participant. The Case Manager Monthly Review (CMMR) will need to reflect this contact time with a separate entry for each interaction that captures the time spent and a detailed description of what occurred.

25. **Q: If a one (1) hour in-home visit is required, what if we don't have enough time to complete the requirement for a participant? Will we still get paid the full monthly case management fee?**

    A: As noted above, the one (1) hour of person to person contact does not have to be completed in its entirety during the monthly home visit. It can be split between the visit and phone calls, for example. In order to bill for a monthly unit of case management you will need to fulfill the requirements. Other waivers already utilize this standard, and case managers have generally found it manageable to complete the required hour of person-to-person contact.

26. Q: If the participant does not want us in their home for that length of time, do we have to make up that time for a total of an hour?

A: No, as noted above the entire hour of person to person contact does not need to be at the participant's home. Some can be accomplished through phone calls or other times in which you make direct contact with the participant. It is important to remind participants who agree to services on this waiver that this is a waiver of choice. Part of their agreement to participate in this waiver is to allow for regular, ongoing contact with their case manager. Making up time does not focus on the overall expectations of case management, instead the focus should be on meaningful interactions and support for the participant to assist them in achieving their goals and maintaining as independent life as possible.

27. Q: What if the client ends up in the hospital and then goes into a SNF for rehab a couple weeks before we see them in their home?

A: If your client is in a hospital or other institutional setting throughout the month, they are not able to receive waiver services and you should not bill for case management services.

If you are concerned about the ability to manage your schedule throughout the month and plan for unforeseen events, we suggest planning home visits during a week at the beginning of the month. If the visit is completed within the first weeks, the monthly requirement is fulfilled. If a participant is unable to meet during the first week of the month, then case managers can schedule a time for later in the month when the participant's conflict has ended.

28. Will case managers have to start the EVV process for the case management visits in their home?

A: Case Management is not currently an EVV-required service in Wyoming. The Division continues to evaluate the benefits and drawbacks of implementing EVV for additional services.

29. What changes are being made to the Case Manager Monthly Review (CMMR), and when will the monthly visit verification form be available in the document library?

A: A change being made to the CMMR is to eliminate the free-text notes field from the bottom of the page. The intent of this change is to support case managers in filling in relevant information in the appropriate fields. The Monthly Home Visit Verification form effective July 1st has been posted to the HCBS Document Library under the current Quarterly Visit Verification form.

30. **Q: During a survey that was completed with random Waiver participants, the Division reported that some participants didn't know who their case managers were or that they stated that they hadn't even seen them or talked to them for several months. Was the monthly home visit requirement a result to ensure that they get their time with their case managers? Case managers and/or agencies of these participants should be audited and dealt with rather than enforcing such extreme requirements on us each month for each client.**

    A: Thank you for this feedback. While the Division addresses individual performance issues as they arise, we hold all case managers to high standards due to the critical nature of the services they provide to CCW participants. These standards require thorough documentation of time spent with clients and confirmation of monthly contact. The current Medicaid reimbursement rate is based on an assumed four hours of work per client each month. As with all Medicaid transactions, providers must maintain sufficient documentation to support their claims. To ensure the responsible management of taxpayer funds, the Division must apply this standard to CCW case managers uniformly. Because the lack of required documentation is a widespread issue rather than an isolated one, enforcing this baseline expectation is necessary to ensure all case managers can verify the work they are being paid to perform.

31. **Q: The service index mentions that socialization is not covered, but if case managers are in fact expected to complete a one-hour visit with the participant in their home, most likely, a lot of that time will be a social call in order to make up that hour.**

    A: As noted previously, the entire hour of person-to-person contact for the month does not need to be completed during the home visit. The Division feels confident that the skilled case managers working with CCW clients will be able to be deliberate and reflective in their conversations, diligent with follow up, and use a variety of interview techniques. Current practices may need to be altered to ensure that conversations are person-centered, go beyond the surface, and discuss client needs. Motivational interviewing or other techniques should be explored to be able to have more structured and meaningful conversations regarding a participant's needs. If you need additional training and support regarding how to conduct interviews and why certain topic areas are included on the Case Manager Monthly Review, please feel free to contact your assigned Benefits and Eligibility Specialist.

32. **Q: When will case management rates increase to accommodate these new responsibilities?**

    A: The Division has completed the CCW rate study and is actively pursuing the appropriate avenues for rate increases. Please keep in mind that the current rate paid for monthly monitoring for case management includes an assumption of four (4) hours of casework throughout the month. Review of all CMMRs indicate that

case managers currently spend an average of 37 minutes with clients, which is substantially below the level of work the rate pays. In addition, the requirement for monthly visits was established due to consistent health and safety concerns of participants identified by the Division.

33. Q: How should case managers document client phone calls?

A: All case management documentation must be entered into the Case Management Monthly Review (CMMR). Each entry must be individualized to that specific interaction and recorded in the case note section with a detailed description. Time spent documenting these monthly activities is considered billable time.

34. Q: Can case management agencies use an internal monthly home visit verification form instead of the one in the document library if we write extensive handwritten notes?

A: No, case managers must use the official state form. While extensive note-taking is acceptable, those notes must ultimately be transcribed into the CMMR within EMWS. This standardized data entry is critical for the state to pull statistics, perform consistent reviews, and ensure case managers document activities to support paid claims.

35. Q: Are case managers expected to bring a computer into the field to log notes in real time? Can case mangers download or upload notes directly into the CMMR?

A: Case managers are encouraged to reflect on the most appropriate methods to accomplish the requirements of including all notes appropriate in the CMMR. Methods may include using a tablet while in the field or other methods. While case managers can still take handwritten notes, those handwritten notes must be transcribed appropriately in the Case Manager Monthly Review.

36. Q: When documenting monthly visits, do we include travel times, UR reviews, and note-writing in the same case note?

A: Travel time is built directly into the service rate and is considered a non-billable activity; therefore, it cannot be captured within billable case notes. Furthermore, effective July 1, the master note box is being removed from the CMMR. Case managers must log individual, broken-out entries for each distinct activity to ensure real-time accountability and clearer tracking.

37. Q: Is a monthly visit verification form required?

A: Yes, the Monthly Home Visit Verification form located in the HCBS Document Library is required to be completed and uploaded to the Case Manager Monthly Review.

38. Q: Can you clarify the 1-hour person-to-person contact requirement? Does the in-person home visit itself need to last a full hour, or can it be a combination of a shorter visit and phone calls?

A: The full hour does not have to be spent entirely inside the home. Please keep in mind that the requirement for contact in the home is to evaluate the state of the home, the participant's ability to navigate their surroundings, and gather other important information to help identify any new or changing needs. The 1-hour direct contact minimum can be achieved through a combination of the required monthly home visit, follow-up phone calls, or other direct, natural person-to-person interactions.

39. Q: What other aspects of communication equal suitable person-to-person contact besides face-to-face? If a client does not enjoy talking for more than 10 minutes during a home visit, how do we demonstrate compliance to the State?

A: As noted, phone calls and other direct, natural person-to-person interactions would be considered person-to-person contact. The Division feels confident that the skilled case managers working with CCW clients will be able to be deliberate and reflective in their conversations, diligent with follow up, and use a variety of interview techniques. Current practices may need to be altered to ensure that conversations are person-centered, go beyond the surface, and discuss client needs. Motivational interviewing or other techniques should be explored to be able to have more structured and meaningful conversations regarding a participant's needs. If the case manager struggles with specific participants, please reach out to the assigned BES for additional support.

40. Q: How is a 35-client caseload considered "full-time" if direct contact requirements were reduced from 2 hours to 1 hour?

A: The underlying rate study assumes 4 hours of total monthly casework per client. That overall volume of work (4 hours per month) has not changed. The state is simply shifting the framework so that 1 of those 4 hours must be dedicated to direct client contact every month, replacing the previous quarterly in-person visit schedule.

41. Q: If we are supposed to do 4 hours of casework per client monthly, will we eventually be able to bill for all 4 hours? Will we be required to hire more case managers if our caseload exceeds 35 clients?

A: The monthly case management rate currently has a built-in assumption that case managers will spend roughly 4 hours of work per month per client. Please note that this is the assumption that goes into the rate buildup; at this point in time, there are no limits or minimums to caseload size. If a case manager wishes to carry a higher or lower caseload with corresponding payment, that is currently allowable. When considering hiring additional case managers for larger caseloads, please be reflective of the quality and quantity of work a case

manager is able to carry. Are current caseloads so heavy that clients are not receiving adequate support? How much time is a case manager able to spend on a monthly basis working each case? What are the needs of each client, which may vary from month to month?

The Division considers the questions above when reviewing CMMRs and caseload size. It is recommended that each case manager or case management agency be deliberate and thoughtful when hiring case managers and assigning caseloads.

42. Q: Is the 35-client caseload strictly a guideline, since many case managers currently manage more than that?

A: The 35-client caseload is the assumption of full-time work. This assumption is used in the rate buildup as the rationale for establishing the rate of payment. It is not a requirement for a case manager to have a specific caseload size.

43. Q: Can we meet face-to-face with clients anywhere outside of their homes and have it count as a billable service?

A: If there is meaningful case management support outlined in the service index occurring outside of their home, it can count as a billable service. The monthly home visit is still required, but contact can be made outside of their home.

44. Q: What is the definition of "real time" regarding documentation?

A: The Division has noted a common practice of writing a brief undated summary of monthly activities in the overall notes box at the end of the CMMR. This practice will no longer be allowed. The appropriate use of the CMMR form is to record dated activities within the appropriate subject area throughout the month. For example, if a phone call with the participant occurred on the 4th of the month where health concerns were noted, the case manager should record the contents of the conversation after it occurs, not at or after the 30th of the month. The Division considers at the point of service “real time”. Once the interaction or service has concluded, it should be documented as soon as possible. Please also note that all topics included in the CMMR should be addressed each month.

45. Q: Is there a specific point of contact at the Division to discuss individual participant circumstances regarding the monthly home visit?

A: Case managers can contact their assigned County Benefits and Eligibility Specialist if they are having difficulty completing a home visit with a participant.

46. Can you give an example or expand on the definition of part-time and intermittent?

A: Part-time or intermittent services of professional personnel and home health aides is usually service for a few hours a day several times a week. Occasionally, more service; i.e., eight hours, may be provided for a limited period.

47. **Are case managers required to keep track of the employee/employer screening checks?**

    A: No, case managers are not responsible for keeping track of the background checks. The background screenings are conducted by the FMS and it is the participant-directed (PD) employer's responsibility to make sure that the activities that they need to do or the employee needs to do are being completed timely. ACES$ works with the PD employer to make sure that they know how to do the OIG check for themselves and that they know how to request the DFS checks, which cannot be done by the FMS.

48. **How do case managers complete the service budget calculator for the new services in EMWS?**

    A: There is a known issue in EMWS. When we rolled out the new services in July, the budget calculator was not adjusted. We are working with our vendor to resolve that.

    For now, when you complete the calculator for each individual service, use the service index limits to make sure that the items being added to the calculator are included as allowable tasks in the service index so that those participant direction budget totals are being calculated correctly. Once the EMWS budget calculator is updated, there will be those specific tasks for services. We will update you with more information once the budget calculator is updated.

49. **When creating a plan in EMWS, it asks case managers to upload a document when we add homemaker if they are receiving personal support services. What is the document?**

    A: The person-centered service plan should document the need for both services and explain how the services are not duplicating what is already being completed with personal support services.

Participant-Direction

50. **Please clarify that the cap is 40 hours is employee based and not participant. For example, the participant has multiple employees and needs more than 40 hours a week. As long as the employee does not go over the 40 hours they are ok, correct?**

    A: For participant direction, each employee can work up to 40 hours per employer. So, for example, if one participant who is their own employer has multiple employees, they can be receiving more than 40 hours per week. That

being said, all services need to align with the part-time and intermittent service levels within the service index.

51. **Are participants still able to use paper timesheets that have been previously approved by the state and reviewed on a regular basis?**

    A: Existing EVV exceptions previously approved by the State will remain in place for the specified time period that they were approved for. We want to make sure that exception requests submitted are for those situations where there is an absolute need. New exception and extension requests will be reviewed more

52. **Under participant direction, if there are multiple services on the plan, when the provider is there, do they need to clock in and out for each part? For example, if they are delivering personal support services and then go to take the participant out to go shopping, run errands, or to a doctor's appointment, do they clock out of personal support and into transportation, and vice versa?**

    A: Yes, every service that is delivered needs to have a provider clock in and clock out appropriately, with documentation as to the specific service provided. However, please thoroughly review the Service Index to determine what services include what type of activities. Some services, like Companion Services, include transportation in the rate. Other services, like Personal Support Services, do not include transportation in the rate and the employee would need to clock out of Personal Support Services and into Non-Medical Transportation in order to get reimbursed for transportation. stringently moving forward in order to comply with the federal mandate.

53. **Can you clarify that the additional services—companion services, homemaker, personal support, respite, and transportation—are available through the participant direction option? The budget calculator does not include those services.**

    A: Those services can be provided through the participant-directed option. We know that it is not currently in the budget calculator that is in EMWS. We do ask that you do the best that you can using the budget calculator that's there. When you add a companion service for participant-direction, use the budget calculator that's currently in EMWS and rely on the services index to confirm what tasks are allowable. We're working on getting that updated and will let case managers know when the budget calculator has been updated.

54. **Can an employee get more than 40 hours per week if they are providing services for more than one employer?**

    A: An employee may work more than 40 hours per week if they are providing services for more than one employer. Some delegate employers act in that role for more than one participant. If the participant-directed employer, for example, is

acting in that role for two participants and they only have one employee that provides support to both of the participants, that employee can only work up to 40 hours that week for that one employer. It is important to remember that the 40 hours per week limit is not per participant, but it's per employer.

55. Will there be a cap on how much a self direction budget can be?

A: There is not an explicit cap on self-direction budgets. It varies depending on participant need, the choice of services added on the participant-direction option, and the wage paid to the PD employee.

56. How do PD employees mark it in the EVV app when they are providing transportation or homemaking? Currently, they have no way of showing when they are providing the other services.

A: The EVV solution on the app does break out those different tasks and the different services that have been added.

57. Do PD employees need to clock in and out on the EVV app for each service they do? Do traditional providers need to clock in and out for each service?

A: This depends on the service index. For example, if someone is providing a service that does not include non-medical transportation, but they are transporting the participant, they would need to clock out of the one service and into the non-medical transportation while they are providing transportation.

It's important to remember that each service is its own standalone service. If someone is providing homemaker and they complete that service, they would need to clock out and clock in companion services separately.

58. Do PD employees need to be keeping documentation separate from what is in EVV to show what they are doing during service times?

A: Yes, PD employees need to keep separate service documentation. EVV is not a substitute for service documentation. EVV does not capture all of the state requirements for service documentation as outlined in Chapter 34, Section 20. Service documentation must include the participant's name, the location of the service, the date the service was provided, the time the service began and ended, an initial or signature of the employee performing the service, and a detailed description of the service. Some services may have additional documentation requirements. Proper documentation is necessary for Medicaid reimbursement.

The May 18, 2026 CCW Provider Support Call training covered provider documentation standards. The slides and recorded training are available on the CCW Providers & Case Managers page under the *Provider Support Calls* tab. The Division suggests reviewing that training for more information on service documentation standards.

59. The written documentation requirement was dropped several years ago. If that has changed, a form should be supplied by the state.

A: Service documentation requirements are separate from EVV and have not been dropped. It is the responsibility of each provider, and PD employee, to be able to prove that they provided the service according to the service index and participant's person-centered service plan (PCSP). It is also the PD employer's responsibility to ensure that those services were delivered according to the service index and PCSP. However, it is the responsibility of the PD employer and PD employee to decide how best to fulfill the service documentation requirements outlined in Chapter 34, Section 20.

60. How is the service added to the plan of care? Is the new wage form and modified plan sufficient notification to ACES$ for services to be added to the EVV app for the employee?

A: The plan of care must be modified in EMWS to add or change participant-direction services, but simply adding or changing the services in EMWS does not satisfy that notification requirement to ACES$. The employer has to contact ACES$ to add each service and set a wage for each of the services. The wage form is how the PD employer can notify ACES$. This notification ensures that new services show up in the employee's EVV app.

61. On the ACES$ wage form, for companion, homemaker, personal support services, respite, and transportation, if we can't add those services in the budget calculator in plan of care in EMWS, do we leave that wage blank or just put the wage under personal support services as that will be the tasks completed in the budget calculator?

A: While the budget calculator itself is not reflecting those tasks that can happen within the services correctly, it is calculating those services. When the budget is sent over to ACES$, they can see which services were added. If you've added companion, homemaker, personal support, respite, or transportation in EMWS to the budget, the only way that the participant can receive that service through participant-direction is if the employer fills out a wage form for that service.

62. Is the employee limited to 40hrs/week for an employer if they are providing 2 or 3 different services to that employer?

A: Medicaid pays a set amount for services that are provided, and that applies to participant-directed employees as well. There is a 40 hour per week per employer limit, regardless of what services they are providing. If an employee is providing multiple different participant-directed services to the participant, they are limited to only providing 40 hours per week for any combination of the participant-directed services.

63. Is there an easy way to determine a wage for each new service?

A: In order to set an appropriate hourly wage for your employee(s), you should review the service index and fee schedule for the waiver you are enrolled in, and work with the case manager and the FMS agency to identify any specific limits. In most cases, your employee's wage should be somewhere around the average wage for other providers of this type of service and must be at or above the federal or state minimum wage, whichever is higher.

64. Q: How would a participant on the Participant Directed Option (PDO) utilize companion services for a Direct Support Worker (DSW), especially if they provide 9 hours per day? Can they have additional DSW services without overlapping tasks, even if the plan exceeds 40 hours per week? Will this be allowed?

A: Please carefully review the Service Index effective July 1, 2026, for all details regarding Companion Services. Companion Services have a maximum limit of nine (9) hours per day. This maximum is for the person *receiving* the service. Please keep in mind that this service is intended to be part-time and intermittent, and no participant should be receiving Companion Services on a full-time basis. Additionally, a participant-directed employee can only work 40 hours per week per employer, and employers must follow state and federal labor laws.

If a participant is utilizing companion services, no other direct service can overlap. If the participant has hired two participant-directed employees, one could provide an indirect service, like Homemaker Services, while the other provides Companion Services. Please be sure to consult the Service Index to determine what is a direct and indirect service.