



HOME AND
COMMUNITY-
BASED
SERVICES
WYOMING MEDICARE
DIVISION OF HEALTHCARE FINANCING

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

COMPREHENSIVE AND SUPPORTS WAIVER SERVICE INDEX

Effective September 1, 2022

PARTICIPANT DIRECTED SERVICES AVAILABLE

Child Habilitation

Community
Living Services
(excluding Host Home)

Companion

Homemaker

Individual Habilitation Training

Personal Care

Respite

Supported
Employment
(excluding Group
Supported Employment)

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Division of Healthcare Financing Service Requirements

The home and community-based Supports and Comprehensive Waiver (DD Waiver) services defined in this document shall be performed in the manner described in the service definitions. Services must meet each participant's assessed needs. Certified DD Waiver providers and case managers must be knowledgeable of the Department of Health's Medicaid Rules affecting DD Waiver programs.

Each service, in combination with other services included in an individualized plan of care (IPC), must fit within the individual budget amount (IBA) assigned to each participant. The IPC must account for services to cover the entire plan year. The Division of Healthcare Financing (Division) will adhere to service caps identified in service definitions. With the exception of case management services, which participants must receive each month, a minimum number of service units is not required.

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

Participant-directed services shall be performed in the manner described in the service definitions and meet the participant's assessed needs. Services offered through participant-direction are only billable in 15-minute increments. Daily rates are not available through participant-direction. The Employer of Record must ensure that all participant-directed services fit within the participant-directed budget, and must cover the entire plan year.

For the purposes of these service definitions, a relative is defined as a biological, adoptive, or step parent. Relatives, spouses, and legally authorized representatives are prohibited from providing participant-directed services. Additionally, legally authorized representatives are prohibited from providing waiver services, with the exception of personal care services for an individual under the age of 18, as established in the personal care service definition.

Habilitation services, which require training on objectives as part of the provision of services, include the following:

- Child habilitation services
- Community living services (all levels, including host home)
- Community support services
- Individual habilitation services
- Special family habilitation home
- Supported employment services

A National Provider Identifier (NPI) number is required for providers of the following services:

- Case Management
- Dietician
- Occupational and Physical Therapy
- Skilled Nursing
- Speech, Language, and Hearing



As of January 1, 2017, other waiver services do not require referring or ordering provider NPIs to be submitted on billing claims. The Financial Management Service (FMS) contracted to provide support to participants who -direct services through participant-direction on the DD Waivers shall maintain a single NPI that is associated with the Home Care Services Unit (HCSU) within the Division. The FMS is not required to obtain a second NPI to process DD claims.



* Please note that prior authorization is required for waiver services.					
Service	Programs	Code(s)		Rate(s)	Unit
Adult Day Services	Comprehensive Waiver Supports Waiver	S5100	Basic	\$2.53	15 Minute
		S5100 UA	Intermediate	\$3.52	
		S5108 U9	High (Agency)	\$6.49	
		S5108	High (Independent)	\$6.06	
		S5102	Basic	\$60.66	Daily
		S5102 U2	Intermediate	\$84.47	
		S5105 U9	High (Agency)	\$155.87	
		S5105	High (Independent)	\$145.55	

Adult day services consist of meaningful daytime activities that maximize or maintain skills and abilities; keep participants engaged in their environment and community through optimal care and support; actively stimulate, encourage, develop, and maintain personal skills; introduce new leisure pursuits; establish new relationships; improve or maintain flexibility, mobility, and strength; or build on previously learned skills. Adult day services provide active, person-centered supports which foster independence as identified in the participant's IPC.

Adult day services include personal care, protective oversight, and health maintenance activities such as medication assistance and routine activities that may be provided by unlicensed, Division certified direct support professionals identified in the IPC. Personal care services shall not exceed 20% of the provided service.

Adult day services may be provided in the participant's home if the participant/legally authorized representative and the plan of care team decides the home is a more appropriate place to receive the service and the approved plan of care supports the medical, behavioral, or other reason for the service to be provided in the person's home. Transportation is a component of adult day services and is included in the rate to providers.

As authorized in 42 U.S.C 1396a(h), this service may be provided in an acute care hospital if the services are:

- Identified in the participant's IPC;
- Provided to meet needs of the participant that are not met through the provision of acute care hospital services;
- Not a substitute for services that the acute care hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and
- Designed to ensure smooth transitions between the acute care setting and the home and community-based settings, and to preserve the individual's functional abilities.



Case managers and providers must coordinate with hospital staff and plan of care team members in order to ensure that the participant's transition from a temporary hospital stay to their home is seamless.

Adult day services is billed as a 15-minute or daily rate.

A participant receives a tiered service approved in the IPC based upon need, according to the following tier descriptions:

Basic Level of Care

A participant with a Level 1 or 2 Level of Service (LOS) score will generally be in this tier. This service tier requires limited staff supports for, and personal attention to, a participant daily due to a moderately high level of independence and functioning. Behavioral needs, if any, can be met with medication or informal direction by staff. The person may have periods of time with indirect staff supervision where staff are onsite and available through hearing distance of a request. This service may be provided through virtual supports. The participant and legally authorized representative must have a choice in where and how the service will be received, and it must be documented in the participant's IPC. Documentation shall demonstrate that opportunities for community integration, support for employment, and social interactions are still incorporated in the participant's life. If remote monitoring does not facilitate the wishes and desires of a participant, it is not an option. Providers and plan of care teams must follow all requirements and standards established in the HCBS Waiver Virtual Supports document, which is located on the [Service Definitions and Rates](#) page of the HCBS Section website.

Intermediate Level of Care

A participant with a Level 3 or 4 LOS will generally be in this tier. Service tier requires full-time heightened supervision with staff available as indicated in the IPC due to significant functional limitations, or medical or behavioral needs. Behavioral and medical supports are not generally intense and can be provided in a shared staffing environment. Regular personal attention is given throughout the day for personal care, reinforcement, community, or social activities.

High Level of Care

A participant with a Level 5 or 6 LOS will generally be in this tier. Service tier requires full-time supervision with staff available within close proximity and as indicated in the IPC. Frequent staff interaction and personal attention for significant functional limitations and medical or behavioral needs shall be provided. Support and supervision needs are moderately intense, but can still generally be provided in a shared staffing environment unless otherwise specified in the IPC. Frequent personal attention shall be given throughout the day for reinforcement, positive behavior support, personal care, community, or social activities.

Scope and Limitations

Adult day services are available to individuals who are 21 years of age or older. This is not a habilitation service. Approved units will be based on individual level of support need and must fit within the assigned budget. A minimum of six hours per day must be provided in order for the daily rate to be billed. A 15-minute unit and daily rate shall not be billed on the same day.



A relative provider (defined as a biological, adoptive, or step parent) may provide this service subject to compliance with Chapter 45, Section 31 of the Department of Health's Medicaid Rules. Adult day services shall not be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the State Medicaid Agency.

Support with personal care needs, including medication assistance, is a component of the service, but shall not comprise the entirety of the service. Personal care services shall not be billed at the same time as this service. Individuals in adult day services shall not be paid for work activities performed during this service.

A participant shall not receive a service tier that is higher than the tier level associated with his or her level of service score. A participant's IPC may include two or more non-community living services as long as service times do not overlap. Services shall not exceed an average weekly amount of 35 hours if the individual receives level 3 – 6 community living services. The daily rate shall not be billed if the participant receives level 3 – 6 of community living services and receives other non-community living services during the day.



*** Please note that prior authorization is required for waiver services.**

Service	Programs	Code(s)		Rate(s)	Unit
Behavioral Support Services	Comprehensive Waiver Supports Waiver	97151	BCBA Level	\$31.64	15 Minute
		97152	BCaBA Level	\$20.12	
		97153	RBT Level	\$18.85	

Behavioral support services are used to develop and implement individualized behavior plans based on behavioral sciences that focus on positive behaviors and identified challenges to improve a variety of well-defined skills. This service includes development of a functional behavior analysis, positive behavior support plan, training in appropriate expression of emotions and desires through the implementation of positive behavior support, and interventions to increase adaptive replacement behaviors. Behavioral support services can also be accessed for the purpose of reducing the use of restrictions and restraints within a participant's current IPC.

Definitions:

- BCBA – Board Certified Behavior Analyst
- BCaBA – Board Certified Assistant Behavior Analyst
- RBT – Registered Behavior Technician

Activities required for reimbursement:

- Direct contact and observation with the participant (and collaterals as necessary) for the purposes of baseline determinations and positive behavior support plan (PBSP) development, which must comply with Chapter 45, Section 17 of the Department of Health's Medicaid Rules.
- Completing a functional behavior analysis and developing a PBSP and subsequent revisions utilizing positive behavior supports and interventions.
- Conducting participant training to support effective implementation of an individual's desired outcomes through comprehensive positive behavior support.
- Creating templates and providing training and technical assistance with primary caregiver(s) on the implementation of the participant's PBSP.
- Documenting work completed, including case notes on training provided to primary caregivers and participants. Documentation shall be made available to the case manager by the tenth (10th) business day of the month following the date that the services were rendered.
- Regularly reviewing the effectiveness of the PBSP with the participant and team.
- Generating summary documents to include baseline data regarding the behaviors, any progress that has been made, intervention strategies that have been implemented, and identified barriers that may inhibit progress. Summary documents shall be completed and submitted to the case manager by the by the end of the participant's plan year, or upon request by the Division.

Scope and Limitations

Behavioral support services are available for participants who are 21 and older. Participants under the age of 21 can access this service through early education programs, school programs, and the Medicaid State Plan (for



individuals with an Autism diagnosis). Applied behavior analysis therapy is only available to participants with a diagnosis of autism who are age 21 or older.

Behavioral support services shall require a service request form, shall be subject to prior authorization by the Division, and shall not be covered under any billable service through the Medicaid State Plan.

Behavioral support services is a 1:1 service. A maximum of 120 units per plan year are available at the BCBA/BCaBA levels, combined, for initial assessment, completion of a functional behavior analysis, and PBSP development. If participant exhibits significant behavioral challenges, which require them to receive skill acquisition and behavior support that is more appropriately provided at the BCBA or BCaBA skill level, additional units may be requested. The provider must submit an explanation of why the RBT level of support is not adequate, and the specific supports the higher level professional will provide, with the request for additional units.

Documentation must be submitted to substantiate the need for continued behavioral support services on subsequent plans as this service isn't meant to be a continuous long term service.

Activities that are not allowed under this service:

- Aversive techniques – Any technique not approved by the individual's person centered planning team and the provider's human rights committee, if applicable.
- Restrictive interventions described in Chapter 45 of the Department of Health's Medicaid Rules.
- Direct care services.
- Counseling, therapy, or other services covered under the Medicaid State Plan.

Relative providers (defined as biological, step, or adoptive parents) shall not provide this service.

Provider Qualification Note

A provider of behavioral support services shall follow the requirements and certifications established by the Board of Certified Behavior Analysts, per <https://www.bacb.com>, in order to provide behavioral support services. Each individual providing this service must meet the certification standards for the service that is being provided.



* Please note that prior authorization is required for waiver services.				
Service	Programs	Code(s)	Rate(s)	Unit
Case Management	Comprehensive Waiver Supports Waiver	T2022	\$334.87	Month
		T1016	\$20.93	15 Minute
	Targeted Case Management	T2023	\$8.00	15 Minute

Case management is a required service to assist participants in gaining access to needed waiver and other Medicaid State Plan services, as well as medical, social, educational and other services, regardless of the funding source.

Case managers shall be responsible for conducting the following functions:

- Assessing or reassessing the need for waiver services;
- Initiating the level of care evaluation or re-evaluation process;
- Linking waiver participants to other federal, state, and local programs;
- Providing choice of services and providers;
- Developing person centered IPCs in accordance with Division policies and procedures;
- Coordinating multiple services and providers;
- Ongoing monitoring of the implementation of IPCs in accordance with Chapter 45 and 46 of the Department of Health's Medicaid Rules;
- Ongoing monitoring of individual budget amounts (IBAs) to assure that services are provided within the IBA, and addressing identified concerns;
- Ongoing monitoring of participants' health and welfare and addressing identified concerns;
- Responding to participant crises;
- For each provider or participant-directed employee, quarterly service observations for each habilitation service, and service observations every six months for non-habilitation services on the IPC.

Monthly Requirements

- Maintain direct contact with participant and legally authorized representative (if applicable), which may include a visit to the participant's place of residence, service observations, and telephone or person to person contact with participant or legally authorized representative to complete follow up on concerns identified through incident reports, complaints, or other means.
- Follow-up on concerns or questions raised by the participant, legally authorized representative, or plan of care team, or identified through incident reports, complaints, or service observations.
- Review service utilization and documentation of traditional and participant-directed services to assure the amount, frequency, and duration of services is appropriate.
- Monitor and evaluate the positive behavior support plan, as applicable, and complete follow-up on concerns.
- Evaluate the use of restraints and complete follow-up on concerns.
- When a participant chooses to direct services through participant-direction:
 - Complete and submit referral form, with all required information, to the Financial Management Services Agent (FMS).
 - Interact with the FMS to assist participants with enrollment in participant-direction.



- Assist the employer of record (EOR) in completing employee paperwork, and address questions or issues that arise.
- Conduct regular follow-up with the EOR to assure service delivery aligns with the IPC.
- Use the FMS portal to review provider time sheets, determine budget usage, and provide ongoing monitoring of the participant's budget. Report improper budget usage to the assigned Division staff member.

Billable Activities

A billable case management activity is any task or function defined by the Division as an activity that only the case manager or the designated back up case manager when appropriate, can provide to, or on behalf of, the participant or legally authorized representative. Billable time may be cumulative during the span in which a case manager bills. The monthly case management review must be completed prior to billing for services, and must be submitted by the 10th business day of the month following the month that the services were rendered. These services cannot be performed by a case manager delegate or another employee of a case management organization.

Billable case management services include:

- Plan development;
- Plan monitoring and follow-up, including documentation review;
- Second-line medication monitoring;
- Service observation and interviews;
- Visits to the participant's place of residence;
- Team meetings, which may occur virtually at the participant or legally authorized representative's request;
- Participant specific training;
- Meetings with participants, legally authorized representatives, and family;
- Advocacy and referral;
- Crisis intervention and management;
- Coordination of natural supports;
- Offering and discussing choice;
- Completing monthly responsibilities;
- Division required reporting;
- Quarterly meetings with back-up case manager.

Non-billable activities include:

- Ancillary activities, such as mailing, copying, filing, faxing, drive time, supervisory, or administrative. The administrative costs of these activities, and other normal and customary business overhead costs, have been included in the reimbursement rate for billable activities.
- Time spent with the participant or guardian for social reasons, unless billable case management activities are also occurring. Incidental contact and social exchanges are part of conducting and building a business and offering customer service, and are not considered a case management service by the Centers for Medicare and Medicaid Services (CMS).
- Time spent acquiring continuing education units.
- Travel time, which has already been included as part of the rate for the service.



Scope and Limitations

Case management is available as a 15-minute unit or a monthly unit. Monthly and 15-minute units shall not be billed for the same participant in the same month.

Monthly Unit

The monthly unit shall be billed on or after the last day of the month. A minimum of two hours of billable services shall be documented in order to bill, but all billable services shall be documented each month.

- A monthly visit to the participant's place of residence, with the participant present, is required to monitor the participant's health and welfare, as well as to discuss satisfaction with services and needed changes to the IPC.
- At least one hour of person to person contact with the participant or legally authorized representative is required to bill a monthly unit.

15 Minute Unit

The rate for the 15-minute unit is based on the same methodology as the monthly unit, and allows for an average of four (4) hours per month of case management to be billed.

- At least one unit of case management shall be provided each month to discuss participant satisfaction and address any needs or concerns.
- Case managers shall use units based on the needs of the participant or legally authorized representative, up to the amount approved in the IPC.
- The number of units on a plan may not exceed 224 units annually.
- Monthly visits to the participant's place of residence shall be required if a participant receives community living services. The participant shall be present during the visit.
- Quarterly visits to the participant's place of residence shall be required if a participant does not receive community living services. The participant shall be present during the visit. Monthly home visits may be completed if desired.
- Case managers may complete additional visits to the participant's place of residence during times of crisis, or when requested by the participant or legally authorized representative.

Conflict Free Case Management

In order for a case manager to have the authority to develop, implement, and monitor plans of care in the best interest of the participant, the case manager shall not have a conflict of interest. To address conflicts of interest, the Division has implemented exclusions for case managers, which are outlined in Chapter 45 of the Department of Health's Medicaid Rules. Relatives (defined as biological parents, step parents, or adoptive parents) and legally authorized representatives shall not provide case management services. Additionally, case managers shall not serve participants to whom they are related by blood or marriage within the third degree. Relationships within the third degree include the spouse; mother, father, sister, or brother in-law; children (including step and adoptive); siblings; grand and great grandparents; and aunts, uncles, nieces or nephews.

The Division may establish caseload limits to ensure the case manager effectively coordinates services with all participants on his or her caseload.



Targeted Case Management

Targeted Case Management (TCM) allows a case manager to be paid for the time that they spend working with a new waiver applicant. This service may be used while an applicant is applying for the waiver and after they have been placed on the waiting list. A targeted case manager may bill for up to 120 fifteen minute units of TCM per 12 month time period for new applicants. A case manager may provide and bill for the following functions:

- **Gathering Information:** Completing the level of care screening (LT104) and assisting the individual to gather necessary documentation, such as the ICAP assessment, medical records, psychological or neuropsychological assessment, etc. to enable the Division to determine eligibility.
- **Linkage:** Working with individuals and service providers to secure access to services. Activities include making telephone calls to agencies to arrange for appointments, or services following the initial referral process, and preparing new applicants and their families for these appointments.
- **Monitoring/Follow up:** Contacting the individual or others to ensure a new applicant is moving through the eligibility process, is still interested in pursuing a waiver spot, and that all demographic information is up to date in EMWS on an ongoing basis. It is expected that, while the applicant is on the waiting list, contact is made with some regularity to ensure that the applicant's needs are being met.
- **Referral:** Arranging initial appointments for individuals with service providers, informing individuals of services available, and providing addresses and telephone numbers of agencies and service providers.
- **Advocacy:** Providing advocacy for a specific person for the purpose of accessing needed services.
- **Crisis Intervention:** Providing crisis intervention and stabilization in situations requiring immediate attention or resolution for a specific individual
- **Direct service such as transportation is NOT a billable service.**

Case Manager Responsibilities for Institutional Placements

Case managers supporting a participant who is placed in the Wyoming State Hospital or Wyoming Life Resource Center must work with the assigned Participant Support Staff for that participant to understand the case manager's role in supporting the participant, as well as the documentation that will be required in order to bill for services during the institutional placement of the participant.



* Please note that prior authorization is required for waiver services.					
Service	Programs	Code(s)		Rate(s)	Unit
Child Habilitation Services	Comprehensive Waiver Supports Waiver • <i>May be participant-directed</i>	T2027 HA	Ages 0 – 12	\$3.58	15 Minute
		T2027	Ages 13 – 17	\$3.83	

Child habilitation services provide regularly scheduled activities and supervision to children for a portion of their day. Services include training, coordination, and intervention directed at skill development and maintenance, physical health promotion and maintenance, language development, cognitive development, socialization, social and community integration, and domestic and economic management. This includes services not otherwise available through public education programs in the participant's local school district, including after school supervision, daytime services when school is not in session, and services to preschool age children.

Services may be provided at various times of the day in multiple settings, when other waiver services would not be more appropriate, such as respite or personal care. Services may occur in a single physical environment or in multiple environments, including settings in the community.

The rate for children ages 0 – 12 includes the provision of supplementary staffing necessary to meet the child's exceptional care needs in a daycare setting. For children ages 13 – 17, this service is available for the cost of child care, which is no longer required after age 12.

Transportation is included in the reimbursement rate.

This is a habilitation service. This means that training on objectives is expected as part of the provision of services, and progress shall be documented and made available to the participant, legally authorized representative, and case manager each month.

Scope and Limitations

This service is limited to children under age 18. On the Comprehensive Waiver, there is an annual cap of 9,400 units a year. There is no service cap on the Supports Waiver. Services approved shall be based on assessed need and fit within the person's assigned budget. This service shall exclude any services available through public education programs funded under the Individuals with Disabilities Education Act (IDEA).

This service does not include the basic cost of child care, which is the rate charged by and paid to a child care center or worker for children who do not have special needs.

A provider staff member may receive reimbursement for up to two participants at one time, but shall limit the total combined number of persons to whom they are providing services to no more than three people, unless approved by the Division. The provider shall adhere to the supervision levels identified in each participant's IPC.



A relative provider (defined as a biological, adoptive, or step parent) shall not provide this service. Child habilitation services shall not be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the State Medicaid Agency.

Support with personal care needs, including medication assistance, is a component of the service, but may not comprise more than 20% of the service. Personal care services shall not be billed at the same time as child habilitation services.

This service is subject to electronic visit verification.



* Please note that prior authorization is required for waiver services.				
Service	Programs	Code(s)	Rate(s)	Unit
Cognitive Retraining	Comprehensive Waiver Supports Waiver Only available to participants with an acquired brain injury	H2014	\$13.30	15 Minute

Cognitive retraining provides training and rehabilitation services to the participant and family members that assists in the restoration of cognitive function (e.g. ability or skills for learning, analysis, memory, attention, concentration, orientation, and information processing) in accordance with the IPC. This service is specifically for individuals with an acquired brain injury (ABI), who meet the criteria outlined in Chapter 46, Section 5 of the Department of Health's Medicaid Rules.



* Please note that prior authorization is required for waiver services.					
Service	Programs	Code(s)		Rate(s)	Unit
Community Living Services	Comprehensive Waiver Supports Waiver (Basic level only) - May be participant-directed (excludes host homes) - Participant-directed services are limited to 15-minute units. Daily rates shall not be participant-directed.	T2017	Basic Individual	\$8.67	15 Minute
		T2017 UN	Basic – Group of two	\$4.65	
		T2017 UP	Basic – Group of three or more	\$3.45	
		T2031	Basic	\$133.66	Daily
		T2016	Level 3	\$141.58	
		T2016 U7	Level 4	\$173.54	
		T2016 TF	Level 5 Agency	\$278.03	
		T2016 U6	Level 5 Independent	\$253.68	
		T2016 TG	Level 6 Agency	\$475.93	
		T2016 U5	Level 6 Independent	\$433.54	
		T2016 UD	Host Home	\$255.01	
		T2017 UC	Participant-Directed Level 3 – 6		15 Minute

Community living services are individually-tailored supports that assist the participant with the acquisition, retention, or improvement of skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living including medication assistance, light housekeeping, community inclusion, transportation, adult educational supports, and social and leisure skill development that assist the participant to reside in the most integrated setting appropriate for their needs. Community living includes personal care, protective oversight, and supervision as indicated in the IPC.

- Community living services are reimbursed based on the Level of Service (LOS) score of the participant, and include some level of ongoing 24-hour support (i.e., 24-hour on-call support) by a provider, as defined in the level of service and outlined in the IPC.
- Community living services may be furnished in a setting owned or leased by a provider, participant, or the participant's family. Basic community living services may be provided in the family home.
- Provider owned or leased settings where community living services are furnished shall be fully accessible to the individuals living in that setting.
- With the exception of host homes, community living services may be delivered through participant-direction.
- Participant's receiving community living services shall have one primary residence.



- Transportation between the participant's place of residence, other service sites, or places in the community is included in the rate.
- Community living is a habilitation service. This means training on objectives is expected as part of the provision of services, and progress shall be documented and made available to the participant, legally authorized representative, and case manager each month.
- Family visits and trips are encouraged. The provider shall be reimbursed on the days the participant leaves for and returns from a trip.
- Health related services may be provided after staff are trained by the appropriate trainer or medical professional, and documentation of training is evident.

As authorized in 42 U.S.C 1396a(h), this service may be provided in an acute care hospital if the services are:

- Identified in the participant's IPC;
- Provided to meet needs of the participant that are not met through the provision of acute care hospital services;
- Not a substitute for services that the acute care hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and
- Designed to ensure smooth transitions between the acute care setting and the home and community-based settings, and to preserve the individual's functional abilities.

Case managers and providers must coordinate with hospital staff and plan of care team members in order to ensure that the participant's transition from a temporary hospital stay to their home is seamless.

Host Home

Host home services consist of participant specific, individually designed and coordinated services within a family (other than biological, step or adoptive parents) host home environment. Host homes differ from other community living settings by featuring one sponsor working with one participant living together in the sponsor's home. A sponsor is defined as an individual who is an independent certified provider to one person in their home. The sponsor is the only residential provider for the participant, does not employ staff, and is not a subcontractor. This service is not open to new participants without going through the Extraordinary Care Committee (ECC) approval process for an out of home placement. The provider is the primary caregiver and assumes 24-hour care of the individual. Relative providers (defined as biological, step, or adoptive parents) shall not provide this service. Host home services shall not be participant-directed.

Tiered Levels

A participant receives a tiered service approved in the IPC based upon need, according to the following tiers descriptions. Tier levels for this service align with the assessed LOS for the participant, and the expectations of the service as specified in the definition. All supervision and supports delivered shall align with the participant's IPC, and meet the needs of each participant present as appropriate to assure health and safety.



Basic Level – Due to a high to moderately high level of independence and functioning, and few significant behavioral or medical issues that require minimal staff support, monitoring, or personal care, this tier requires periodic staff availability on-site and meeting periodically with the participant during awake hours on each day billed to provide general supervision, support, monitoring, and training. On-call 24-hour support is not required for this tier level, but a contingency plan for emergency situations must be outlined in the IPC. Personal care shall not exceed 20% of the provided service.

This service may be provided through virtual supports. The participant and legally authorized representative must have a choice in where and how the service will be received, and it must be documented in the participant's IPC. Documentation shall demonstrate that opportunities for community integration, support for employment, and social interactions are still incorporated in the participant's life. If remote monitoring does not facilitate the wishes and desires of a participant, it is not an option. Providers and plan of care teams must follow all requirements and standards established in the HCBS Waiver Virtual Supports document, which is located on the [Service Definitions and Rates](#) page of the HCBS Section website.

Level 3 – Due to moderate functional limitations in activities of daily living, and possible behavioral support needs, this tier requires regular staff availability on-site within hearing distance of the participant, and meeting periodically with the participant on each day billed for general supervision, support, personal care, positive behavior support, monitoring, and training. Staff support shall be available through the night, and overnight expectations shall be stipulated in the IPC.

Level 4 – Due to significant functional limitations and medical or behavioral support needs, this tier requires full-time staff to be on-site when the participant is in this service, with regular personal attention given throughout the day for training, personal care, reinforcement, positive behavior support, and community or social activities. Behavioral and medical supports are not generally intense and may be provided in a shared staffing setting. There shall be staff support through the night as indicated in the IPC.

Level 5 – Due to significant and somewhat intensive functional limitations and medical or behavioral support needs, this tier requires one or more full-time staff support to be on-site and in close proximity during most awake hours when the participant is in this service, with frequent personal attention given throughout the day for training, personal care, reinforcement, and community or social activities. Behavioral and medical supports or personal care may be somewhat intense, but service may be provided in a smaller shared staffing setting. There shall be staff support in the residence through the night, as indicated in the IPC. Participants who receive this service tier shall not be eligible for remote monitoring.

Level 6 – Due to the high medical, behavioral, or personal care needs, this tier requires frequent personal support and supervision with full-time staff on-site and within immediate proximity during most awake hours. The expectation is that the participant shall receive the personal attention of at least one staff person unless otherwise outlined in the IPC and approved by the Division. Occasional 2:1 support is included in this rate, and shall be specified in the IPC. There shall be staff support in the residence through the night, as indicated in the IPC. Participants who receive this service tier shall not be eligible for remote monitoring.

Remote Monitoring

Remote monitoring, as specifically defined in the HCBS Waiver Remote Monitoring Requirements, may be utilized for supervision for individuals at the **Basic Daily Level, Level 3, or Level 4 tier**. Remote monitoring



will be based on an individual risk assessment and protocol, and as outlined in the IPC. Remote monitoring shall be reviewed by the Division prior to implementation. Providers and plan of care teams must follow all requirements and standards established in the HCBS Waiver Remote Monitoring Requirements document, which is located on the [Services Definitions and Rates](#) page of the HCBS Section website.

In order to consider remote monitoring as a support for the participant:

- The participant must have an informed choice between in person and remote support services.
- The participant must choose service delivery through remote monitoring, and that choice must be documented in the participant's IPC, and demonstrated through a signed consent form.
- Remote monitoring must fit within the scope and definition of the community living service being received.
- Remote monitoring must not be used for the provider's convenience. The option must be used to support a participant to reach identified outcomes in the participant's IPC.
- The use of the remote monitoring option must not block, prohibit or discourage the use of in-person services or access to the community. Participants must be encouraged to engage with friends and family and actively participate in their community.
- If remote monitoring does not facilitate the wishes and desires of a participant, it is not an option.

Scope and Limitations

Participants shall be at least 18 years old to receive community living services. Services shall not duplicate or replace services covered under IDEA or through Department of Family Services programs.

Community living is a 24-hour service. The following requirement shall be met in order for payment to be allowed:

- Basic daily rate – a minimum of four hours of documented service per calendar day.
- Levels 3 – 6 daily rate – a minimum of eight hours of documented staff support, in the residence during awake and asleep hours, in a 24-hour period (from 12:00am-11:59pm).

Community living basic services can be billed as a 15 minute unit for a maximum of 4,745 units per plan year for individual services, or for a maximum of 5,475 per plan year for group services. The 15-minute unit and daily rate shall not be billed for a participant on the same day.

Participants who choose remote monitoring as a supervision option shall complete a risk assessment and develop a remote monitoring protocol prior to utilization. Additional standards shall apply to providers that implement remote monitoring practices.

Participants who are not receiving Levels 3-6 community living services, and who are at significant risk due to extraordinary needs that cannot be met in their current living arrangement, may request 24-hour community living services if the participant meets the definition of an emergency outlined in Chapter 46, Section 14 of the Department of Health's Medicaid Rules.

Support with personal care needs is a component of community living services, so service times for community living services and personal care services shall not overlap.



Payment shall not be made for the cost of room and board, including the cost of building maintenance, upkeep, and improvement. The method by which the costs of room and board are excluded from payment for community living services is specified in Appendix I-5 of the Comprehensive and Supports Waiver applications.

A relative provider (defined as the biological, adoptive, or step parent of a participant) may provide all components of this service as defined, but shall form a Limited Liability Company (LLC) or a corporation, be a certified provider or an employee of a certified provider, and shall not reside in the same residence as the participant.



*** Please note that prior authorization is required for waiver services.**

Service	Programs	Code(s)	Rate(s)	Unit
Community Support Services	Comprehensive Waiver Supports Waiver	T2021 Basic	\$2.77	15 Minute
		T2021 U1 Intermediate	\$4.17	
		T2021 HB High	\$8.93	
		T2020 Basic	\$66.37	Daily
		T2020 U3 Intermediate	\$100.15	
		T2020 U4 High	\$214.34	

Community support services offer assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills. Services include activities designed to keep participants engaged in their environment, develop and maintain relationships, and build on previously learned skills. Services shall be furnished consistent with the participant's IPC, and include full access to the community to the same degree as community members who do not receive Medicaid home and community based services. Adult educational supports are an approved activity of this service.

Community support services shall not be scheduled or provided in the participant's private residence. Services shall be furnished in a variety of settings in the community, and shall not be limited to only fixed-site or congregate settings. Activities and environments shall foster the acquisition of skills, appropriate behavior, greater independence, community networking, and personal choice. Transportation is a component of community support services and is included in the rate to providers.

Community support services shall focus on enabling the participant to attain or maintain his or her maximum functional level, and shall serve to reinforce skills or lessons taught in other settings, including skills learned during therapy services. Participants shall not be paid for work activities performed during this service. Community support is a habilitation service. Training on objectives, which shall be focused on community access, is expected as part of the provision of services, and progress shall be documented and made available to the participant, legally authorized representative, and case manager each month.

Community support services are reimbursed as a 15-minute or daily rate.

A participant receives a tiered service approved in the IPC based upon need, according to the following tier descriptions:

Basic Level of Care

A participant with a Level 1 or 2 Level of Service (LOS) score will generally be in this tier. This service tier requires limited staff supports for, and personal attention to, a participant daily due to a moderately high level of independence and functioning. Behavioral needs, if any, can be met with medication or informal direction by staff. The person may have periods of time with indirect staff supervision where staff are onsite and available through hearing distance of a request.



Intermediate Level of Care

A participant with a Level 3 or 4 LOS will generally be in this tier. Service tier requires full-time heightened supervision with staff available as indicated in the IPC due to significant functional limitations, or medical or behavioral needs. Behavioral and medical supports are not generally intense and can be provided in a shared staffing environment. Regular personal attention is given throughout the day for personal care, reinforcement, community, or social activities.

High Level of Care

A participant with a Level 5 or 6 LOS will generally be in this tier. Service tier requires full-time supervision with staff available within close proximity and as indicated in the IPC. Frequent staff interaction and personal attention for significant functional limitations and medical or behavioral needs shall be provided. Support and supervision needs are moderately intense, but can still generally be provided in a shared staffing environment unless otherwise specified in the IPC. Frequent personal attention shall be given throughout the day for reinforcement, positive behavior support, personal care, community, or social activities.

Scope and Limitations

Community support services shall be available for participants ages 18 and older. Services shall not duplicate or replace services covered under IDEA. Evidence demonstrating that school district services have been exhausted (graduation certificate) must be submitted for participants under the age of 21. Approved units shall be based on individual level of support need, and shall fit within the person's assigned budget. A minimum of six hours per day must be provided in order to bill the daily rate. The 15-minute and daily rate shall not be billed on the same day.

The high level of care tiered rate for community support services shall be available to participants who want help building meaningful relationships and social connections in the community with a more individualized approach from the provider. A participant with any LOS score may add the high level of care rate for this service to the IPC for individual services with up to one other waiver participant, during which the entire time is spent solely in the community and not in a provider setting.

A relative provider (defined as a biological, adoptive, or step parent) may provide this service subject to compliance with Chapter 45, Section 31 of the Department of Health's Medicaid Rules. Community support services shall not be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the State Medicaid Agency.

Support with personal care needs, including medication assistance, is a component of the service, but shall not comprise more than 20% of the service. Personal care services shall not be billed at the same time as this service.

A participant's IPC may include two or more non-community living services as long as service times do not overlap. Services shall not exceed an average weekly amount of 35 hours if the individual receives level 3 – 6 community living services. The daily rate shall not be billed if the participant receives level 3 – 6 of community living services and is receiving other non-community living services during the day.



* Please note that prior authorization is required for waiver services.					
Service	Programs	Code(s)		Rate(s)	Unit
Companion Services	Comprehensive Waiver Supports Waiver • <i>May be participant-directed</i>	S5135	Individual	\$7.45	15 minute
		S5135 TT	Group up to 3	\$3.14	

Companion services include supervision, socialization, and assistance for a participant to maintain safety in the home and community, and to enhance independence. Companions may assist or supervise the participant with tasks such as meal preparation, laundry, and shopping, but do not perform these activities as discrete services. Companions may also perform light housekeeping tasks that are incidental to the care and supervision of the participant. The provision of companion services does not entail hands-on nursing care, but does include personal care such as medication assistance, and assistance with activities of daily living, as needed, during the provision of services. Routine transportation is included in the reimbursement rate.

As authorized in 42 U.S.C 1396a(h), this service may be provided in an acute care hospital if the services are:

- Identified in the participant's IPC;
- Provided to meet needs of the participant that are not met through the provision of acute care hospital services;
- Not a substitute for services that the acute care hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and
- Designed to ensure smooth transitions between the acute care setting and the home and community-based settings, and to preserve the individual's functional abilities.

Case managers and providers must coordinate with hospital staff and plan of care team members in order to ensure that the participant's transition from a temporary hospital stay to their home is seamless.

Scope and Limitations

This service is available to participants ages 18 and older. It is reimbursed at a 15-minute unit and is available as a 1:1 service or as a group rate serving two or three people. Service shall be provided for no more than nine hours a day except for special events or out of town trips. This service shall not be used in conjunction with community living services, so services times shall not overlap. This service shall not be used to provide monitoring while a participant sleeps or to support a person while they are working.

Companion services provided to participants ages 18 – 21 shall not duplicate or replace services that are covered under IDEA. Services shall not be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit.

Relative providers (defined as biological, adoptive, or step parents) shall not provide this service.



A participant's IPC may include two or more non-community living services as long as service times do not overlap. Services shall not exceed an average weekly amount of 35 hours if the individual receives level 3 – 6 community living services.

This service is subject to electronic visit verification.



*** Please note that prior authorization is required for waiver services.**

Service	Programs	Code(s)	Rate(s)	Unit
Crisis Intervention Support	Comprehensive Waiver Supports Waiver	H2011	\$8.81	15 Minute

Crisis intervention services are available for situations in which a participant's tier level may not provide sufficient support for specific activities, medical conditions, or occurrences of challenging behavior or crisis, but extensive supervision is not needed at all times. Crisis intervention provides funding for extra staff support in order to respond to a potential emerging behavioral emergency, to supervise a participant during times of periodic behavioral episodes when the person is a danger to themselves or others, or if the participant has an occasional or temporary medical situation and is at risk of imminent harm without the extra staff support. Intervention for behavioral purposes is not intended for monitoring the person should the behavior occur, but for the purpose of supporting the participant when the need arises, using positive behavior supports and interventions outlined in the IPC to de-escalate a situation, teach appropriate behaviors, and keep the participant safe until he or she is stable.

Scope and Limitations

The service shall only be provided to a participant age 18 years or older in community living services levels 3 – 5 or habilitation day services. Due to the expectation that participants in level 6 community living services shall receive the attention of at least one to two staff members as specified in the plan of care, this level of service is not eligible for crisis intervention.

Crisis intervention units shall be based on verified need and evidence of the diagnosis or condition requiring this service. Documentation of progress, and data on behavior and outcomes of the intervention services, must be submitted to the case manager and Division at the frequency specified in the IPC.

Relatives (defined as biological, adoptive, or step parents) shall not provide this service.



* Please note that prior authorization is required for waiver services.				
Service	Programs	Code(s)	Rate(s)	Unit
Dietician Services	Comprehensive Waiver Supports Waiver	S9470	\$30.85	Session

Dietician services shall be provided by a registered dietician, and include services such as menu planning, consultation with and training for caregivers, and participant education. The service does not include the cost of meals. This service shall be cost effective and necessary to prevent institutionalization.

Scope and Limitations

Dietician services are available for participants who are 21 and older. Participants under the age of 21 can access this service through Early Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

Dietician services are available on the Medicaid State Plan; therefore, the waiver service shall not be used unless the state plan services are exhausted. Dietician services shall be designated in the participant's IPC. Services shall be supported by a formal assessment completed by a registered dietician, and ordered by a licensed medical professional. Referrals and claims billed for this service shall include the referring entity's NPI number. A third party liability form shall be required.

Relative providers (defined as biological, adoptive, and step parents) shall not provide this service.

At least 30 minutes of service shall be provided per session in order to bill.



* Please note that prior authorization is required for waiver services.					
Service	Programs	Code(s)		Rate(s)	Unit
Environmental Modification	Comprehensive Waiver Supports Waiver	S5165 NU	New	PA#	Per Event
		S5165	Repair		

Environmental modifications include physical adaptations to the private residence of the participant or the participant's family, as outlined in the participant's IPC, that are necessary to ensure the health, welfare, and safety of the participant, or that enable the participant to function with greater independence in the home. Adaptations include the installation of ramps and grab-bars, widening of doorways, and modifications to bathroom facilities for the purpose of participant accessibility. All services shall be provided in accordance with applicable State or local building codes.

Pursuant to Chapter 44, Section 5 of the Department of Health's Medicaid Rules, environmental modification shall meet at least two of the following criteria:

- Be functionally necessary.
- Contribute to a participant's ability to remain in or return to his or her home, and out of an intermediate care facility for individuals with intellectual or developmental disabilities (ICF/IID) setting.
- Be necessary to ensure the participant's health, welfare, and safety.

Scope and Limitations

A lifetime cap of \$20,000 per family for any current or previous Developmental Disability waiver will be calculated for purchases made after July 1, 2013.

Environmental modifications that shall not be covered include, but are not limited to:

- Modifications to a residence that are of general utility or are primarily for the convenience of persons other than the participant, such as caregivers or family members;
- Modifications to a residence that are not of direct medical or functional benefit to the participant;
- Modifications to a residence when the cost of such modifications exceeds the value of the residence before the modification; and
- Modifications that are covered by another funding source.

Excluded modification include, but are not limited to the installation or repair of carpeting; roof repair or replacement; air conditioning; installation or repair of carports, porches, patios, garages, porticos, decks; installation of pools, hot tubs, or spas; landscaping or yardwork; pest extermination; modifications that are part of new construction; repair or replacement of structural building components; and window replacements.

Modifications that add to the total square footage of the home are excluded from this benefit, except when necessary to complete an adaptation (e.g., in order to improve entrance or egress to a residence or to configure a bathroom to accommodate a wheelchair). Modifications of rented or leased homes shall be extraordinary alterations that are uniquely needed by the individual, and for which the property owner would not ordinarily be responsible.



Case managers are required to determine that the requested modification is not covered by another funding source. The provider must then sign a third party verification form indicating that the waiver is the payer of last resort. Home accessibility adaptations shall not be furnished to modify settings that are owned or leased by providers of waiver services.

Pursuant to Chapter 44 of the Department of Health's Medicaid Rules, the case manager shall not obtain quotes until the overall scope of the project is approved by the Division. The Division may use a third party to conduct a site inspection to assess the proposed modification and need for the modification to ensure cost effectiveness.

Relative providers (defined as biological, adoptive, or step parents) may provide this service in accordance with Chapter 45 of the Department of Health's Medicaid Rules, adhering to the following requirements:

- They are a certified Medicaid waiver environmental modification provider; and
- The Division receives at least one other bid from another provider to ensure cost effectiveness.



* Please note that prior authorization is required for waiver services.				
Service	Programs	Code(s)	Rate(s)	Unit
Homemaker Services	Comprehensive Waiver Supports Waiver	S5130	\$6.49	15 Minute
	May be participant-directed			

Homemaker services consist of chore-type activities such as meal preparation and routine household care. Services shall be available when the individual who is regularly responsible for these activities is temporarily unavailable or unable to manage the home and care for him or herself or others in the home. Homemaker is not a direct care service, so other waiver direct care services can be provided by a different provider or provider staff during the same time frame.

Scope and Limitations

A maximum of three hours per week per household (624 units per year) is allowed. Relative providers (defined as biological, adoptive, and step parents) shall not provide this service.

This service is not available to participants who receive special family habilitation home, host home, or CLS level 3 – 6 services.

- A provider of homemaker services shall not bill for two participants during the same time frame.

*** Please note that prior authorization is required for waiver services.**

Service	Programs	Code(s)	Rate(s)	Unit
Individual Habilitation Training	Comprehensive Waiver Supports Waiver <i>May be participant-directed</i>	T2038	\$7.34	15 Minute

Individual habilitation training is a specialized 1:1 intensive training service to assist a participant with the acquisition or improvement in skills not yet mastered that will lead to more independence and a higher level of functioning. Individual habilitation training services are available for participants who live with unpaid caregivers or who need less than 24-hour paid supervision and support.

- Training objectives are required, must be meaningful to the participant, and may include: adaptive skill development; assistance and training on activities of daily living; transportation safety and navigation; building social capital and connections; and hobby skill development for work on fine or gross motor skills.
- Objectives must be specific and measureable, and data must be tracked and analyzed for trends. Summary reports on progress or lack of progress must be provided to the case manager and participant or guardian monthly. Objectives shall be revised as needed when skills are acquired or the objective is not yielding any progress.
- Services may be provided in the participant's home or in the community.
- Supports may include inclusion within a community group or volunteer organization; opportunities for the participant to join associations and community groups; opportunities for inclusion in a broad range of community activities including opportunities to pursue social and cultural interests, choice making, and volunteer time.
- Transportation relating to the participant's training objective shall be provided by the service provider and is included in the rate for the service.
- This service includes services not otherwise available through IDEA or other public education programs in the participant's local school district, including after school supervision, daytime services when school is not in session, and services to preschool age children.

Scope and Limitations

Individual habilitation training is an intensive training service; therefore, it is expected that training is occurring at all times this service is being provided. If the participant is unable to sustain intensive training, the IPC shall identify an alternate service to be used during times in which supervision is provided but training is not conducted. Individual Habilitation Training is a 1:1 service. It is available to participant's ages 0 – 20, and shall be approved based upon the participant's needs and budget limit. Individual habilitation training is limited to four hours a day.

Relative providers (defined as a biological, adoptive, or step parent) shall not provide this service.

Individual habilitation training shall not be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the State Medicaid Agency.



* Please note that prior authorization is required for waiver services.					
Service	Programs	Code(s)		Rate(s)	Unit
Occupational Therapy	Comprehensive Waiver Supports Waiver	97139	Individual	\$24.68	15 Minute
		97150	Group	\$18.43	Session

Occupational therapy services consist of the full range of activities provided by a licensed occupational therapist. Services include assessing needs, developing a treatment plan, determining therapeutic intervention, and training and assisting with adaptive aids. Occupational therapy services through the waiver may be used for maintenance and the prevention of regression of skills.

Scope and Limitations

Occupational therapy services are available for participants who are 21 and older. Participants under the age of 21 can access this service through Early Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

Units shall be subject to prior authorization, and require a prescription and treatment letter or recommendation from a licensed medical professional. Referrals and claims billed for this service must include the referring entity's NPI number. Restorative services are available on the Medicaid State Plan. Maintenance therapy may be provided under the waiver, and shall be supported with a third party liability form. Medicaid State Plan restorative therapy and waiver maintenance therapy shall not be billed on the same day.

Relative providers (defined as biological, adoptive, or step parents) shall not provide this service.

Services are available as an individual 15-minute unit or as a group session unit, which requires a minimum of 30 minutes in service in order to bill.



* Please note that prior authorization is required for waiver services.				
Service	Programs	Code(s)	Rate(s)	Unit
Personal Care Services	Comprehensive Waiver Supports Waiver May be participant-directed	T1019	\$7.22	15 Minute

Personal care services consist of a range of assistance to enable participants to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may include hands-on assistance or prompting the participant to perform a task. Personal care services may be provided on an episodic or on a continuing basis. Health-related services that may be provided include care relating to medical or health protocols, medication assistance or administration, and range of motion exercises. Health related services may be provided after staff are trained by the appropriate trainer or medical professional, and documentation of training is evident.

Personal care services may include assistance in performing activities of daily living (i.e., bathing, dressing, personal hygiene, bathroom assistance, transferring, maintaining continence) and more complex instrumental activities of daily living on the participant's property (i.e., light housework, laundry, meal preparation exclusive of the cost of the meal, medication and money management).

The participant shall be physically present during this service. Personal care services shall be provided in the participant's home or on their property. Personal care services shall be essential to the health and welfare of the participant rather than the participant's family. If the individual providing this service is not employed and supervised by an agency, then the participant is responsible for supervising the individual and may coordinate monitoring of the service with their case manager.

As authorized in 42 U.S.C 1396a(h), this service may be provided in an acute care hospital if the services are:

- Identified in the participant's IPC;
- Provided to meet needs of the participant that are not met through the provision of acute care hospital services;
- Not a substitute for services that the acute care hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and
- Designed to ensure smooth transitions between the acute care setting and the home and community-based settings, and to preserve the individual's functional abilities.

Case managers and providers must coordinate with hospital staff and plan of care team members in order to ensure that the participant's transition from a temporary hospital stay to their home is seamless.

Scope and Limitations

This service is available to all ages, and is a 1:1 service. The number of personal care service units authorized by the Division will be based upon individual extraordinary care needs as specified in the IPC



and other assessments. On the Comprehensive Waiver, there is an annual cap of 7,280 units. There is no cap on the Supports Waiver.

Personal care services are included in adult day, companion, child habilitation, community support, supported employment, and community living services. Personal care services cannot be billed during the same time frame as other waiver services, which is subject to audit by the Program Integrity Unit within the State Medicaid Agency. Personal care services shall not be provided on the same IPC as special family habilitation home or host home services. Waiver participants who need personal care services shall utilize providers that can provide the type, amount, and flexible hours of services deemed most appropriate for them.

A relative provider (defined as a biological, adoptive, or step parent) may provide this service with certain restrictions:

- A relative shall only provide this service if they are either a certified provider and form a limited liability company (LLC) or other corporation, or they work for a certified provider.
- The number of units approved for a relative provider will depend on the individual needs of the participant and shall not exceed four hours per day or 5,840 units per year. The number of service units shall be justified in the IPC.
- If the participant is under 18 years of age, the provision of personal care services by a relative shall only be authorized for assessed extraordinary care services as documented in the IPC.

Extraordinary care cases shall meet the following criteria:

1. The participant's Adaptive Behavior Quotient is 0.35 or lower on the Inventory for Client and Agency Planning (ICAP) assessment; and
2. The participant needs assistance with activities of daily living (ADLs) or instrumental activities of daily living (IADLs) exceeding the range of expected activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, which are necessary to assure the health and welfare of the participant, and which will avoid institutionalization. (Example: a 12 year old needing assistance with dressing and bathing, whereas the average 12 year old does not.); or
3. The participant requires care from a person with specialized medical skills relating to the participant's diagnosis or medical condition as determined appropriate by the participant's medical professional and the Division.

A legally authorized representative of a person under the age of 18 may provide personal care services to their ward if they meet the restrictions noted above. A legally authorized representative shall not be authorized to provide personal care services to an individual 18 years of age or older. If a legally authorized representative is providing personal care services to their minor ward, the IPC shall be developed and monitored by a case manager without a conflict of interest to ensure the provision of services is in the best interest of the participant.

Relative providers and legally authorized representatives shall not provide this service through participant-direction.

The IPC shall state that services do not duplicate similar services, natural supports, or services otherwise available to the participant.



Transportation costs are not included as part of this service.

This service is subject to electronic visit verification.



*** Please note that prior authorization is required for waiver services.**

Service	Programs	Code(s)		Rate(s)	Unit
Physical Therapy	Comprehensive Waiver Supports Waiver	97110	Individual	\$29.11	15 Minute
		97150	Group	\$18.43	Session

Physical therapy services consist of the full range of activities provided by a licensed physical therapist. This service assists participants to preserve and improve their abilities for independent function such as range of motion, strength, tolerance, and coordination. It may also prevent, insofar as possible, progressive disabilities through the use of assistive and adaptive devices, positioning, and sensory stimulation.

Scope and Limitations

Physical therapy services are available for participants who are 21 and older. Participants under the age of 21 can access this service through Early Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

Units shall be subject to prior authorization, and require a prescription and treatment letter or recommendation from a licensed medical professional. Referrals and claims billed for this service shall include the referring entity's NPI number. Restorative services are available on the Medicaid State Plan. Maintenance therapy may be provided under the waiver, and shall be supported with a third party liability form. Medicaid State Plan restorative therapy and waiver maintenance therapy shall not be billed on the same day.

Relative providers (defined as biological, adoptive, or step parents) shall not provide this service.

Services are available as an individual 15-minute unit or as a group session unit, which requires a minimum of 30 minutes in service in order to bill.



* Please note that prior authorization is required for waiver services.					
Service	Programs	Code(s)		Rate(s)	Unit
Respite	Comprehensive Waiver Supports Waiver - May be participant-directed - Participant-directed services are limited to 15-minute units. Daily rates shall not be participant-directed.	T1005	Individual	\$7.35	15 Minute
		T1005HQ	Group of 2	\$4.15	
		S5151	Individual	\$264.67	Daily
		S5151U8	Group of 2	\$149.26	

Respite services are intended to be utilized on a short-term basis to provide relief for an unpaid or primary caregiver from the daily burdens of care. Respite includes assistance with personal care and activities of daily living (ADLs), medication assistance if needed, and supervision.

Respite may be provided in the caregiver's home, the provider's home, or in community settings. The respite setting and services shall support the identified needs of the participant. Respite shall only be provided for up to two participants at the same time. Three participants may be supported in this service if they are family members, live in the same household, and can be safely supported by one provider. A provider of respite services may also provide supervision to other children under the age of 12, or other individuals requiring support and supervision, but shall limit the total combined number of people for whom they are providing services to no more than three, unless approved by the Division. The provider shall adhere to the supervision levels identified in each participant's IPC.

Routine transportation is included in the service rate.

Respite is reimbursed as a 15-minute unit or a daily rate.

Scope and Limitations

Respite shall not be used to substitute care while the primary caregiver is at work, or during services otherwise available through public education programs including education activities, after school supervision, daytime services when the school is not in session, or services to preschool age children. The participant may choose to receive a more appropriate service, such as child habilitation or companion services, for supports and supervision while their primary caregiver is working. Respite shall not replace community living or day services.

Respite shall not be billed at the same time as any other waiver service. This prohibition includes billing for or providing respite on the same day the participant receives a daily unit of community living services.

Respite shall not be provided to individuals under the age of 18 and individuals 18 and older at the same time. When participants are members of the same family, respite may be provided to adults and children at the same time with Division approval. In these situations, a detailed description of how respite will be provided must be included in each participant's IPC.



On the Comprehensive Waiver, there is an annual cap of 5,616 individual 15-minute units. Each daily unit counts as 48 units against the 5,616 individual 15-minute units. There is no service cap on the Supports Waiver.

- The 15-minute and daily rate shall not be billed for a participant on the same day.
- Respite provided for 9 hours or less must be billed as a 15-minute unit. Any use of respite over nine hours a day must be billed as a daily unit. This includes services that are delivered by more than one provider.
- Approved service units are based upon the participant's need and budget limit
- Relative providers (defined as biological, adoptive, or step parents) shall not provide this service.
- Respite services shall not be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the State Medicaid Agency.

This service is subject to electronic visit verification.



* Please note that prior authorization is required for waiver services.				
Service	Programs	Code(s)	Rate(s)	Unit
Skilled Nursing Services	Comprehensive Waiver Supports Waiver	T1002	\$19.38	15 Minute
	Skilled Nursing Assessment	T1001	\$77.52	Session

Skilled nursing services are medical care services delivered on an intermittent or part time basis to individuals with complex chronic medical conditions, which are performed within the nurses' scope of practice as defined by Wyoming's Nurse Practice Act. Skilled Nursing services must meet the scope and nature of the services provided under the Medicaid State Plan, and may only be available when State Plan services are exhausted.

Services must require a level of expertise that is undeliverable by non-medically trained individuals, and must be supported by an order from a licensed medical professional. Referrals and claims billed for this service shall include the referring entity's NPI number. The form required by the Division must be submitted to the Division contractor that approves skilled nursing services, and prior authorization must be obtained before services can be added to the IPC.

An annual skilled nursing assessment, with a maximum of one (1) unit per plan year, may be added to the IPC. An in-person assessment of the individual's skilled nursing needs is required as part of the assessment, and a the form required by the Division, which includes a plan to address the identified needs, must be submitted in order to bill for the assessment or request prior authorization of skilled nursing services.

Scope and Limitations

Skilled nursing services are available for participants who are 21 and older. Participants under the age of 21 can access this service through Early Periodic Screening, Diagnostic, and Treatment (EPSDT) services. Skilled nursing services are an extension of the Medicaid State Plan and require a prior authorization approval letter before services can be added to a participant's plan. The prior authorization approval letter will include the number of units that have been approved for the participant's plan.

- A billable skilled nursing service unit is considered to be a service that is provided up to 15 minutes and that involves one-on-one direct participant care.
- Providers cannot be reimbursed for skilled nursing services that do not include direct participant care, or services that do not include skilled nursing duties. For example, skilled nursing providers cannot be reimbursed for participant supervision, transportation to and from medical appointments, time spent in a waiting room with the participant, or time spent charting or completing paperwork.
- Relative providers (defined as biological, adoptive, or step parents) shall not provide this service.
- Certified Nursing Assistants and other non-licensed individuals shall not provide this service.

This service is subject to electronic visit verification



* Please note that prior authorization is required for waiver services.					
Service	Programs	Code(s)		Rate(s)	Unit
Specialized Equipment	Comprehensive Waiver Supports Waiver	T2029NU	New	PA#	Per Event
		T2029	Repair		
		Annual Cap \$2,000			

Specialized equipment includes:

1. Devices, controls, or appliances that enable participants to increase their ability to perform activities of daily living;
2. Devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment or community in which they live;
3. Items necessary for life support or to address physical conditions, including ancillary supplies and equipment necessary for the proper functioning of such items;
4. Other durable and non-durable medical equipment not available under the Medicaid State Plan or Individualized Educational Plan (IEP) that is necessary to address participant functional limitations; and,
5. Necessary medical supplies not available under the Medicaid State Plan or other insurance held by the participant. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the Medicaid State Plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.

The IPC shall reflect the need for equipment, how the equipment addresses health, safety, or accessibility needs of the participant or allows them to function with greater independence, and specific information on how often and where the equipment is used. Criteria for approval and the limitations on this service are outlined in Chapter 44 of the Department of Health's Medicaid Rules. The case manager shall check with Medicaid, Medicare, and/or a participant's other insurance carrier to see if the requested equipment is covered under their plans. Waiver funds are a payer of last resort.

If the participant has an IEP or Individualized Family Service Plan, the case manager will be required to submit a copy of that document, along with documentation as to why the equipment is not available through those services.

Specialized equipment shall be functionally necessary and meet at least two of the following criteria and is subject to the Division approval:

1. Be necessary to increase the participant's ability to perform activities of daily living or to perceive control, or communicate with the environment in which the person lives;
2. Be necessary to enable the participant to function with greater independence and without which the person would require institutionalization; or
3. Be necessary to ensure the person's health, welfare, and safety.

Relative providers (defined as biological, adoptive, and step parents) may provide this service with the following requirements:

- They are a certified Medicaid waiver specialized equipment provider; and



- They do not impose a mark-up to the total cost of the equipment when providing this service to their relative (unless they operate a non-profit corporation); and
- They receive at least one other bid from another provider to ensure cost effectiveness.

Scope and Limitations

Specialized equipment has a \$2,000 annual limit and is subject to prior authorization through the Division. The cost of the assessment must be funded as a part of the \$2,000 cap.

Specialized equipment shall not include the following, even if prescribed by a licensed medical professional:

- Items paid for by any other entity;
- Educational or therapy items that are an extension of services provided by the local school district or the Department of Education;
- Items of general use that are not specific to a disability, or that would normally be available to any child or adult; and
- Items of recreational or diversional use.

Items that are not funded through specialized equipment services include, but are not limited to furniture; appliances; games; toys; human-powered and motorized vehicles; books; clothing; pools and hot tubs; computers and computer equipment; iPads and other tablet; corrective lenses; and telecommunication devices and services.

Case managers are required to determine that the specialized equipment is not covered through another funding source prior to submitting a request for the Division to pay for the equipment. The provider must then sign a third party verification form indicating that the waiver is the payer of last resort. In accordance with Chapter 45, Section 5 of the Department of Health's Medicaid Rules, any provider of specialized equipment must have a certification or licensure for the type of equipment they are providing in order to deliver this waiver service.

The purchase of electronic technology devices shall be allowed once every five years, and like items shall not be purchased during those five years unless the device is used as a primary means for communication and the request is accompanied by a letter of necessity from a Speech Language Pathologist. The Division shall limit the purchase of general items (i.e., iPad, electronic tablet), and shall require a written recommendation by a CSE professional before such an item is approved.



*** Please note that prior authorization is required for waiver services.**

Service	Programs	Code(s)		Rate(s)	Unit
Speech, Language, and Hearing Services	Comprehensive Waiver Supports Waiver	92507	Individual	\$42.02	Session
		92508	Group	\$15.73	

Speech, hearing, and language services consist of the full range of activities provided by a licensed speech therapist. Services include screening and evaluation of participants with respect to speech function; development of therapeutic treatment plans; direct therapeutic intervention; selection, assistance, and training with augmentative communication devices, and the provision of ongoing therapy.

Scope and Limitations

Speech, hearing, and language services are available for participants who are 21 and older. Participants under the age of 21 can access this service through Early Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

Units shall be subject to prior authorization, and require a prescription and treatment letter or recommendation from a licensed medical professional. Referrals and claims billed for this service shall include the referring entity's NPI number. Restorative services are available on the Medicaid State Plan. Maintenance therapy may be provided under the waiver, and shall be supported with a third party liability form. Medicaid State Plan restorative therapy and waiver maintenance therapy shall not be billed on the same day.

Relative providers (defined as biological, adoptive, or step parents) shall not provide this service.

Services are available as an individual or group session unit, both of which require a minimum of 30 minutes in service in order to bill.



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Service	Programs	Code(s)		Rate(s)	Unit
Supported Employment Services	Comprehensive Waiver Supports Waiver • <i>May be participant-directed (excludes group supported employment)</i>	T2019	Individual	\$8.07	15 Minute
		T2019UQ	Group	\$2.79	
		T2019TS	SEFA	\$8.07	

The outcome of using employment services is to help a participant find and maintain a job that meets personal and career goals. Supported employment services offer a variety of supports to assist a participant age 18 or older who, because of their disability, needs intensive support to find and maintain self-employment or a job in a competitive, integrated work setting for which a participant is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by an individual without a disability.

Services are conducted in a variety of settings, particularly work sites where people without disabilities are employed. Services include activities needed in order for a participant to sustain paid work, including supervision and training. Payment is made only for the adaptations, supervision, and training required by participants as a result of their disabilities, but does not include payment for the supervisory activities rendered as a normal part of doing business.

Consistent with the Olmstead decision and with person-centered planning, a participant's IPC shall be developed in a manner that reflects individual choice and goals relating to employment, and ensures provision of services in the most integrated setting appropriate. Objectives that support the need for continued job coaching with a plan to lessen the job coaching over time, if possible, shall be identified in the participant's IPC.

Small Group Supported Employment

Small group supported employment shall be provided under a group rate for groups ranging from two to eight persons, and include mobile work crews or enclaves. Group employment for groups larger than eight people shall not be reimbursed by the waiver.

The provider shall be in the immediate vicinity and available for immediate intervention and support. Services shall ideally be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities in these workplaces. Small group supported employment may include employment in community businesses or businesses that are part of a provider organization.

Individual Supported Employment

Individual supported employment services are 1:1 supports available to a participant, and include customized and self-employment. Individual supported employment also includes 1:1 career planning and discovery support services that focus on individualized determination of the strengths, needs, and interests of the participant, and are designed to meet the specific needs of the employee and employer relationship. These services include employment developed through job carving, self-employment or entrepreneurial initiatives, or other job development or restructuring strategies that result in job

responsibilities being customized and individually negotiated to fit the needs of participants. These services presume the provision of reasonable accommodations and supports necessary to perform functions of a job that is individually negotiated and developed.

A final component of individual supported employment is a direct follow along service, which enables a participant who is paid at or above minimum wage to maintain employment in an integrated community employment setting. This service is provided for a participant through job support and communication with the participant's supervisor or manager, while the participant is present. Reimbursable activities include teaching job tasks and monitoring performance to ascertain the success of the job placement, support services not specifically related to job skill training that enable the participant to be successful in integrating into the job setting, and time spent at the participant's work site conducting observation and supervision of the participant.

Individual supported employment shall be provided in a community employment setting, unless the support is to address issues necessary to maintain a current job, or to develop customized employment, self-employment, or home-based employment (subject to prior approval of the Division).

Supported Employment Follow Along

Supported employment follow along (SEFA) services enable a participant, who is paid at or above the federal minimum wage, to maintain employment in an integrated community employment setting. SEFA is intended to be an indirect service, meaning the service is provided for, or on behalf of, a participant through intermittent and occasional job support and communication with the participant's supervisor or manager, while the participant is not present. However, this definition does not preclude the participant from being present during the provision of this service. SEFA may include phone calls between support staff and the participant's managerial staff. SEFA reimburses up to 100 units annually; approved units are based upon individual need in order to maintain employment. SEFA services shall be specifically outlined in the IPC.

SEFA reimbursable activities include:

- Regular contact and follow-up with the employer in order to reinforce and stabilize the job placement
- Facilitation of natural supports at the work site
- Individual program development, writing tasks analyses, monthly reviews, termination reviews and behavioral intervention programs
- Advocacy on behalf of the participant, but only with persons at the employment site (i.e., employers, co-workers, customers) and only for purposes directly related to employment
- Staff time to travel to and from a work site

SEFA non-reimbursable activities include:

- Transportation of an individual participant
- Observations of activities taking place in a group, i.e., work crews or enclaves
- Public relations
- Community education
- In-service meetings, department meetings, individual staff development
- Sheltered work observation



Approved services shall be directly related to a participant's employment needs and fit within the person's assigned budget.

Scope and Limitations

Documentation that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 (Vocational Rehabilitation or Workforce Services) or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) shall be maintained in the case manager and provider file. Services shall not be provided during the same timeframes that an individual is receiving services through an Individualized Educational Plan (IEP). A third party liability form may be required by the Division unless the participant is using the first 100 units of this service to help access assistance from the Division of Vocational Rehabilitation (DVR), to complete a career planning assessment tool, or for indirect SEFA services.

This service shall not be used to fund incentive payments including:

1. Payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for training that is not directly related to a participant's supported employment program.

Relative providers (defined as a biological, adoptive, or step parent), spouses, and legally authorized representatives shall not provide these services.

Transportation is included in the reimbursement rates for a direct service, but shall not be used for SEFA services or solely for the purpose of transporting a participant to and from work.



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Service	Programs	Code(s)	Rate(s)	Unit
Transportation Services	Comprehensive Waiver Supports Waiver	A0090	\$13.30	5 Mile Trip
		T2001	\$16.71	10 Mile Trip
		\$2,000 Annual Cap		

Transportation is a gap service that enables participants to gain access to employment sites, community services, activities, and resources as specified in the IPC, when a service provider is not needed at the event. This service is not intended to replace formal or informal transportation options, such as the use of natural supports, city transportation services, travel vouchers, and Medicaid State Plan services. Transportation services under the waiver shall be offered in accordance with an individual's IPC, and only when family, neighbors, friends, or community agencies are unable to provide transportation alternatives.

Scope and Limitations

Transportation services are available to participants 18 and older.

This service does not include transportation to medical appointments required under 42 CFR 431.53, or transportation services available under the Medicaid State Plan.

Service will be reimbursed by trip. A trip may be rounded up to five miles if at least two miles are traveled. A trip may be rounded up to ten miles if at least seven miles are traveled. Service is capped at \$2,000 per year.

Transportation services shall not be used in conjunction with, or to access, other waiver services that include transportation as part of the service rate.

