# Notice of Intent to Adopt Rules

A copy of the proposed rules may be obtained at http://rules.wyo.gov

Revised July 2019

## 1. General Information

| | | | |
|---|---|---|---|
| a. Agency/Board Name* | Wyoming Department of Health, Division of Healthcare Financing | | |
| b. Agency/Board Address | 6101 Yellowstone Road, Suite 210 | c. City: Cheyenne | d. Zip Code: 82002 |
| e. Name of Agency Liaison | Shirley Pratt | f. Agency Liaison Telephone Number | (307) 777-2525 |
| g. Agency Liaison Email Address | shirley.pratt@wyo.gov | | |
| h. Date of Public Notice | September 17, 2019 | i. Comment Period End Date | November 1, 2019 |
| j. Public Comment URL or Email Address: | shirley.pratt@wyo.gov | | |
| k. Program | Medicaid | | |

* ☐ *By checking this box, the agency is indicating it is exempt from certain sections of the Administrative Procedure Act including public comment period requirements. Please contact the agency for details regarding these rules.*

## 2. Legislative Enactment

For purposes of this Section 2, "new" only applies to regular non-emergency rules promulgated in response to a Wyoming legislative enactment not previously addressed in whole or in part by prior rulemaking and does not include rules adopted in response to a federal mandate.

a. Are these non-emergency regular rules new as per the above description and the definition of "new" in Chapter 1 of the Rules on Rules?

☒ No. ☐ Yes. If the rules are new, please provide the Chapter Numbers and Years Enacted (e.g. 2015 Session Laws Chapter 154):

## 3. Rule Type and Information

For purposes of this Section 3, "New" means an emergency or regular rule that has never been previously created.

a. Provide the Chapter Number, Title* and Proposed Action for Each Chapter. *Please use the "Additional Rule Information" form to identify additional rule chapters.*

| Chapter Number: | Chapter Name: | |
|---|---|---|
| 44 | Environmental Modifications, Specialized Equipment, and Self-Directed Goods for Medicaid Home and Community-Based Waivers (Environmental Modifications and Specialized Equipment for Medicaid Home and Community-Based Waivers) | ☐ New ☒ Amended ☐ Repealed |
| 45 | DD Waiver Provider Standards, Certification, and Sanctions | ☐ New ☒ Amended ☐ Repealed |
| 46 | Medicaid Supports and Comprehensive Waivers | ☐ New ☒ Amended ☐ Repealed |
| | | ☐ New ☐ Amended ☐ Repealed |
| | | ☐ New ☐ Amended ☐ Repealed |
| | | ☐ New ☐ Amended ☐ Repealed |
| | | ☐ New ☐ Amended ☐ Repealed |
| | | ☐ New ☐ Amended ☐ Repealed |

* If the name of a chapter of rules is changing, please provide the NEW chapter name in parenthesis following the OLD chapter name. *Example:* Old Chapter Name: General Provisions; New Chapter Name: General Provisions and Requirements. This would appear as "General Provisions (General Provisions and Requirements)."

## *4. Public Comments and Hearing Information*

a. A public hearing on the proposed rules has been scheduled. ■ No. ☐ Yes. Please complete the boxes below.

| Date: | Time: | City: | Location: |
|---|---|---|---|
| | | | |

b. What is the manner in which interested persons may present their views on the rulemaking action?

■ By submitting written comments to the Agency at the physical and/or email address listed in Section 1 above.

☐ At the following URL: _____

A public hearing will be held if requested by 25 persons, a government subdivision, or by an association having not less than 25 members. Requests for a public hearing may be submitted:

■ To the Agency at the physical and/or email address listed in Section 1 above.

☐ At the following URL: _____

c. Any person may urge the Agency not to adopt the rules and request the Agency to state its reasons for overruling the consideration urged against adoption. Requests for an agency response must be made prior to, or within thirty (30) days after adoption, of the rule, addressed to the Agency and Agency Liaison listed in Section 1 above.

## *5. Federal Law Requirements*

a. These rules are created/amended/repealed to comply with federal law or regulatory requirements. ■ No. ☐ Yes. Please complete the boxes below.

Applicable Federal Law or Regulation Citation:

Indicate one (1):

☐ The proposed rules meet, but do not exceed, minimum federal requirements.

☐ The proposed rules exceed minimum federal requirements.

Any person wishing to object to the accuracy of any information provided by the Agency under this item should submit their objections prior to final adoption to:

☐ To the Agency at the physical and/or email address listed in Section 1 above.

☐ At the following URL: _____

## *6. State Statutory Requirements*

a. Indicate one (1):

■ The proposed rule change *MEETS* minimum substantive statutory requirements.

☐ The proposed rule change *EXCEEDS* minimum substantive statutory requirements. Please attach a statement explaining the reason that the rules exceed the requirements.

b. ■ The Agency has completed a takings assessment as required by W.S. 9-5-304. A copy of the assessment used to evaluate the proposed rules may be obtained:

■ By contacting the Agency at the physical and/or email address listed in Section 1 above.

☐ At the following URL: _____

## *7. Additional APA Provisions*

a. Complete all that apply in regards to uniform rules:

■ These rules are not impacted by the uniform rules identified in the Administrative Procedure Act, W.S. 16-3-103(j).

☐ The following chapters do not differ from the uniform rules identified in the Administrative Procedure Act, W.S. 16-3-103(j):

_____

(Provide chapter numbers)

☐ These chapters differ from the uniform rules identified in the Administrative Procedure Act, W.S. 16-3-103(j) (see Statement of Principal Reasons).

_____

(Provide chapter numbers)

b. Checklist

■ The Statement of Principal Reasons is attached to this Notice and, in compliance with Tri-State Generation and Transmission Association, Inc. v. Environmental Quality Council, 590 P.2d 1324 (Wyo. 1979), includes a brief statement of the substance or terms of the rule and the basis and purpose of the rule.

☐ If applicable: In consultation with the Attorney General's Office, the Agency's Attorney General representative concurs that strike and underscore is not required as the proposed amendments are pervasive (Chapter 3, *Types of Rules Filings*, Section 1, Proposed Rules, of the Rules on Rules).

## *8. Authorization*

a. I certify that the foregoing information is correct.

| | |
|---|---|
| *Printed Name of Authorized Individual* | Michael A. Ceballos |
| *Title of Authorized Individual* | Director |
| *Date of Authorization* | September 5, 2019 |

Rules and Regulations for Supports and Comprehensive Waiver Services
Intent to Amend Rules

Wyoming Medicaid Chapters 44 through 46

Statement of Reasons

The Wyoming Department of Health proposes to amend the following chapters pursuant to its statutory authority in Wyoming Statute § 9-2-102 and the Wyoming Medical Assistance and Services Act at Wyoming Statutes §§ 42-4-101 through -121:

1. *Wyoming Medicaid Rules – Chapter 44 – Environmental Modifications, Specialized Equipment, and Self-Directed Goods for Medicaid home and Community Based Waiver Services*;

2. *Wyoming Medicaid Rules – Chapter 45 – DD Waiver Provider Standards, Certification, and Sanctions*; and

3. *Wyoming Medicaid Rules – Chapter 46 – Medicaid Supports and Comprehensive Waivers*.

The Department has determined that these chapters addressing Supports and Comprehensive Waiver services need to be updated to reflect federal requirements, state statute, and Division of Healthcare Financing practice.

All chapters are amended to align with the Supports and Comprehensive Waiver agreements, which have been approved by the Centers for Medicare and Medicaid Services, and to reflect overall language clean up and clarification.

Chapter 44 outlines the specific requirements of environmental modifications, specialized equipment, and self-directed goods and services. This amendment changes the name of the chapter and removes Sections 9 and 10, which refer to "Self-directed Goods." This service has been eliminated from the Supports and Comprehensive Waivers.

Chapter 45 governs certification of providers under the Supports and Comprehensive Waivers. It describes waiver provider standards, participant rights, and certification and sanction requirements. Although the list is not exhaustive, key modifications are described below:

1. Section 4 - Rights of Participants Receiving Services – clarifies participant rights and establishes additional plan of care team requirements if the right to be free from restraint is limited.
2. Section 10 - Individualized Plan of Care – revises the timeframe a case manager has to provide notice of the plan of care meeting to at least twenty (20) calendar days prior to the meeting.
3. Section 13 - Home and Community Based Standards for Waiver Services – outlines additional requirements of waiver providers related to site inspections, emergency plans, and remote monitoring.

4. Section 14 - Background Check Requirements – updates background screening requirements for waiver providers.
5. Section 17 - Positive Behavior Supports – establishes additional situations in which a positive behavior support plan shall be reviewed.
6. Section 18 - Restraint Standards – establishes additional provider training requirements in the event an injury occurs as a result of a restraint.
7. Section 25 - Additional Standards for Providers that Require National Accreditation – updates provider obligations to obtain national accreditation.

Chapter 46 replaces Emergency Chapter 46 and addresses Supports and Comprehensive Waiver requirements, including assessment, eligibility, cost limits, and emergency services. It establishes a person-centered approach to determine participant support needs in the individualized plan of care. Although the list is not exhaustive, key modifications are described below:

1. All sections subsequent to Section 3 have been renumbered.
2. Section 4 (previously Section 5) – Assessment and Eligibility – changes title to Eligibility Requirements. Rearranges and simplifies section to make the flow of the eligibility process more understandable.
3. New Sections added to make the eligibility process more understandable.
    a. Section 5 – Loss of Eligibility
    b. Section 6 – Institutional Level of Care Requirements
    c. Section 7 – Clinical Eligibility Diagnoses
    d. Section 8 – Inventory for Client and Agency Planning Assessment
4. Section 15 (previously Section 13) – Extraordinary Care Committee – modifies requirements for Extraordinary Care Committee reviews.

As required by Wyoming Statute § 16-3-103(a)(i)(G), these proposed rules meet minimum substantive state statutory requirements

# CHAPTER 44

## ENVIRONMENTAL MODIFICATIONS AND SPECIALIZED EQUIPMENT FOR MEDICAID HOME AND COMMUNITY-BASED WAIVER SERVICES

**Section 1. Authority.** This Chapter is promulgated by the Department of Health pursuant to Wyoming Statute 9-2-102 and the Wyoming Medical Assistance and Services Act at Wyoming Statutes 42-4-101 through -121.

**Section 2. Purpose and Applicability.**

(a) This Chapter shall apply to and govern Medicaid reimbursement of environmental modification and specialized equipment services provided under the Wyoming Medicaid Comprehensive Waiver and Wyoming Medicaid Supports Waiver, (herein collectively referred to as the "DD Waivers").

(b) This Chapter, in addition to Chapters 45 and 46 of the Department of Health's Medicaid Rules, shall govern services and provider requirements of the DD Waivers.

(c) The Division of Healthcare Financing, hereafter referred to as the "Division," may issue provider manuals and provider bulletins to providers or other affected parties to interpret the provisions of this Chapter. Such provider manuals and provider bulletins shall be consistent with and reflect the policies contained in this Chapter. The provisions contained in provider manuals and provider bulletins shall be subordinate to the provisions of this Chapter.

(d) Wyoming's currently approved Centers for Medicare and Medicaid Services (CMS) Comprehensive and Supports Waiver Applications and the Comprehensive and Supports Waiver Service Index apply to this Chapter.

(e) The requirements of Title XIX of the Social Security Act, 42 C.F.R. Part 441, Subpart G and the Medicaid Sate Plan apply to this Chapter.

**Section 3. General Provisions.**

(a) Except as otherwise specified in Chapter 1 of the Department of Health's Medicaid Rules, or as defined in this Section, the terminology used in this Chapter is the standard terminology and has the standard meaning used in accounting, health care, Medicaid, and Medicare.

(b) "Case manager" means individual who provides case management services, as established in Chapter 45, Section 9.

(c) "Relative" means a participant's biological, step, or adoptive parent(s).

**Section 4. Environmental Modifications – Scope and Limitations.**

(a) Environmental modifications to a participant's residence shall meet at least two of the following criteria:

(i) Be functionally necessary;

(ii) Contribute to a person's ability to remain in or return to his or her home and out of an intermediate care facility for individuals with an intellectual or developmental disability (ICF/IID) setting; and

(iii) Be necessary to ensure the person's health, welfare, and safety.

(b) Environmental modifications may include, but are not limited to:

(i) The installation of ramps;

(ii) The installation of grab-bars;

(iii) Widening of doorways;

(iv) A bathroom modification that is the most cost effective option to meet the needs of the participant.

(v) Installation of specialized electric or plumbing systems necessary to accommodate specialized medical equipment or supplies, which are necessary for the welfare of the participant;

(vi) Modifications that address accessibility limitations;

(vii) Modifications that address fire code requirements; and

(viii) Fences for health or safety concerns.

(A) Fences shall not take the place of required supervision of the participant.

(B) Payment for fences shall not exceed the cost for 200 linear feet of the material needed to ensure the safety of the participant, and shall be consistent with the neighborhood standard.

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

(i) 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;

(ii) Modifications to a residence that are not of direct medical or functional benefit to the participant;

(iii) Installation or replacement of carpeting;

(iv) Roof repair or replacement;

(v) Central air conditioning;

(vi) New carports, porches, patios, garages, porticos, decks, or repairing such structures;

(vii) Pools, spas, hot tubs or modifications to install pools, spas or hot tubs;

(viii) Landscaping or yard work, landscaping supplies, pest exterminations, or removal of yard items;

(ix) Modifications that are part of new construction costs;

(x) Modifications that add to the square footage of the home except bathroom modifications as specified in (b)(iv) of this Section;

(xi) Window replacements;

(xii) Repairs or replacement of structural building components;

(xiii) Modifications to a residence when the cost of such modifications exceeds the value of the residence before the modification; and

(xiv) Any adaptations that are covered by another source, such as a state independent living center or a vocational rehabilitation provider.

(d) Covered modifications of rented or leased homes shall be those extraordinary alterations that are uniquely needed by the individual, and for which the property owner would not ordinarily be responsible.

(i) Such modifications shall require written approval from the homeowner or landlord.

(ii) Modifications shall include the minimum necessary to meet the functional requirements of the participant.

(iii) A participant shall not purchase home accessibility adaptations to adapt living arrangements that add value to a home that is owned or leased by providers of waiver services.

(e) The homeowner shall be responsible for general maintenance of environmental modifications.

(f) All services shall be provided in accordance with State or local building codes.

**Section 5. Environmental Modifications Approval Process**.

(a) The plan of care team may request environmental modifications during the six-month or annual plan of care meeting. Environmental modification requests submitted at other times during the plan of care year may be submitted if significant health, safety, or access

concerns are identified.

(b) When the plan of care team identifies an environmental concern or need, the case manager shall submit the following information to the Division for the overall scope of the project:

(i) A description of the environmental concern or need;

(ii) A description of how the environmental concern is related to the participant's diagnosed disability, based on an assessment from an occupational or physical therapist; and

(iii) A description of how the environmental modification will:

(A) Contribute to the participant's ability to remain in, or return to, his or her home;

(B) Increase the participant's independence;

(C) Address the participant's accessibility concerns; and

(D) Address health and safety needs of the participant.

(c) The case manager shall work with the participant or legally authorized representative to identify two certified environmental modification providers, and contact the providers to obtain quotes. Quotes shall include:

(i) A detailed description of the work to be completed, including drawings or pictures when appropriate;

(ii) An estimate of the material and labor needed to complete the job, including costs of clean up;

(iii) An estimate for building permit, if needed;

(iv) An estimated timeline for completing the job;

(v) Name, address, and telephone number of the provider; and

(vi) Signature of the provider.

(d) The case manager shall submit the service authorization section of the individualized plan of care to the Division, including:

(i) The assessment completed by the professional team or the written approval from the Division to proceed with quotes; and

(ii) Two (2) quotes completed by certified environmental modification providers.

(A) If two quotes cannot be obtained, the case manager shall include an explanation as to why only one quote was submitted.

(B) The Division may review any request that does not include more than one quote.

(e) The Division may schedule an on-site assessment of the environmental concern, including an evaluation of functional necessity with appropriate professionals under contract with the Division. To ensure cost effectiveness, the Division may use a third party to assess the proposed modification and need for the modification. The assessment shall include:

(i) A statement verifying that the request meets at least two (2) of the criteria pursuant to Section 4(a) of this Chapter; and

(ii) A description of the modification that will address the environmental concern, including the minimum quality and quantity of material needed, and estimated cost range for modification.

(f) The Division shall notify the participant and case manager of the approval, including which quote was approved.

(i) Modifications shall be completed by the date stated in the individualized plan of care unless otherwise authorized by the Division.

(ii) If the cost of a modification increases due to a significant change in costs of material, the case manager shall submit a revised quote detailing the change in cost.

(iii) The case manager shall not give copies of the individualized plan of care to the environmental modification provider. The environmental modification provider shall receive a copy of the approved service authorization printout.

(g) Upon completion of the environmental modification, the provider shall have the homeowner sign the original quote verifying that the modification is complete.

(i) The environmental modification provider shall submit the signed quote to the participant’s case manager.

(ii) If the homeowner has concerns with the modification, they shall contact the case manager. The case manager shall inform the Division of the concerns.

(iii) The Division or its representative agent shall complete an on-site review of the modification to determine if it is completed as described in the original quote.

(h) The Division or its representative agent may conduct on-site visits or any other investigations deemed necessary prior to approving or denying the request for an environmental modification.

(i) The Division reserves the right to deny requests for environmental modifications

that are not within usual and customary charges or industry standards.

(j) A relative, as defined in Section 3 of this Chapter, may become certified to provide this service in accordance with Chapter 45 of the Department of Health's Medicaid Rules. If a relative provider quotes an environmental modification, the case manager shall always include one (1) other quote from a non-relative environmental modification provider.

(k) In accordance with Chapter 45 of the Department of Health's Medicaid Rules, provider agencies shall be certified by the Division to provide environmental modifications prior to providing the service.

(l) There is a lifetime cap of $20,000 for environmental modifications per family, regardless of waiver. Cap begins for purchases made after July 1, 2013 on previous Wyoming waivers. Critical health or safety service requests that exceed the lifetime cap are subject to available funding and approval by the Extraordinary Care Committee (ECC).

**Section 6. Specialized Equipment – Scope and Limitations**.

(a) Specialized equipment shall be functionally necessary and meet at least two of the following criteria:

(i) Be necessary to increase ability to perform activities of daily living or to perceive, control, or communicate with the environment in which the person lives;

(ii) Be necessary to enable the participant to function with greater independence and without which the person would require institutionalization; and

(iii) Be necessary to ensure the person's health, welfare, and safety.

(b) The individualized plan of care 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 include specific information on how often the equipment is used and where it is used.

(i) The case manager shall inquire with Medicaid, Medicare, or a participant's other insurance carrier to see if the requested equipment is covered under their plans.

(ii) Medicaid is a payer of last resort, and shall not pay for specialized equipment that can be paid through another source.

(c) Specialized equipment may include but is not limited to:

(i) Devices, controls, or appliances, specified in the individualized plan of care, that enable participants to increase their ability to perform activities of daily living;

(ii) Devices, controls, or appliances that enable the participant to perceive, control or communicate with the environment in which they live;

(iii) Items necessary for life support or to address physical conditions along with the ancillary supplies and equipment necessary to the proper functioning of such items;

(iv) Durable and non-durable medical equipment not available under the Medicaid state plan that is necessary to address participant functional limitations; and

(v) Necessary medical supplies not available under the Medicaid state plan or other insurance held by the participant.

(f) Items reimbursed with waiver funds are in addition to 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.

(e) Specialized equipment shall not include the following, even if prescribed by a licensed health care professional:

(i) Items paid for under the Medicaid state plan or under Early Periodic Screening, Diagnosis, and Treatment (EPSDT);

(ii) Educational or therapy items that are an extension of services provided by the Department of Education;

(iii) Items of general use that are not specific to a disability, or that would normally be available to any child or adult, including but not limited to furniture, recliners, desks, shelving, appliances, bedding, bean bag chairs, crayons, coloring books, other books, games, toys, videotapes, CD players, radios, cassette players, tape recorders, television, VCRs, DVD players, electronic games, cameras, film, swing sets, other indoor and outdoor play equipment, trampolines, strollers, play houses, bike helmets, bike trailers, bicycles, health club memberships, merry-go-rounds, golf carts, four wheelers, go-carts, scooters, vehicles, automotive parts, and motor homes;

(iv) Pools, spas, or hot tubs;

(v) Computers and computer equipment, including the CPU, hard drive, and printers, except for situations pursuant to (c) of this Section;

(vi) Items that are not proven interventions through either professional peer reviews or evidence based studies; and

(vii) Communication items such as telephones, pagers, pre-paid minute cards and monthly services.

(f) Repairs on specialized equipment shall be completed by the manufacturer, if a warranty is in place.

(g) Requests for repairs on specialized equipment not covered by warranty may be submitted to the Division for approval.

(h) Sale of specialized equipment shall not profit the participant or family.

**Section 7. Specialized Equipment Approval Process**.

(a) The team may submit requests for specialized equipment during the six-month or annual plan of care meeting. Specialized equipment requests submitted at other times during the plan of care year may be submitted if significant health, safety, or access concerns are identified.

(b) Approval for specialized equipment shall require:

(i) Prior authorization from the Division; and

(ii) A recommendation from a therapist or professional with expertise in the area of need. The recommendation shall include:

(A) A description of the functional need for the specialized equipment;

(B) How the specialized equipment will contribute to a person's ability to remain in or return to his or her home and out of an ICF/IID, or other institutional setting;

(C) How the specialized equipment will increase the individual's independence and decrease the need for other services;

(D) How the specialized equipment addresses accessibility, health, or safety needs of the participant;

(E) Documentation that the participant has the capability to use the equipment;

(F) Documentation that the waiver is the payer of last resort;

(G) A description of how equipment shall be delivered and who will train the person and providers on the equipment; and

(H) Documentation of two (2) quotes for the purchase of the equipment, including a maximum markup on the equipment of 20%.

(I) The quotes may include a detailed description of the need and costs for expert assembly of the equipment in addition to the 20% markup.

(II) The quotes may include a detailed description of the need and cost for training on the specialized equipment in addition to the 20% markup.

(III) If two (2) quotes cannot be obtained, an explanation as to why only one (1) quote was submitted.

(IV) The Division may review any request that does not include more than one (1) quote.

(c) The Division may schedule a review of the specialized equipment quote, including an evaluation of functional necessity, with appropriate professionals under contract with the Division. The review shall include a statement verifying that the request meets at least two (2) of the criteria pursuant to Section 6(a) of this Chapter.

(d) If the participant has an Individualized Education Plan (IEP) or Individual Family Service Plan (IFSP), the case manager shall submit a copy of that document, along with documentation as to why the equipment is not sent home with the participant, or a reason why the equipment is necessary at home but not at school.

(e) The Division may request documentation that a less expensive, comparable alternative to requested equipment or supplies are not available or practical. If a more cost-effective alternative is determined to be available, the Division shall deny the original request or specify that only the less costly equipment or supplies are approved.

(f) Equipment purchases shall not exceed $2,000 per year. If an item needed exceeds that amount, the team may request an exception to the cap through the ECC. The Division may require an assessment for specialized equipment needs by a Certified Specialized Equipment (CSE) professional. The assessment is funded as part of the $2,000 cap. Insurance on items is not covered by waiver but may be purchased by the participant separately.

(g) Electronic technology devices are only allowed once every five (5) years and like items shall not be purchased during those five (5) years. Electronic technology devices used as augmentative and alternative communication devices are exempt from this five (5) year limitation if accompanied by a letter of necessity from a Speech Language Pathologist.

(h) In accordance with Chapter 45 of the Department of Health's Medicaid Rules, provider agencies shall be certified by the Division to provide specialized equipment.

**Section 8. Interpretation of Chapter**.

(a) The order in which the provisions of this Chapter appear is not to be construed to mean that any one provision is more or less important than any other provision.

(b) The text of this Chapter shall control the titles of its various provisions.

**Section 9. Superseding Effect.** This Chapter supersedes all prior rules or policy statements issued by the Division, including Provider Manuals and Provider Bulletins, which are inconsistent with this Chapter.

**Section 10. Severability.** If any portion of this Chapter is found to be invalid or unenforceable, the remainder shall continue in full force and effect.

**Section 11. Incorporation by Reference.**

(a) For any code, standard, rule, or regulation incorporated by reference in these rules:

(i) The Department has determined that incorporation of the full text in these rules would be cumbersome or inefficient given the length or nature of the rules;

(ii) The incorporation by reference does not include any later amendments or editions of the incorporated matter beyond the applicable date identified in subsection (b) of this section; and

(iii) The incorporated code, standard, rule, or regulation is maintained at the Department and is available for public inspection and copying at cost at the same location.

(b) Each code, rule, or regulation incorporated by reference in these rules is further identified as follows:

(i) Referenced in Section 2 of this Chapter is title XIX of the Social Security Act, 42 C.F.R. Part 441, Subpart G, incorporated as of the effective date of this Chapter and can be found at http://www.ecfr.gov.

(ii) Referenced in Section 2 of this Chapter is Wyoming Medicaid's State Plan, incorporated as of the effective date of this Chapter and can be found at http://www.health.wyo.gov/healthcarefin/medicaid/spa.

(iii) Referenced in Section 2 of this Chapter is Wyoming's Comprehensive and Supports Waiver Applications, incorporated as of the effective date of this Chapter and can be found at https://www.health.wyo.gov/behavioralhealth/dd/waivers/.

(iv) Referenced in Section 2 of this Chapter is Wyoming's Comprehensive and Supports Waiver Service Index, incorporated as of the effective date of this Chapter and can be found at https://www.health.wyo.gov/behavioralhealth/dd/comprehensive-support-waivers/.

## CHAPTER 44

## ENVIRONMENTAL MODIFICATIONS~~,~~ AND SPECIALIZED EQUIPMENT~~, AND SELF-DIRECTED GOODS~~ FOR MEDICAID HOME AND COMMUNITY-BASED WAIVER SERVICES

**Section 1. Authority.** This Chapter is promulgated by the Department of Health pursuant to Wyoming Statute ~~§~~ 9-2-102 and the Wyoming Medical Assistance and Services Act at Wyoming Statutes ~~§§~~ 42-4-101 through -121.

**Section 2. Purpose and Applicability.**

(a) This Chapter shall apply to and govern Medicaid reimbursement of environmental modification ~~services,~~ and specialized equipment services~~, and self-directed goods~~ provided under the Wyoming Medicaid Comprehensive Waiver and Wyoming Medicaid Supports Waiver, (herein collectively referred to as the "DD Waivers").

(b) This Chapter, in addition to Chapters 45 and 46 of the Department of Health's Medicaid Rules, shall govern services and provider requirements of the DD Waivers.

(c) The ~~Behavioral Health~~ Division of Healthcare Financing, hereafter referred to as the "Division," may issue ~~P~~provider ~~M~~manuals and ~~P~~provider ~~B~~bulletins to providers or other affected parties to interpret the provisions of this Chapter. Such ~~P~~provider ~~M~~manuals and ~~P~~provider ~~B~~bulletins shall be consistent with and reflect the policies contained in this Chapter. The provisions contained in ~~P~~provider ~~M~~manuals and ~~P~~provider ~~B~~bulletins shall be subordinate to the provisions of this Chapter.

(d) ~~(i)~~ Wyoming's currently approved Centers for Medicare and Medicaid Services (CMS) Comprehensive and Supports Waiver Applications and the Comprehensive and Supports Waiver Service Index apply to this Chapter.

(e) ~~(ii)~~ The requirements of Title XIX of the Social Security Act, 42 C.F.R. Part 441, Subpart G and the Medicaid Sate Plan apply to this Chapter.

**Section 3. General Provisions.**

(a) ~~Terminology.~~ Except as otherwise specified in Chapter 1 of the Department of Health's Medicaid Rules, or as defined in this Section, the terminology used in this Chapter is the standard terminology and has the standard meaning used in accounting, health care, Medicaid, and Medicare.

~~(b) Definitions.~~

(b) ~~(i)~~ "Case ~~M~~manager" means individual who provides case management services, as ~~defined~~ established in Chapter 45, Section 9.

~~(i) "Division" means the Wyoming Department of Health, Behavioral Health Division.~~

(c) ~~(iii)~~ "Relative" means a participant's biological, step, or adoptive parent(s) ~~or stepparent(s)~~.

~~(c) Methodology. This Chapter establishes standards for environmental modification services, specialized equipment services, and self-directed goods provided through Behavioral Health Division Home and Community-Based Waivers.~~

**~~Section 4. Philosophy.~~**

~~(a) All persons possess inalienable rights under the Constitutions of the United States and the State of Wyoming. Persons with developmental disabilities also possess the rights outlined in the Developmental Disabilities Assistance and Bill of Rights Act of 2000, 42 U.S.C. § 15001.~~

~~(b) It is the philosophy of the Division to develop reasonable and enforceable rules for the provision of services to individuals with developmental disabilities in community settings in lieu of unnecessary institutionalization. This philosophy is mandated in the Supreme Court ruling on *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999).~~

~~(c) This Chapter is designed not only to support the philosophy of community-based services but to also protect the health, welfare, and safety of participants.~~

**Section ~~5~~4. Environmental Modifications – Scope and Limitations.**

(a) Environmental modifications ~~requests for~~ to a participant's residence shall meet at least two of the following criteria ~~for approval by the Division~~:

(i) Be functionally necessary;

(ii) Contribute to a person's ability to remain in or return to his or her home and out of an intermediate care facility for individuals with an intellectual or developmental disability (ICF/IID) setting; and

(iii) Be necessary to ensure the person's health, welfare, and safety.

(b) Environmental modifications may include, but are not limited to:

(i) The installation of ramps;

(ii) The installation of grab-bars;

(iii) Widening of doorways;

(iv) A bathroom modification ~~of a bathroom~~ that is the most cost effective option to meet the needs of the participant;

~~(A) Modifications to a bathroom, which add square feet to the home, shall only be covered if it is the most cost effective modification that meets the needs of the~~

~~participant.~~

(v) Installation of specialized electric or plumbing systems necessary to accommodate specialized medical equipment or supplies, which are necessary for the welfare of the participant;

(vi) Modifications that address accessibility limitations;

(vii) Modifications that address fire code requirements; and

(viii) Fences for health or safety concerns.

(A) Fences shall not take the place of required supervision of the participant.

(B) Payment for fences shall not exceed the cost for 200 linear feet of the material needed to ensure the safety of the participant, and shall be consistent with the neighborhood standard.

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

(i) 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;

(ii) Modifications to a residence that are not of direct medical or functional benefit to the participant;

(iii) Installation or replacement of carpeting;

(iv) Roof repair or replacement;

(v) Central air conditioning;

(vi) New carports, porches, patios, garages, porticos, decks, or repairing such structures;

(vii) Pools, spas, hot tubs or modifications to install pools, spas or hot tubs;

(viii) Landscaping or yard work, landscaping supplies, pest exterminations, or removal of yard items;

(ix) Modifications that are part of new construction costs;

(x) Modifications that add to the square footage of the home except bathroom modifications as specified in (b)(iv) of this Section;

(xi) Window replacements;

(xii) Repairs or replacement of structural building components;

(xiii) Modifications to a residence when the cost of such modifications exceeds the value of the residence before the modification; and

(xiv) Any adaptations that are covered by another source, such as a state independent living center or a vocational rehabilitation provider.

(d) Covered modifications of rented or leased homes shall be those extraordinary alterations that are uniquely needed by the individual, and for which the property owner would not ordinarily be responsible.

(i) Such modifications shall require written approval from the homeowner or landlord.

(ii) Modifications shall include the minimum necessary to meet the functional requirements of the participant.

(iii) A participant shall not purchase home accessibility adaptations to adapt living arrangements that add value to a home that is owned or leased by providers of waiver services.

(e) The homeowner shall be responsible for general maintenance of environmental modifications.

(f) All services shall be provided in accordance with State or local building codes.

**Section ~~6~~5. Environmental Modifications Approval Process**.

(a) The plan of care team may request environmental modifications during the six-month or annual plan of care meeting. Environmental modification requests submitted at other times during the plan of care year may be submitted if significant health, safety, or access concerns are identified.

(b) When the plan of care team identifies an environmental concern or need, the ~~C~~case ~~M~~manager shall submit the following information to the Division for the overall scope of the project:

(i) A description of the environmental concern or need;

(ii) ~~Based on an assessment from an occupational or physical therapist, a~~ A description of how the environmental concern is related to the participant's diagnosed disability, based on an assessment from an occupational or physical therapist; and

(iii) A description of how ~~How addressing~~ the environmental ~~concern~~ modification will:

(A) Contribute to the participant's ability to remain in, or return to, his

or her home;

(B) Increase the participant's independence;

(C) Address the participant's accessibility concerns; and

(D) Address health and safety needs of the participant.

(c) The ~~C~~case ~~M~~manager shall work with the participant or legally authorized representative to identify two certified environmental modification providers, and contact the providers to obtain quotes. Quotes shall include:

(i) A detailed description of the work to be completed, including drawings or pictures when appropriate;

(ii) An estimate of the material and labor needed to complete the job, including costs of clean up;

(iii) An estimate for building permit, if needed;

(iv) An estimated timeline for completing the job;

(v) Name, address, and telephone number of the provider; and

(vi) Signature of the provider.

(d) The ~~C~~case ~~M~~manager shall submit the service authorization section of the individualized plan of care to the Division, including:

(i) The assessment completed by the professional team or the written approval from the Division to proceed with quotes; and

(ii) Two (2) quotes completed by certified environmental modification providers.

(A) If two quotes cannot be obtained, the ~~C~~case ~~M~~manager shall include an explanation as to why only one quote was submitted.

(B) The Division may review any request that does not include more than one quote.

(e) The Division may schedule an on-site assessment of the environmental concern, including an evaluation of functional necessity with appropriate professionals under contract with the Division. To ensure cost effectiveness, the Division may use a third party to assess the proposed modification~~,~~ and need for the modification. The assessment shall include:

(i) A statement verifying that the request meets at least two (2) of the criteria pursuant to Section ~~5~~4(a) of this Chapter; and

(ii) A description of the modification that will address the environmental concern, including the minimum quality and quantity of material needed, and estimated cost range for modification.

(f) The Division shall notify the participant and ~~C~~case ~~M~~manager of the approval, including which quote was approved.

(i) Modifications shall be completed by the date stated in the individualized plan of care unless otherwise authorized by the Division.

(ii) If the cost of a modification increases due to a significant change in costs of material, the Case Manager shall submit a revised quote detailing the change in cost.

(iii) The ~~C~~case ~~M~~manager shall not give copies of the individualized plan of care to the environmental modification provider. The environmental modification provider shall receive a copy of the approved service authorization printout.

(g) Upon completion of the environmental modification, the provider shall have the homeowner sign the original quote verifying that the modification is complete.

(i) The environmental modification provider shall submit the signed quote to the participant's ~~C~~case ~~M~~manager.

(ii) If the homeowner has concerns with the modification, they shall contact the ~~C~~case ~~M~~manager. The ~~C~~case ~~M~~manager shall inform the Division of the concerns.

(iii) The Division or its representative agent shall complete an on-site review of the modification to determine if it is completed as described in the original quote.

(h) The Division or its representative agent may conduct on-site visits or any other investigations deemed necessary prior to approving or denying the request for an environmental modification.

(i) The Division reserves the right to deny requests for environmental modifications that are not within usual and customary charges or industry standards.

(j) A r~~R~~elative ~~providers, including parents and stepparents,~~ as defined in Section 3 of this Chapter, may ~~also~~ become certified to provide this service in accordance with Chapter 45 of the Department of Health's Medicaid Rules. If a relative provider quotes an environmental modification, the ~~C~~case ~~M~~manager shall always include one (1) other quote from a non-relative environmental modification provider.

(k) In accordance with Chapter 45 of the Department of Health's Medicaid Rules, provider agencies shall be certified by the Division to provide ~~E~~environmental ~~M~~modifications prior to providing the service.

(l) There is a lifetime cap of $20,000 for environmental modifications per family, regardless of waiver. Cap begins for purchases made after July 1, 2013 on previous

Wyoming ~~W~~waivers. Critical health or safety service requests that exceed the lifetime cap are subject to available funding and approval by the Extraordinary Care Committee (ECC).

**Section ~~7~~6. Specialized Equipment – Scope and Limitations**.

(a) Specialized equipment shall be functionally necessary and meet at least two of the following criteria:

(i) Be necessary to increase ability to perform activities of daily living or to perceive, control, or communicate with the environment in which the person lives;

(ii) Be necessary to enable the participant to function with greater independence and without which the person would require institutionalization; and

(iii) Be necessary to ensure the person's health, welfare, and safety.

(b) The individualized plan of care 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 include specific information on how often the equipment is used and where it is used.

(i) The ~~C~~case ~~M~~manager shall inquire with Medicaid, Medicare, or a participant's other insurance carrier to see if the requested equipment is covered under their plans.

(ii) ~~The~~ Medicaid ~~Waiver~~ is a payer of last resort, and shall not pay for specialized equipment that can be paid through another source.

(c) Specialized equipment may include but is not limited to:

(i) Devices, controls, or appliances, specified in the individualized plan of care, that enable participants to increase their ability to perform activities of daily living;

(ii) Devices, controls, or appliances that enable the participant to perceive, control or communicate with the environment in which they live;

(iii) Items necessary for life support or to address physical conditions along with the ancillary supplies and equipment necessary to the proper functioning of such items;

(iv) ~~Such other d~~Durable and non-durable medical equipment not available under the Medicaid state plan that is necessary to address participant functional limitations; and

(v) Necessary medical supplies not available under the Medicaid state plan or other insurance held by the participant.

(d) ~~(A)~~ 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.

(e) ~~(d)~~ Specialized equipment shall not include the following, even if prescribed by a licensed health care professional:

(i) Items paid for under the Medicaid state plan or under Early Periodic Screening, Diagnosis, and Treatment (EPSDT);

(ii) Educational or therapy items that are an extension of services provided by the Department of Education;

(iii) Items of general use that are not specific to a disability, or that would normally be available to any child or adult, including but not limited to furniture, recliners, desks, shelving, appliances, bedding, bean bag chairs, crayons, coloring books, other books, games, toys, videotapes, CD players, radios, cassette players, tape recorders, television, VCRs, DVD players, electronic games, cameras, film, swing sets, other indoor and outdoor play equipment, trampolines, strollers, play houses, bike helmets, bike trailers, bicycles, health club memberships, merry-go-rounds, golf carts, four wheelers, go-carts, scooters, vehicles, automotive parts, and motor homes;

(iv) Pools, spas, or hot tubs ~~or modifications to install pools, spas, or hot tubs~~;

(v) Computers and computer equipment, including the CPU, hard drive, and printers, except for situations pursuant to (c) of this Section;

(vi) Items that are not proven interventions through either professional peer reviews or evidence based studies; and

(vii) Communication items such as telephones, pagers, pre-paid minute cards and monthly services.

(f) ~~(e)~~ Repairs on specialized equipment shall be completed by the manufacturer, if a warranty is in place.

(g) ~~(f)~~ Requests for repairs on specialized equipment not covered by warranty may be submitted to the Division for approval.

(h) ~~(g)~~ Sale of specialized equipment shall not profit the participant or family.

**Section ~~8~~7. Specialized Equipment Approval Process**.

(a) The team may submit requests for specialized equipment during the six-month or annual plan of care meeting. Specialized equipment requests submitted at other times during the plan of care year may be submitted if significant health, safety, or access concerns are identified.

(b) Approval for specialized equipment shall require:

(i) Prior authorization from the Division; and

(ii) A recommendation from a therapist or professional with expertise in the area of need. The recommendation shall include:

(A) A description of the functional need for the specialized equipment;

(B) How the specialized equipment will contribute to a person's ability to remain in or return to his or her home and out of an ~~Intermediate Care Facilities for Individuals with Intellectual Disabilities (~~ICF/I<u>I</u>D~~)~~, or other institutional setting;

(C) How the specialized equipment will increase the individual's independence and decrease the need for other services;

(D) How the specialized equipment addresses accessibility, health, or safety needs of the participant;

(E) Documentation that the participant has the capability to use the equipment;

(F) Documentation that the waiver is the payer of last resort;

(G) A description of how equipment shall be delivered and who will train the person and providers on the equipment; and

(H) Documentation of two (2) quotes for the purchase of the equipment, including a maximum markup on the equipment of 20%.

(I) The quotes may include a detailed description of the need and costs for expert assembly of the equipment in addition to the 20% markup.

(II) The quotes may include a detailed description of the need and cost for training on the specialized equipment in addition to the 20% markup.

(III) If two (2) quotes cannot be obtained, an explanation as to why only one (1) quote was submitted.

(IV) The Division may review any request that does not include more than one (1) quote.

(c) ~~(iii)~~ The Division may schedule a review of the specialized equipment quote, including an evaluation of functional necessity, with appropriate professionals under contract with the Division.

~~(iv)~~ The review shall include a statement verifying that the request meets at least two (2) of the criteria pursuant to Section ~~7~~6(a) of this Chapter.

(d) ~~(v)~~ If the participant has an Individualized Education Plan (IEP) or Individual Family Service Plan (IFSP), the ~~C~~c<u>c</u>ase ~~M~~m<u>m</u>anager shall submit a copy of that document, along

with documentation as to why the equipment is not sent home with the participant, or a reason why the equipment is necessary at home but not at school.

(e) ~~(c)~~ The Division may request documentation that a less expensive, comparable alternative to requested equipment or supplies are not available or practical. If a more cost-effective alternative is determined to be available, the Division shall deny the original request or specify that only the less costly equipment or supplies are approved.

(f) ~~(d)~~ Equipment purchases ~~have an annual cap of~~ shall not exceed $2,000 per year. If an item needed exceeds that amount, the team may request an exception to the cap through the ~~Extraordinary Care Committee (~~ECC~~)~~. The Division may require an assessment for specialized equipment needs by a Certified Specialized Equipment (CSE) professional. The assessment is funded as part of the $2,000 cap. Insurance on items is not covered by waiver but may be purchased by the participant separately.

(g) ~~(e)~~ Electronic technology devices are only allowed once every five (5) years and like items shall not be purchased during those five (5) years. Electronic technology devices used as augmentative and alternative communication devices are exempt from this five (5) year limitation if accompanied by a letter of necessity from a Speech Language Pathologist.

(h) ~~(f)~~ In accordance with Chapter 45 of the Department of Health's Medicaid Rules, provider agencies shall be certified by the Division to provide ~~S~~specialized ~~E~~equipment.

~~**Section 9. Self-Directed Goods.**~~

~~(a) Goods include equipment and supplies that provide direct benefit to the participant, support specific outcomes in the individualized plan of care, and have not been specifically excluded under the specialized equipment waiver service.~~

~~(b) The equipment or supply shall:~~

~~(i) Reduce the reliance of the participant on other paid supports;~~

~~(ii) Be directly related to health or safety of the participant in the home or community;~~

~~(iii) Be habilitative and contribute to a therapeutic objective;~~

~~(iv) Increase the participant's ability to be integrated into the community; or~~

~~(v) Provide resources to expand self-advocacy skills and knowledge.~~

~~(c) Goods may include:~~

~~(i) Equipment not otherwise available, but not specifically excluded under the specialized equipment waiver service;~~

~~(ii) Devices, aids, controls, supplies, or household appliances which enable~~

~~individuals to increase the ability to perform activities of daily living or to perceive, control, or communicate with the environment and community in which he or she lives;~~

~~(A) Self-Directed Goods include items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan.~~

~~(B) All items shall meet applicable standards of manufacture and design.~~

~~(iii) Home modifications not otherwise allowed in the environmental modification waiver service.~~

~~(A) Allowable modifications may include physical adaptations which are necessary to ensure the health, welfare, and safety of the individual in the home, enhance the individual's level of independence, or which enable the individual to function with greater independence in the home.~~

~~(B) The cost of installation is not included.~~

**~~Section 10. Self-Directed Goods, Limits on the Amount, Frequency, or Duration.~~**

~~(a) Self-Directed Goods have a $2,000 annual limit, which includes all associated costs such as markups and fees.~~

~~(b) All goods under Section 9 shall be subject to prior authorization by the Division and shall not be available nor specifically excluded through Specialized Equipment or Environmental Modifications.~~

~~(c) The Extraordinary Care Committee may approve requests above the limit if the request meets the criteria outlined in Chapter 46of the Department of Health's Medicaid Rules, or the participant loses eligibility for other resources because of age and provides documentation that vocational rehabilitation services are not available to meet those needs.~~

~~(d) The Division may require an assessment for an equipment purchase by a Certified Specialized Equipment (CSE) professional. Assessment is funded as a part of the $2,000 cap.~~

~~(e) Electronic technology devices are only allowed once every five (5) years and like items shall not be purchased during those five (5) years. There are no exceptions. The Division shall limit the purchase of any general item, such as a computer or tablet, unless recommended by CSE professional.~~

~~(f) The Division, after approving the goods, will only pay for the actual cost of purchase.~~

~~(i) The Case Manager shall inquire with Medicaid, Medicare, or a participant's other insurance carrier to see if the requested equipment is covered under their plans.~~

~~(ii) The Medicaid Waiver is a payer of last resort, and shall not pay for goods that can be paid through another source.~~

~~(g) This service is only available for participants self-directing at least one (1) direct care service through the Fiscal Employer Agent. This service may be provided by a relative, excluding parents and stepparents. This service shall not duplicate any Medicaid State Plan service.~~

~~(h) Modifications to a residence that are not covered under the environmental modification service may be approved, if the cost of such modifications does not exceed the value of the improvement before the modification. Covered modifications of rented or leased homes shall be those extraordinary alterations that are uniquely needed by the individual and for which the property owner would not ordinarily be responsible. The approved cost does not include adaptations or improvements to the home, which are:~~

~~(i) Of general utility and are not of direct medical or remedial benefit;~~

~~(ii) Adaptations that add to the total square footage of the home; or~~

~~(iii) Adaptations that are covered as an environmental modification.~~

**Section ~~11~~8. Interpretation of Chapter**.

(a) The order in which the provisions of this Chapter appear is not to be construed to mean that any one provision is more or less important than any other provision.

(b) The text of this Chapter shall control the titles of its various provisions.

**Section ~~12~~9. Superseding Effect.** This Chapter supersedes all prior rules or policy statements issued by the Division, including Provider Manuals and Provider Bulletins, which are inconsistent with this Chapter.

**Section ~~13~~10. Severability.** If any portion of this Chapter is found to be invalid or unenforceable, the remainder shall continue in full force and effect.

**Section ~~14~~11. Incorporation by Reference.**

(a) For any code, standard, rule, or regulation incorporated by reference in these rules:

(i) The Department has determined that incorporation of the full text in these rules would be cumbersome or inefficient given the length or nature of the rules;

(ii) The incorporation by reference does not include any later amendments or editions of the incorporated matter beyond the applicable date identified in subsection (b) of this section; and

(iii) The incorporated code, standard, rule, or regulation is maintained at the

Department and is available for public inspection and copying at cost at the same location.

(b) Each code, rule, or regulation incorporated by reference in these rules is further identified as follows:

(i) Referenced in Section 2 of this Chapter is title XIX of the Social Security Act, 42 C.F.R. Part 441, Subpart G, incorporated as of the effective date of this Chapter and can be found at http://www.ecfr.gov.

(ii) Referenced in Section 2 of this Chapter is Wyoming Medicaid's State Plan, incorporated as of the effective date of this Chapter and can be found at http://www.health.wyo.gov/healthcarefin/medicaid/spa.

(iii) Referenced in Section 2 of this Chapter is Wyoming's Comprehensive and Supports Waiver Applications, incorporated as of the effective date of this Chapter and can be found at https://www.health.wyo.gov/behavioralhealth/dd/waivers/.

(iv) Referenced in Section 2 of this Chapter is Wyoming's Comprehensive and Supports Waiver Service Index, incorporated as of the effective date of this Chapter and can be found at https://www.health.wyo.gov/behavioralhealth/dd/comprehensive-support-waivers/.

# CHAPTER 45

## DD WAIVER PROVIDER STANDARDS, CERTIFICATION, AND SANCTIONS

**Section 1**. **Authority.** This Chapter is promulgated by the Department of Health pursuant to Wyoming Statute 9-2-102 and the Wyoming Medical Assistance and Services Act at W.S. 42-4-101 through -121.

**Section 2. Purpose and Applicability.**

(a) This Chapter was adopted to govern certification of providers under the Wyoming Medicaid Supports Waiver and Comprehensive Waiver (hereinafter collectively referred to as the "DD Waivers").

(b) This Chapter, in addition to Chapters 44 and 46 of the Wyoming Medicaid Rules, shall govern services and provider requirements of the DD Waivers.

(c) The Division of Healthcare Financing, hereinafter referred to as the "Division," may issue provider manuals and provider bulletins to providers or other affected parties to interpret the provisions of this Chapter. Such provider manuals and provider bulletins shall be consistent with and reflect the rule provision's policies, as revised in this Chapter. The provisions contained in provider manuals or provider bulletins shall be subordinate to the provisions of this Chapter.

(d) Wyoming's currently approved Centers for Medicare and Medicaid Services (CMS) Comprehensive and Supports Waiver Applications and the Comprehensive and Supports Waiver Service Index apply to this Chapter.

(e) The requirements of Title XIX of the Social Security Act, 42 C.F.R., Part 441, Subpart G and the Medicaid State Plan apply to this Chapter.

**Section 3. General Provisions.**

(a) Except as otherwise specified in Chapter 1 of the Department of Health's Medicaid Rules, or as defined in this Section, the terminology used in this Chapter is the standard terminology and has the standard meaning used in accounting, health care, Medicaid, and Medicare.

(b) "Case manager" means an individual who provides case management services, as established in Section 9 of this Chapter.

(c) "Corrective Action Plan", referred to previously as a quality improvement plan, means a step by step plan of action developed by the provider to achieve targeted outcomes for resolution of identified errors in an effort to eliminate repeated deficient practices.

(d) "Elopement" means the unexpected or unauthorized absence of a participant for

more than is approved in the participant's individualized plan of care when that person is receiving waiver services, or the unexpected or unauthorized absence of any duration of a participant whose absence constitutes an immediate danger to themselves or others. This could be an unexpected participant action, which may not be intentional and may be due to wandering that is secondary to dementia.

(e) "Licensed Medical Professional" means a medical professional licensed to practice in the State of Wyoming and authorized to prescribe medication.

(f) "Relative" means a participant's biological, step, or adoptive parent(s).

**Section 4. Rights of Participants Receiving Services.**

(a) Each participant receiving services has the same legal rights and responsibilities guaranteed to all other U.S. citizens under the United States and Wyoming constitutions and federal and state laws.

(b) Participant rights shall not be modified or suspended except in accordance with state or federal law and this Chapter. A participant's right to dignity and respect, to be free from coercion, and to receive services in settings that are physically accessible to the participant shall not be limited or restricted.

(c) The participant, the participant's legally authorized representative(s), the participant's case manager, and the Division shall be informed in writing of the grounds for the denial or limitation of rights. Such notice shall be written in plain language and shall include a statement that the participant may choose an alternative provider, if the participant or legally authorized representative disagrees with the denial or limitation. If the Division disallows a limitation of a right in an individualized plan of care, this decision will apply to any provider offering services to the participant. Rights restrictions shall constitute a material change to the individualized plan of care. The following participant rights shall not be denied or limited, except for the purpose of an identified health or safety need, which shall be included in the participant's individualized plan of care:

(i) The right to privacy;

(ii) The right to freedom from restraint;

(iii) The right to privacy in their sleeping or living quarters;

(iv) The right to sleeping and living quarters that have entrance doors that can be locked by the individual, with only appropriate staff having keys to doors;

(v) If individuals share sleeping quarters, the right to choose roommates in that setting, and choose with whom and where they live;

(vi) Freedom to furnish and decorate their sleeping or living quarters within the lease or other agreement;

(vii) Freedom and support to control their own schedules and activities;

(viii) Freedom and support to have access to food at any time;

(ix) Freedom to have visitors of their choosing at any time, and associate with people of their choosing;

(x) Freedom to communicate with people of their choosing;

(xi) Freedom to keep and use their personal possessions and property;

(xii) Control over how they spend their personal resources;

(xiii) The right to access the community; and

(xiv) The right to make and receive telephone calls. No person shall limit a participant's right to make calls to Protection & Advocacy, or state and federal oversight or protection agencies as protected by 42 U.S.C. 10841(1)(M), such as the Division or Department of Family Services.

(d) A participant's right to be free from physical, mechanical, and chemical restraints shall not be denied or limited unless a court, the participant, or the participant's legally authorized representative authorizes the denial or limitation in writing. The request shall be accompanied by letters from a licensed medical and behavioral professional that detail medical and psychological contraindications that may be associated with a restraint.

(i) Such denial or limitation shall be included in the participant's individualized plan of care, shall address how other less restrictive interventions will be used prior to a restraint, and shall detail the manner in which a restraint may be used pursuant to Section 18 of this Chapter.

(ii) The authorizing document shall be made part of the participant's individualized plan of care.

(e) Procedural requirements regarding rights. A provider that offers direct services shall have and implement policies and procedures that ensure:

(i) Except as identified in this section, participants have the opportunity to maximize their rights and responsibilities;

(ii) Participants have the right to refuse services and shall not be disciplined or charged with a monetary fee for refusing home and community based waiver services;

(iii) Participants, parents of a minor, and legally authorized representatives are informed of the participant's rights and responsibilities;

(A) The information shall be given at the time of entry to direct care and case management services, annually thereafter, and when significant changes occur; and

(B) The information shall be provided in a manner that is easily understood, given verbally and in writing, in the native language of the participant or legally authorized representative(s), or through other modes of communication necessary for understanding;

(iv) Participants are supported in exercising their rights while receiving waiver services;

(v) Rights shall not be treated as privileges or things that should be earned; and

(vi) Retaliation against a participant's services and supports due to the participant, family members, or legally authorized representatives advocating on behalf of the participant or initiating a complaint with an outside agency, is prohibited.

(f) Providers shall not request or require participants to waive or limit their rights as a condition of receiving service.

(g) Providers shall not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any individual who exercises any right established by, or for participation in any process provided in, these rules or the Wyoming Medical Assistance and Services Act.

(h) When rights restrictions are deemed necessary, the individualized plan of care shall include a rights restriction protocol that addresses the reasons for the rights restriction(s), including the legal document, court order, guardianship papers, or medical order, that allows a person other than the participant to authorize a restriction to be imposed.

(i) For any rights restriction imposed, the following items shall be addressed and documented in the individualized plan of care:

(A) Identification of the specific and individualized assessed need;

(B) Documentation of the positive interventions and supports used prior to any modifications to the individualized plan of care;

(C) Documentation of less intrusive methods of meeting the need that have been tried but did not work;

(D) A clear description of the condition that is directly proportionate to

the specific assessed need;

(E) A system of regular data collection and review to measure the ongoing effectiveness of the modification;

(F) Established time limits for periodic reviews, not to exceed six (6) months, to determine if the modification is still necessary or can be terminated;

(G) Informed consent of the individual; and

(H) Assurance that interventions and supports will cause no harm to the individual.

(ii) In addition to the items mentioned in this Section, the individualized plan of care shall address how the team will work to restore any right described in this Section that has been limited or denied.

**Section 5. Provider Qualifications for Each Waiver Service**.

(a) All individual waiver providers, subcontractors, and provider employees offering direct services to waiver participants shall meet the following requirements unless otherwise specified in this Section:

(i) Be eighteen (18) years or older;

(ii) Be certified by the Division to provide the indicated service;

(iii) Maintain current CPR and First Aid Certification, which includes hands-on training from a trainer certified with a curriculum consistent with training standards set forth by the American Heart Association or the American Red Cross;

(iv) Have a valid email address, internet access, and the means to upload documentation into a Division designated portal; and

(v) If assisting with medications, maintain a current certificate in medication assistance training offered through the Division.

(b) A provider shall also meet the following specific requirements for the service in which they want to receive and maintain certification:

(i) Behavioral Support Services. A provider of Behavioral Support Services shall have either:

(A) A Master's Degree and be a Board Certified Behavior Analyst; or

(B) A current license to practice from the Wyoming Board of

Psychology.

(ii) Case Management.

(A) All providers of case management services shall have one (1) of the following:

(I) A Master's degree from an accredited college or university in one (1) of the following related human service fields:

(1.) Counseling;

(2.) Education;

(3.) Gerontology;

(4.) Human Services;

(5.) Nursing;

(6.) Psychology;

(7.) Rehabilitation;

(8.) Social Work;

(9.) Sociology; or

(10.) A related degree, as approved by the Division.

(II) A Bachelor's degree in one (1) of the related fields from subsection (I) above from an accredited college or university, and one (1) year work experience as a case manager or in a related human services field.

(III) An Associate's degree in a related field from subsection (I) above from an accredited college, and four (4) years of work experience as a case manager or in a related human services field.

(B) A case manager shall obtain and maintain his or her own National Provider Identifier (NPI) number for case management services through the Medicaid enrollment process.

(C) A case manager shall obtain and provide evidence of eight (8) hours of continued education relating to the delivery of case management services during each year of certification.

(D) A provider agency certified to provide case management services shall:

(I) Identify a back-up case manager from the list of Division certified case managers for each participant, and have policies and procedures for backup case management for each person's caseload, which include a process for how and when the case manager will notify the plan of care team that the backup case manager should be the primary contact. Case managers shall meet with their designated backup to review all participant cases on a quarterly basis. The review shall be documented in case notes.

(II) Document on the individualized plan of care that they have no conflict of interest with the participant or family.

(III) Meet all of the following conflict of interest requirements.

(1.) The case management agency and any managing employee shall not own, operate, be employed by, or have a financial interest in or financial relationship with any other person or entity providing services to a participant.

(2.) The case management agency may be certified in other waiver services, but shall not provide case management services to any participant to whom they are providing any other waiver services, including self-directed services.

(3.) The owner, operator, or managing employee of a case management agency shall not be related within the third degree by blood or marriage to the owner, operator, or managing employee of any other waiver service provider on the participant's individualized plan of care. A relationship within the third degree includes the spouse; biological, step, or adoptive parent; mother, father, brother, or sister-in-law; biological, step, or adoptive child; biological, step, or adoptive sibling; grand or great grand-parent or child; or aunt, uncle, niece, or nephew.

(4.) Any employee of a guardianship agency shall not provide case management to any participant who is receiving any services from the guardianship agency.

(5.) The case management agency shall not:

a. Employ case managers that are related to the participant, the participant's guardian, or a legally authorized representative, within the third degree, served by the agency. If the case management agency is a sole proprietor, the case manager shall not be related to the participant, the participant's guardian, or a legally authorized representative, within the third degree, served by the agency;

b. Make financial or health-related decisions on behalf of the participant receiving services from that agency, including but not limited to a guardian, representative payee, power of attorney, or conservator; or

c. Provide case management services to, or live in the same residence of, any provider on a participant's individualized plan of care in which they provide case management services.

(E) If a rural area of the State does not have a case manager without a conflict of interest for a participant, the participant or legally authorized representative may request to have a case manager with a conflict. If the Division confirms that there are no other case managers available in the region or a nearby region to provide case management, then the conflicted case manager may be approved on an annual basis. A third party entity without a conflict shall be involved in the participant's team to mediate, advocate for the participant as needed, and address unresolved grievances for any conflicts that are approved.

(F) All case managers shall notify the provider of a participant's or legally authorized representative's decision to discontinue services within three (3) business days.

(iii) Child Habilitation. A Child Habilitation provider, if operating a day care while also providing child habilitation services, shall follow the Department of Family Services licensing rules in addition to meeting the Medicaid waiver provider rules.

(iv) Cognitive Retraining. A Cognitive Retraining provider shall:

(A) Be certified in Cognitive Retraining from an accredited institution of higher learning;

(B) Be a certified Brain Injury Specialist through the Brain Injury Association of America; or

(C) Be a licensed professional with one year of acquired brain injury training or Bachelor's degree in related field and three (3) years of experience in working with acquired brain injuries.

(v) Dietician. A Dietician provider or provider staff shall have a license to provide dietician services by the Wyoming Dietetics Board and a National Provider Identifier (NPI).

(vi) Environmental Modification. Environmental Modification providers shall have all applicable building, construction, and engineer license and certifications that may be required to work as a contractor at the location where services will be provided. Employees do not have to be certified in CPR or First aid, complete a background check, or have participant specific training. The provider shall report critical incidents as defined in Section 20.

(vii) Individual Habilitation Training. Within one (1) year of being certified in this service, and annually thereafter, the provider or staff providing the service shall successfully complete at least eight (8) hours of continued education in any of the following areas: specific

disabilities or diagnosed conditions relating to the population served, writing measurable objectives, gathering and using data to develop better training programs, or training modules posted by the Division.

(viii) Homemaker. A provider of Homemaker services shall be at least eighteen (18) years old but does not have to be certified in CPR and First Aid.

(ix) Occupational Therapy. An Occupational Therapy provider or provider staff shall have a current license to practice occupational therapy by the Wyoming Board of Occupational Therapy and a National Provider Identifier (NPI).

(x) Physical Therapy. A Physical Therapy provider or provider staff shall have a current license to practice physical therapy by the Wyoming Board of Physical Therapy and a NPI.

(xi) Skilled Nursing. A skilled nursing provider or provider staff shall be licensed to practice nursing by the Wyoming Board of Nursing, and have a current NPI.

(xii) Special Family Habilitation Home. A Special Family Habilitation Home provider shall be at least 21 years of age.

(xiii) Specialized Equipment. A Specialized Equipment provider shall have the applicable license or certification for the type of equipment purchased, and does not have to be certified in CPR or First Aid.

(xiv) Speech, Hearing, and Language Services. A Speech, Hearing, and Language Service provider or provider staff shall have a current license to practice Speech, Hearing and Language Services by the Wyoming Board of Speech Pathology and Audiology, and have a current NPI.

(xv) Transportation. A Transportation provider shall have a current, valid driver's license; automobile insurance; and additional liability insurance for transporting people for business purposes.

**Section 6. Standards for all Providers.**

(a) Consistent with the provisions of this chapter, providers shall:

(i) Protect participants from abuse, neglect, mistreatment, intimidation, and exploitation;

(ii) Treat participants with consideration, respect, and dignity;

(iii) Honor participants' preferences, interests, and goals;

(iv) Provide participants with daily opportunities to make choices and participate in decision making;

(v) Facilitate activities that are meaningful and functional for each participant;

(vi) Direct services toward maximizing the growth and development of each participant for maximum community participation and citizenship;

(vii) Provide services in the most appropriate, least restrictive, most integrated environment;

(viii) Encourage participants to express their wishes, desires, and needs;

(ix) Protect and promote the health, safety, and well-being of each participant;

(x) Design services to meet the needs of all participants served by the provider; and

(xi) Establish and implement written policies and procedures that:

(A) Are available to staff, participants, legally authorized representatives and, upon request, the general public;

(B) Are updated or revised as needed by rule or policy changes;

(C) Are reviewed at least annually with employees; and

(D) Describe the provider's operation and how systems are set up to meet participants' needs.

(b) Before providing services to a participant, the provider shall gather and review referral information regarding the participant so, to the greatest extent possible, the provider is aware of the participant's preferences, strengths, and needs. The provider shall use this information to:

(i) Make a determination as to whether the provider is capable of providing services to meet the participant's needs;

(ii) Consider the safety of all participants who the provider serves in the decision to accept new participants to services or the location for the services; and

(iii) Consider whether the provider has the capacity, commitment, and resources necessary to provide supports to the participant served. The provider shall not serve a participant if the provider cannot reasonably assure the participant, legally authorized representative, and case manager that it has the ability to meet the participant's needs.

(c) The provider shall orient, train, and manage staff with the skills necessary to meet the needs of participants in their services, and be able to respond to emergencies.

(d) The provider shall facilitate opportunities for all participants to receive services consistent with the needs and preferences of the participant.

(e) The provider shall develop a process for detecting and preventing abuse, neglect, exploitation, and intimidation, and handling allegations of abuse, neglect, exploitation, and intimidation in accordance with state and federal statutes and rules.

(f) The provider shall, at all times, maintain documentation to demonstrate sufficient staff provide services, supports, and supervision to meet the needs of each participant per the participant's individualized plan of care.

(g) The provider shall implement reasonable and appropriate policies and procedures to comply with the standards, specifications, and requirements of this Chapter and the Comprehensive and Supports Waiver Service Index, which is incorporated by reference. Compliance with this provision does not permit or excuse a violation of any standard, specification, or requirement of this chapter. A provider may change its policies or procedures at any time, provided that the changes are documented, implemented, and maintained in accordance with the standards, specifications, and requirements of these rules.

(h) Any person who provides a service for which a license, certification, registration, or other credential is required shall hold the current license, certification, registration, or credential in accordance with applicable state laws. The license holder shall notify the Division if the license, certification, registration, or credential is revoked, within ten (10) business days. The provider shall maintain documentation of the staff credentials.

(i) If the Division receives information that the provider no longer meets the qualifications for a service for which the provider is certified, the Division shall send notice to the provider within five (5) business days regarding this missing qualification and the applicable sanction. If the missing qualification is not obtained within the timeframe given by the Division, the provider is disqualified from providing such waiver service(s).

(j) Providers that subcontract for services shall be responsible for assuring that the subcontractors meet all applicable requirements, qualifications, and standards for the services being provided. Failure of a provider who subcontracts to assure that the subcontractor meets all applicable requirements and standards may result in revocation of the provider's certification pursuant to Section 30 of this Chapter.

**Section 7. Provider Recordkeeping and Data Collection.**

(a) The provider shall collect and maintain data, records, and information as necessary to provide services.

(b) The provider shall develop and maintain a record keeping system that includes a separate record for each participant served.

(c) The provider shall develop and implement a systematic organization of records to ensure permanency, accuracy, completeness, and easy retrieval of information.

(d) The provider shall develop a process relating to retention, safe storage, and safe destruction of the participant's records to ensure retention of necessary information and to protect confidentiality of records. The provider shall retain all records relating to the participant and the provision of services in accordance with Chapter 3 of the Department of Health's Medicaid Rules.

(e) If there are changes in ownership of the provider agency, complete and accurate copies of all participant records shall be transferred to the participant's newly chosen provider. Before dissolution of any provider agency, the provider shall follow Medicaid disenrollment procedures and notify the Division in writing of the location and secure storage of any remaining participant records.

(f) The provider shall establish and implement policies that govern access to, duplication, dissemination, and release of information from the participant's record, which are consistent with applicable state and federal laws.

(g) Except as otherwise provided by law, the provider shall obtain a written authorization from the participant or the participant's legally authorized representative for the release of participant information that identifies or can readily be associated with the identity of a participant. The authorization shall comply with the requirements for hospital records identified in W.S. 35-2-607.

(h) Providers shall make all records maintained or controlled by the provider available upon request to Division staff, representatives from the State or Federal Medicaid programs, or the Medicaid Fraud Control Unit, without prior written authorization, consent, or other form of release.

(i) The provider shall specify the method and frequency for obtaining authorizations for medical treatment and consents.

(j) The provider shall ensure that all record entries are dated, legible, and clearly identify the person making the entry.

**Section 8. Documentation Standards**.

(a) In addition to the requirements of Chapter 3 of the Department of Health's Medicaid Rules, the following provisions shall apply to the documentation of services, and medical and financial records, including information regarding dates of services, diagnoses, services furnished, and claims affected by this Chapter.

(b) A provider shall complete all required documentation, including the required signatures, before or at the time the provider submits a claim.

(i) Documentation prepared or completed after the submission of a claim is prohibited. The Division shall deem the documentation to be insufficient to substantiate the claim, and Medicaid funds shall be withheld or recovered.

(ii) Documentation shall not be altered in any way once billing is submitted, unless the participant or legally authorized representative requests an amendment to the documentation in accordance with the patient privacy rules in the Health Insurance Portability and Accountability Act of 1996.

(c) A provider shall document services either electronically or in writing.

(d) Electronic documentation shall capture all data required by subsection (e) of this Section, shall include electronic signatures and automatic date stamps pursuant to W.S. 40-21-107, and shall have automated tracking of all attempts to alter or delete information that was previously entered.

(i) Electronic records shall not be altered or deleted prior to submission of payment unless incorrect, and the purpose of the correction shall be captured in the electronic documentation system.

(ii) If anyone other than the employee who provided the service completes electronic documentation for the purpose of claims submission, the provider of the service shall separately maintain all written or electronic service documentation to support the claim.

(iii) A provider shall make a participant's electronic case file, specific to the case manager's caseload, available to a case manager in the electronic record in order to comply with the required documentation reviews and service unit utilization specified in this Chapter.

(iv) Case management monthly documentation in the Electronic Medicaid Waiver System (EMWS), or its successor, once marked as final and submitted to the Division in the web portal, meets the requirements for an electronic signature and date stamp. These records cannot be altered once the case manager bills for the service provided.

(e) For written documentation, each physical page of documentation shall include:

(i) The full legal name of the participant;

(ii) The individualized plan of care start date for the participant;

(iii) The name and billing code of the service provided; and

(iv) A legible signature of each person performing a service, if initials are being used for documentation purposes.

(f) The following information shall be included each time a service is documented:

(i) The location of services;

(ii) The date of service, including year, month, and day;

(iii) The time services begin and end, using either AM and PM or military time, with documentation for each calendar day, even when services span a period longer than one calendar day;

(iv) An initial or signature of the person performing the service; and

(v) A detailed description of services provided that:

(A) Consists of a personalized list of tasks or activities that describe a typical day, week, or month for a participant, in which the participant and legally authorized representative has provided input;

(B) Supports recommendations from assessments by therapists, licensed medical professionals, psychologists, and other professionals in a manner that prevents the provision of unnecessary or inappropriate services and supports;

(C) Reflects the participant's desires and goals; and

(D) Includes specific objectives for habilitation services, support needs, and health and safety needs.

(g) Different services shall be documented on separate forms and shall be clearly separated by time in and out, service name, documentation of services provided, signature of staff providing services, and printed name of staff providing the service.

(h) A provider shall not bill for the provision of more than one direct service for the same participant at the same time unless the participant's approved individualized plan of care identifies the need for more than one (1) direct service to be provided at the same time.

(i) A provider staff member shall not bill for the provision of more than one direct service for different participants at the same time.

(j) A provider shall not round up total service time to the next unit, except as outlined in the Skilled Nursing section of the Comprehensive and Supports Waiver Service Index.

(k) Documentation of services shall be legible, retrieved easily upon request, complete, and unaltered. If hand written, documentation shall be completed in permanent ink.

(l) Services shall meet the service definitions outlined in the Comprehensive and Supports Waiver Service Index, and be provided pursuant to a participant's individualized plan of care.

(m) For all direct care waiver services, the participant shall be in attendance in the service in order for the provider to bill for services.

(n) The provider shall make service documentation for services rendered available to the case manager each month by the tenth ($10^{th}$) business day of the month following the date that the services were rendered. If services are not delivered during a month, the provider shall report the zero (0) units used to the case manager by the tenth ($10^{th}$) business day of the following month.

(i) Failure to make documentation available by the tenth ($10^{th}$) business day of the month may result in a corrective action plan or sanctioning.

(ii) The case manager shall give written notification of noncompliance to the provider with a copy submitted to the Behavioral Health Division. Chronic failure to make documentation available may result in provider sanctions.

(o) The provider shall make unit billing information for services rendered available to the case manager by the tenth ($10^{th}$) business day of the month after unit billing has been submitted for payment.

**Section 9. Case Management Services.**

(a) Case management is a mandatory service for all participants enrolled on the waivers.

(b) Case managers shall complete all eligibility paperwork, as established under Chapter 46 of the Department of Health's Medicaid Rules, within thirty (30) calendar days.

(c) A case manager shall use person-centered planning to understand the needs, preferences, goals, and desired accomplishments of the participant. The case manager shall coordinate and assist the participant in accessing all needed and available resources, such as natural, paid, and community support. The case manager shall develop and monitor the implementation of an individualized plan of care.

(d) It is the case manager's responsibility to assure all information, including but not limited to guardianship paperwork and physical and mailing addresses of the participant, legally authorized representative(s), and other contacts is updated and accurate at all times. The case manager shall update the Division and other providers of any changes.

(e) The case manager shall maintain a participant's file and service documentation.

(i) The case manager shall assure information is disseminated to, and received by, the participant and appropriate parties involved in the participant's care or as authorized by a signed release of information by the participant or the participant's legally authorized representative(s).

(ii) The case manager shall arrange and coordinate eligibility for applicants, or waiver participants by providing:

(A) Targeted case management services to an applicant who is in the eligibility process for waiver services or awaiting a funding opportunity; and

(B) Services that include the coordination and gathering of information needed for initial and annual certification, clinical and financial eligibility, and the level of care determination.

(iii) The case manager shall provide the participant and any legally authorized representative(s) with a list of all providers available in their community in order to allow the participant a choice of providers. To the extent that they are available, participant choice shall include any certified waiver provider, self-directed options, Medicaid State Plan services, and services offered by other state agencies, as well as community and natural supports.

(A) At least once every six (6) months, the case manager shall provide information to the participant or the legally authorized representative(s) on all available waiver services, including self-direction service delivery options. This may be done more frequently as requested by the participant or legally authorized representative(s).

(B) The case manager shall coordinate transition plans when the participant chooses to change, stop, or add providers to his or her individualized plan of care, or exit the waiver, as established under Section 22 of this Chapter.

(C) If the case manager chooses to discontinue providing services, the case manager shall give the participant, legally authorized representative(s), and Division thirty (30) calendar days written notice. The case manager shall continue to provide case management services for the thirty (30) calendar days, or until a new case manager is approved, whichever is first.

(iv) The case manager shall involve and assist the participant's plan of care team with developing a person-centered individualized plan of care in accordance with this Chapter. The case manager shall assist the team with planning, budgeting, and prioritizing services for the participant using all available resources and the assigned individual budget amount.

(v) The case manager shall complete and submit the individualized plan of care, including all required components, in EMWS, or its successor, at least thirty (30) days before the intended plan start date.

(vi) If the participant chooses to self-direct services on the waiver, the case manager shall assist the participant in modifying the individualized plan of care as needed, and monitoring the services of the Financial Management Service utilized by the participant in accordance with the approved waiver.

(vii) The case manager shall ensure all providers on the participant's individualized plan of care sign off on the plan, receive a copy of the plan, receive team meeting notes, and complete participant specific training as required in Section 15(g) of this Chapter. Documentation of participant specific training shall be available to the Division upon request.

(viii) The case manager shall monitor and evaluate the implementation of the participant's individualized plan of care, including a review of the type, scope, frequency, duration, and effectiveness of services, as well as the participant's satisfaction with the supports and services. On a quarterly basis, the case manager shall include this information in a report prescribed by the Division.

(ix) The case manager shall report to the provider any concerns with provider implementation of the individualized plan of care, or concerns with the health and safety of a participant. These concerns shall be reported to the Division through the incident reporting or complaint processes.

(x) The case manager shall send the Division and the provider or employer of record written notification of noncompliance with these rules, the health, safety, or rights of the participant specified in the individualized plan of care, or when documentation is not received by the tenth (10th) business day of the following month after services were provided.

(xi) The case manager shall securely store and retain all confidential provider documentation received from other providers for a participant's services for a twelve (12) month period from the month services were rendered and shall follow safe destruction policies as established under Section 7 of this Chapter, even if the participant changes case managers.

(xii) The case manager shall document all monitoring and evaluation activities, follow-up on concerns and actions completed, and make appropriate changes to the individualized plan of care with team involvement, as needed.

(f) A case manager shall be the second-line monitor for participants receiving medications. Second-line monitoring shall help to ensure a participant's medical needs are addressed and medication regimens are delivered in a manner that promotes the health, safety, and well-being of the participant. The case manager shall provide monitoring of, and review trends regarding, the usage of the participant's over-the-counter and prescription medications through a monthly review of medication assistance records and PRN medication usage records.

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

**Section 10. Individualized Plan of Care.**

(a) A case manager shall convene the plan of care team to develop an individualized plan of care for each participant on his or her caseload, and base the plan on the results of the comprehensive assessment(s) and the person-centered planning process. The team shall be comprised of persons who are knowledgeable about the participant and are qualified to assist in developing an individualized plan of care for that person, including: the participant; any legally authorized representative(s); the case manager; providers chosen by the participant; and any other advocate, family member, or entity chosen by the participant or the participant's legally authorized representative(s).

(b) The plan of care meeting shall be timely and occur at times and locations that are convenient for the participant.

(c) The case manager shall provide written notice of the plan of care meeting to all team members at least twenty (20) calendar days prior to the meeting.

(d) The individualized plan of care shall not exceed twelve (12) months and shall be developed in accordance with state and federal rules, which includes the submission of the complete individualized plan of care to the Division at least thirty (30) days prior to the plan start date. Corrections to the individualized plan of care required by the Division shall be submitted by the case manager within seven (7) business days of being issued.

(e) The individualized plan of care shall include:

(i) Necessary information and support to the participant to ensure that the participant directs the process to the maximum extent possible;

(ii) Services in a setting chosen by the participant from all service options available, including non-disability specific settings and alternate settings that were considered;

(iii) Opportunities for the participant to seek employment and work in competitive integrated settings;

(iv) Opportunities for the participant to engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid home and community-based services;

(v) Cultural and religious considerations;

(vi) Services based on the choices made by the participant regarding supports the participant receives and from whom;

(vii) What is important to the participant and for the participant;

(viii) Services provided in a manner reflecting personal preferences and ensuring health and welfare;

(ix) Services based on the participant's strengths and preferences;

(x) Any rights restrictions, including why the restriction is imposed, how the restriction is imposed, and the plan to restore the right to the fullest extent possible;

(xi) Both clinical and support needs;

(xii) Participant's desired outcomes;

(xiii) Risk factors and plans to minimize them;

(xiv) Individualized backup plans and strategies when needed;

(xv) Individuals important in supporting the participant, such as friends, family, professionals, specific staff or providers;

(xvi) Learning objectives for habilitation services that address the training activities, training methods, and the measurement used to gauge learning;

(xvii) Relevant protocols that have been updated within the past year;

(xviii) Informed consent of the participant or legally authorized representative in writing; and

(xix) Signatures of all providers listed in the individualized plan of care after the draft plan, as written, is completed by the team including participant's signature for informed consent.

(f) The individualized plan of care shall include information addressing a provider's inability to provide any of the supports outlined in subsection (e) of this Section.

(g) The individualized plan of care shall be reviewed at least semi-annually, when the participant's circumstances or needs change significantly, or at the request of any team member. The plan shall be revised upon reassessment of functional need, as needs arise, and every twelve (12) months for a new plan year.

(h) The individualized plan of care shall be written in plain language that is understandable to the participant, legally authorized representative(s), and persons serving the participant.

**Section 11. Rate Reimbursement Requirements.**

(a) Providers shall be reimbursed for services through the rate methodology established in the corresponding waiver agreement with CMS.

(b) Rates paid to providers for waiver services shall be less than or equal to the usual and customary rates for similar non-waiver services.

(i) The Department shall consult with waiver service providers, developmental disability waiver program participants and their families to gather information about reimbursement rates prior to calculating the new reimbursement rates.

(ii) If third party expertise is necessary, the Department shall follow a competitive bidding process to procure the services of an expert in the development of cost-based waiver program payments to assist with the development of new reimbursement rates for waiver providers.

(iii) The Department shall receive approval from CMS prior to the implementation of a new or modified reimbursement rate setting methodology.

(c) Upon request, providers shall submit the following information to the Division:

(i) Cost data;

(ii) Claims data; and

(iii) Participant needs assessment data.

(d) Providers shall participate in reasonable audits of the data submitted in subsection (c).

**Section 12. THIS SECTION RESERVED FOR FUTURE RULEMAKING**

**Section 13. Home and Community Based Standards for Waiver Services.**

(a) Certified waiver providers offering direct care services to participants in a provider owned or operated service setting shall meet all applicable federal, state, city, county, and tribal health and safety code requirements. A service setting includes the provider's home, if services are routinely provided in that setting.

(b) Certified waiver providers shall provide services that are home and community-based in nature, which means the service setting:

(i) Assists the participant to achieve success in the setting environment and supports full access to the greater community to the same degree as individuals not receiving Medicaid home and community based services (HCBS);

(ii) Is selected by the individual from options including non-disability specific settings;

(iii) Assists the participant to advocate for him or herself, and participate in life-long learning opportunities;

(iv) Ensures an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint;

(v) Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including daily activities, recreational activities, physical environment, and with whom to interact;

(vi) Facilitates individual choice regarding services and supports and who provides them; and

(vii) Encourages individuals to have visitors of their choosing at any time.

(c) Settings that are not considered home and community-based include, but are not limited to:

(i) Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment;

(ii) Any setting that is in a building on the grounds of, or immediately adjacent to, a public institution; or

(iii) Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

(d) New provider owned or operated community living settings serving five (5) or more participants shall not be certified.

(e) Provider service setting inspections.

(i) For each location where services are provided to a participant, the provider shall obtain an inspection of the service setting by an outside entity at least once every twenty-four (24) months. The Division may require more frequent inspections if the Division suspects that the provider or employee’s service setting would not pass the inspection.

(ii) The inspection of the service setting shall be completed by one or more of the following outside entities:

(A) A fire marshal or designee;

(B) A certified or licensed home or building inspector; or

(C) An appropriate contractor inspecting a part of the service setting within the scope of the contractor’s license.

(iii) Inspections of service settings required by this Section shall include verification that:

(A) All areas are free of fire and safety hazards, including, but not limited to, all living and service areas, as well as the garage, attic, and basement areas; and

(B) The service setting is free of any other significant health or safety concerns, including structural concerns, wiring problems, plumbing problems, and any major system concerns.

(iv) Inspections of service settings shall include a written report that describes the items inspected and recommendations to address areas of deficiencies.

(v) If the inspection of the service setting identifies deficiencies, the provider shall remediate deficiencies within thirty (30) calendar days. If deficiencies cannot be corrected within thirty (30) calendar days, a written plan on how deficiencies will be remediated, including the anticipated date of completion, shall be completed within thirty (30) calendar days of the initial report, and available to the Division upon request.

(A) The written plan shall address all identified deficiencies and the intended completion dates.

(B) The Division may request additional corrective actions or proof of corrections made, based on the inspector's report.

(C) Services shall not be provided in a setting that does not pass the initial inspection until all deficiencies have been corrected.

(vi) External inspections shall be required on all new locations before services are provided in the new location.

(A) The provider shall notify the Division of the new location at least thirty (30) calendar days before the location is to be used to provide services.

(B) The provider shall not provide services in the new location until the Division has reviewed the external inspection report and has verified that all recommendations have been addressed. The Division shall complete an on-site visit within six (6) months.

(vii) Providers that are not required to have an inspection of the home or service setting shall sign a form designated by the Division to verify they are not providing services in a provider-owned or leased service setting.

(viii) Except as described in subsection (a) of this Section, providers shall not provide services in a service setting that is owned or leased by the provider or an employee, which has not had a current inspection completed. The Division may sanction or decertify any

provider or self-directed employee if they are subsequently found to be providing services in a service setting owned or leased by the provider or employee, which has not previously passed inspection.

(f) Self-Inspections. A provider offering services in a service setting they own or lease shall complete an annual self-inspection of the service setting to verify that the provider is in compliance with this Section.

(g) Emergency plans.

(i) Providers shall have written emergency plans and procedures for:

(A) Fires;

(B) Bomb threats;

(C) Natural disasters, including but not limited to earthquakes, blizzards, floods, tornadoes, wildfires;

(D) Power and other utility failures;

(E) Medical emergencies;

(F) Missing person;

(G) Provider incapacity;

(H) Safety during violent or other threatening situations;

(I) Staffing shortages due to other emergency situations;

(J) Vehicle emergencies; and

(K) If applicable, how the provider is able to care for or provide supervision to both participants and any children under the age of 12 or other individuals requiring support and supervision.

(ii) The emergency plans shall include a contingency plan that assures that there is a continuation of essential services when emergencies occur.

(iii) The provider shall document the review of all applicable emergency plans, with staff and participants, at least once every twelve (12) months on routine shifts. The documentation shall include:

(A) Written identification of concerns noted during the review of plans;

(B) Written documentation of follow-up to concerns noted during the review of plans; and

(C) Evidence of one fire drill, including an evacuation of the premises.

(h) Other service standards. All service settings owned or controlled by a provider shall meet the following requirements:

(i) In community living service and day service settings, the provider shall ensure participants have access to food at all times, and provide nutritious meal and snack options. Providers shall not require a regimented meal schedule except as outlined in subsection (n) of this Section.

(ii) Raw and prepared food, if removed from the container or package in which it was originally packaged, shall be stored in clean, covered, dated, and labeled containers. Fruit and vegetable produce may remain unmarked unless partially prepared or used.

(iii) All food shall be served in a clean and sanitary manner.

(iv) Floors and floor coverings shall be maintained in good repair, with the exception of incidental stains natural to the life of the carpet, and shall not be visibly soiled, malodorous, or damaged.

(v) Walls, wall coverings, and ceilings shall be maintained in good repair and shall not be visibly soiled or damaged.

(vi) All doors, windows, and other exits to the outside shall be reasonably protected against the entrance of insects and rodents, and shall be maintained in good repair.

(vii) All windows shall be free of cracks or breaks.

(viii) All medications, chemicals, poisons, and household cleaners shall be secured in a manner that minimizes the risk of improper use or harm to individuals in the setting.

(ix) All restrooms shall contain trash receptacles, towels, hand cleanser, and toilet tissue at all times.

(x) Restrooms shall be kept clean and sanitary, and maintained in good repair.

(xi) The overall condition of the home or service setting shall be maintained in a clean, uncluttered, sanitary, and healthful manner that does not impede mobility or jeopardize a participant’s health or safety, and allows physical access.

(xii) Providers shall not use video monitors in participant bedrooms or bathrooms. Other forms of remote monitoring, remote support, or sensors may be used where appropriate, and shall be documented in the participant's individualized plan of care.

(A) The consent of participants who share living quarters and may be affected shall be obtained prior to the implementation of remote support or monitoring.

(B) Consent shall be documented in each participant's individualized plan of care, which is verified by the plan of care team.

(xiii) A provider service setting with a private water supply shall have testing conducted every three (3) years to demonstrate that the water is safe to drink. The written results shall be submitted to the Division within thirty (30) calendar days of receiving test results.

(xiv) Providers shall ensure that all participants residing in a provider owned or leased service setting have:

(A) A lease or residency agreement for the location in which they are agreeing to reside. The lease or agreement shall be signed by the participant or legally authorized representative, and the provider. The lease or agreement shall allow the same responsibilities and protections from eviction as all tenants under landlord tenant law of the state, as established under W.S. 1-21-1201 through -1211, the county, and the city where the service setting is located. A participant shall not be asked to leave his or her residence on a regular basis to accommodate the provider;

(B) Freedom and support to control their schedules and activities;

(C) Freedom to access the community;

(D) Freedom to furnish and decorate their sleeping and living units within the lease or other agreement;

(E) A private bedroom with no more than one (1) person to a bedroom unless a more preferred situation is identified in his or her individualized plan of care and one (1) of the following criteria is met:

(I) The participant is under two (2) years of age;

(II) The services provided are episodic;

(III) The arrangement is determined medically necessary; or

(IV) The participants request to share a bedroom.

(F) An individual bed, unless the participant is married or joint sleeping accommodations are specifically requested by the participant, and specified in the individualized plan of care;

(G) Access to appropriate egress and a lockable entrance, which can be unlocked by the participant. No devices shall be used that prohibit a participant's entry or exit from the bedroom;

(H) A secure place for personal belongings, which the participant may freely access;

(I) A key or other type of access to a lock for the housing unit, the participant's bedroom, and any form of locked storage where the participant's personal belongings are kept, with only appropriate staff having keys to doors; and

(J) Other appropriate sleeping quarters as necessary to meet health and safety needs for an emergency placement, as long as the sleeping area allows for personal privacy and immediate egress.

(I) Emergency placement, due to situations defined in Chapter 46, Section 14, shall be limited to one week. A participant may request additional emergency placement on a week-by-week basis if the emergency continues and affirmative steps to secure alternative permanent placement are not successful.

(II) Following emergency placement, the participant shall be permitted to transfer to permanent housing. If the provider is no longer able to serve the participant in permanent housing, the case manager will present the participant with options to transition to other certified providers.

(K) Providers shall notify the Division in writing within seven (7) calendar days if additional individuals move into the home or have the intent of staying in the home for a period longer than one month.

(xv) Written policies to address health, safety, and rights. Providers shall share policies with participants and the legally authorized representative before the participant formally chooses the provider. Print information shall be written in plain language. Policies shall include:

(A) A smoking policy that assures protection of the health of the participant, if occupants or visitors of the home smoke;

(B) A pet policy that includes verification that pets have current vaccinations, if occupants or visitors have pets; and

(C) A weapons policy that includes the requirements that weapons are stored in a locked cabinet or inaccessible location, and ammunition is stored separately from firearms, if occupants or visitors have weapons in the home.

(i) The provider may be required to provide written verification of their organization's ability to provide support and supervision to children under the age of twelve (12) or other participants requiring support and supervision who are in the care and responsibility of the provider. This may include, but is not limited to, licensure by the Department of Family Services or other appropriate state agency.

(j) Unless otherwise directed by the participant's licensed medical professional, or is otherwise indicated in the individualized plan of care, community living service providers shall ensure each participant receives a medical evaluation every twelve (12) months.

(k) Each provider shall identify, in writing, the potential conflicts of interest among employees, other service providers on the participant's plan, relatives to participants, or any legally authorized representative(s), and address how a conflict of interest shall be mitigated. The provider shall share this information with potential participants and legally authorized representative(s) before the provider is chosen to provide services.

(l) Any provider that is transporting participants shall comply with all applicable federal, state, county, and city laws and requirements including, but not limited to, vehicle and driver licensing and insurance, and shall:

(i) Maintain vehicles in good repair;

(ii) Keep and replenish first aid supplies in the vehicle; and

(iii) Conduct quarterly self-inspections or have the vehicle inspected by a mechanic to ensure that the vehicle is operational, safe, and in good repair.

(m) Each provider certified to provide employment services, including supported employment and group supported employment services, shall ensure that:

(i) The participant is involved in making informed employment related decisions;

(ii) The participant is linked to services and community resources that enable them to achieve their employment objectives;

(iii) The participant is given information on local job opportunities; and

(iv) The participant's satisfaction with employment services is assessed on a regular basis.

(n) Settings that include any restriction to a participant's right to food, or a non-regimented meal schedule imposed by a provider, shall be ordered by the participant's attending medical professional with evidence in the individualized plan of care that details the assessed need for the order and the protocols that shall be followed.

(o) A participant's right to visitors, communication, privacy, or other standard in this Section may only be restricted as documented in an approved individualized plan of care with the restriction being time-limited and following the requirements listed in Section 4 of this Chapter.

**Section 14. Background Check Requirements**.

(a) All persons providing waiver services including: managers, supervisors, direct care staff, participant employees hired through self-direction, and any other person who may have unsupervised access to participants shall complete and pass a background screening as referenced in this section. Persons who do not successfully pass a background screening shall not supervise, provide, or bill for waiver services, or otherwise have unsupervised access to participants on behalf of a provider.

(b) Certified providers, their employees, and all legal entities supervising, providing, or billing for waiver services shall also pass and maintain documentation of successful Department of Family Services Central Registry screening and an Office of Inspector General Exclusion Database screening. Entities that do not successfully pass these screenings shall be denied certification or terminated.

(c) Any provider or participant who employs an individual or entity to supervise, provide, or bill for waiver services who has not completed all required background checks may be subject to sanctions under these rules.

(d) Providers and self-direction employees shall show evidence of current background screenings for all required persons as part of the provider or employee's certification renewal.

(e) A successful background screening shall include:

(i) A Wyoming Department of Family Services Central Registry Screening, which shows that the individual is not listed on the Central Registry.

(ii) A United States Department of Health and Human Services, Office of Inspector General's Exclusions Database search result, which shows that the individual or entity is not currently excluded.

(iii) A state and national fingerprinted criminal history record check which shows that the individual has not been convicted, plead guilty, no contest to, or does not have a pending deferred prosecution for:

(A) An Offense Against the Person, including:

(I) Homicide (W.S. 6-2-101)

(II) Kidnapping (W.S. 6-2-201)

(III) Sexual assault (W.S. 6-2-301)

(IV) Robbery and blackmail (W.S. 6-2-401)

(V) Assault and battery (W.S. 6-2-501),

(VI) Human trafficking (W.S. 6-2-701), and

(VII) Similar laws of any other state or the United States relating to these crimes.

(B) An Offense Against Morals, Decency and Family including:

(I) Bigamy (W.S. 6-4-401)

(II) Incest (W.S. 6-4-402)

(III) Abandoning or endangering children (W.S. 6-4-403)

(IV) Violation of order of protection (W.S. 6-4-404)

(V) Endangering children; controlled substances (W.S. 6-4-405), and

(VI) Similar laws of any other state or the United States relating to these crimes.

(f) At the discretion of the provider or employer of record, an individual staff member may provide unsupervised services on a provisional basis to a participant who is eighteen (18) years or older following the submission of the background screening, as long as disqualifying crimes or relevant criminal records are not disclosed on the application, until individual provider staff are cleared through successful background screenings.

(g) Persons who do not successfully pass the criminal history screenings listed in subsection (e) of this Section shall not be left unsupervised in the vicinity of any participant, except as provided by subsection (f) of this Section.

(h) Notwithstanding subsection (f) of this Section, staff shall not provide any services to participants ages seventeen (17) or younger until all successful background screenings listed in subsection (e) of this Section have come back with no findings.

(i) Each individual eighteen (18) years of age or older who is living in a provider's home where services are provided, or staying in the home for a period longer than one (1) month, shall pass a background check as listed in subsection (e) of this Section. An Office of Inspector General check is not required.

(i) Waiver participants receiving services in this location are not required to complete a background screening.

(ii) Providers shall not employ or permit individuals registered as a sexual offender to stay in the home. This requirement does not apply to waiver participants.

(j) If a criminal history screening does not include a disposition of a charge, or if an individual is charged with an offense listed in subsection (e)(iii) of this Section, the individual shall not have any unsupervised access or provide billable services to participants until the provider is able to provide proof of a successful background check.

(k) Volunteers and individuals under the age of eighteen (18) shall be under the direct supervision of an adult who has passed a background check. Individuals convicted of a sexual offense are not permitted as volunteers.

(l) Background screenings shall not be transferred from one provider entity to another.

(m) The background screening notification shall not be altered in any manner, including the crossing out of names or use of whiteout. If altered, the screening notification shall be determined null and void.

(n) The Division shall require subsequent background screenings as outlined in this subsection. Any person who fails to pass a subsequent background screening shall not supervise, provide, or bill for waiver services.

(i) Any individual required to receive a background screening under this Section shall undergo subsequent background screenings every five (5) years.

(ii) Providers and any person with an ownership or control interest or who is an agent or managing employee of the provider shall undergo subsequent monthly Office of Inspector General Database screenings.

(o) The Division may request a background screening at the Division's expense as part of an investigation.

**Section 15. Provider Training Standards.**

(a) In addition to the other training standards in this Chapter and the Wyoming Medicaid rules, providers shall ensure that employees, including management staff responsible

for providing supports and services to participants, receive training in the areas specified in this Section prior to working unsupervised with participants in services.

(b) Staff responsible for providing direct services shall receive participant specific training from a trained staff member prior to working alone with participants.

(c) The provider shall maintain documentation that staff are qualified to provide waiver services through evidence of completed trainings, including the date training was completed, who conducted the training, and how the employee demonstrated understanding. The provider shall ensure that training is conducted by persons with expertise in the topic area, who are qualified by education, training, and experience, and maintain complete verification of such.

(d) All persons qualified to provide waiver services shall complete training in the following areas prior to delivering services. Providers may choose to develop their own training modules for employees or use Division modules, as long as the provider covers the key elements of each topic specified in the Division module with Division approval. General training topics include:

(i) Participant choice;

(ii) The rights of participants in accordance with state and federal laws, and any rights restrictions for each participant with whom a person works;

(iii) Confidentiality;

(iv) Dignity and respect;

(v) Preventing, recognizing and reporting abuse, neglect, intimidation, exploitation, and all other categories listed on the Division's Notification of Incident form;

(vi) Responding to injury, illness, and emergencies;

(vii) Billing and documentation of services;

(viii) Releases of information;

(ix) Grievance and complaint procedures for participants, legally authorized representatives, provider employees, and community members; and

(x) Implementing and documenting participant objectives and progress on objectives.

(e) To verify each provider and provider staff meets the qualification standards, evidence of a completed training summary or test of each training topic shall be retained in the employer's files.

(f) One representative from the provider agency shall receive training on the provider certification renewal process.

(g) Participant specific training.

(i) Each provider and provider staff shall receive participant specific training prior to the individualized plan of care start date. Impacted staff shall receive participant specific training prior to changes to the individualized plan of care.

(ii) All case managers shall train one employee from each provider on the individualized plan of care. The provider shall ensure that all other employees of the provider receive plan of care training. The case manager and the participant or any legally authorized representative(s) may request verification of the provider's participant specific training. Training shall occur before the individualized plan of care start date and before each employee provides services.

(iii) A provider of waiver services shall be trained on any specific assistive technology devices, disabilities, diagnoses, or medical or risk conditions as necessary for the participants served by the provider. This training shall be unique to, and meet the needs of, the participant.

(h) Documentation of participant specific training and general training shall include:

(i) The date of the training;

(ii) The name, signature, and title of the trainer;

(iii) The name and signature of the person receiving the training;

(iv) A detailed agenda of the training topic(s), including the method of training; and

(v) How the person receiving training demonstrated understanding.

**Section 16. THIS SECTION RESERVED FOR FUTURE RULEMAKING**

**Section 17. Positive Behavior Supports.**

(a) Habilitation services shall be designed to maximize the potential of the participant. Services shall be provided in the setting that is the least restrictive for the participant.

(b) Participants shall have a positive behavior support plan in place if restraints are outlined in their individualized plan of care.

(c) A participant with a challenging behavior identified by the plan of care team shall have a current functional behavioral analysis conducted within the last year to identify what the person is trying to communicate through the behavior(s), to identify the function or possible purpose for the behavior(s), to explore antecedents and contributing factors to behaviors, and to review and describe potentially positive behavioral supports and interventions in order to develop a positive behavior support plan.

(i) Challenging behaviors may include actions by the participant that constitute a threat to the person's immediate health and safety, the health and safety of others in the environment, a persistent pattern of behaviors that inhibit the participant's functioning in public places and integration within the community, or uncontrolled symptoms of a physical or mental condition.

(ii) The functional behavioral analysis shall include data compiled regarding all challenging behaviors exhibited, and be utilized to develop the positive behavior support plan used by the provider during the provision of waiver services.

(iii) A provider or provider staff knowledgeable of the participant shall complete the functional behavior analysis, which shall include input from the team, participant, and any legally authorized representative(s).

(d) A positive behavior support plan, based upon a current functional behavioral analysis, shall be developed for a participant in order for providers working with the person to understand and recognize the communication and behaviors exhibited by the person. The positive behavior support plan shall describe agreed upon supports to assist the participant using proven support techniques and non-restrictive interventions. At a minimum, a positive behavior support plan shall:

(i) Include the components of the template provided on the Department's website.

(ii) Maintain the dignity, respect, and value of the participant;

(iii) Use a person-centered approach with the participant involved in the development of the plan on a level appropriate for that person;

(iv) Aim to minimize the use of restraints;

(v) Be specific and easily understood, so direct care employees can implement it appropriately and consistently;

(vi) Include a signature of the participant or legally authorized representative(s), which verifies informed consent;

(vii) Define the antecedents and the targeted behavior(s) that need to be replaced or reduced;

(viii) List positive behavioral supports that assist the participant in replacing targeted or challenging behaviors with appropriate replacement behaviors;

(ix) Provide protocols for providers and provider employees to recognize emerging targeted behaviors, and determine the appropriate interventions to implement positive behavioral supports;

(x) Provide protocols, which focus on positive interventions that are deemed least restrictive and most effective, for employees to use when targeted behaviors take place;

(xi) Reference the protocol for the use of any PRN medication that may be a part of the positive behavior support plan, as recommended by the treating medical professional and can be requested by the participant to help manage stress, anxiety, or behaviors;

(xii) Be reviewed every six (6) months by the provider(s) and the case manager to assess the effectiveness of the plan, or more frequently if needed;

(xiii) Include specific guidelines for tracking and analyzing the antecedents related to the occurrence of a targeted behavior, the actual behavior(s) displayed, and the results of positive behavioral interventions; and

(xiv) Be included as a formal component of the individualized plan of care.

(e) A provider employee implementing a positive behavior support plan shall receive participant specific training on the positive behavior support plan, and on specific positive de-escalation techniques and interventions, before they begin working with the participant.

(f) The case manager shall educate the participant and legally authorized representative about positive behavior supports that may be used, and the risks and benefits of any supplemental plan for the use of restraint or prescribed psychoactive medication if the positive behavior support plan fails.

(g) If restraints are used or law enforcement is contacted due to a behavioral emergency, the positive behavior support plan has failed and must be reviewed to possibly add or modify the service environment or behavioral interventions.

**Section 18. Restraint Standards.**

(a) Restraint includes physical, chemical, and mechanical restraints, as further defined in this Section.

(b) The entire plan of care team shall agree to the use of restraints, confirmed with a signature from the participant, legally authorized representative, and all providers involved, and be consistent with this Section.

(c) When the use of positive behavior supports is not effective in modifying or changing a participant's challenging behavior, the participant's plan of care team may implement a restraint protocol to supplement the positive behavior support plan, subject to the provisions of this Section.

(d) Providers shall not use aversive techniques to modify a person's behavior. Aversive techniques include any intervention that causes pain, harm, discomfort, or social humiliation for the purpose of modifying or reducing a behavior.

(e) A provider serving more than five (5) participants with restraints in their plans is required to have one (1) employee complete training on positive behavior supports through any program approved by the Division. An additional employee shall be certified for every ten (10) additional participants with restraints in their plan.

(f) The plan of care team shall review the participant's plan thoroughly to ensure the individualized plan of care is not so restrictive that it repeatedly provokes behaviors that lead to the use of restraints.

(g) When restraints are deemed necessary, the individualized plan of care shall include a restraint protocol that includes:

(i) If a person other than the participant authorizes the use of restraint, the legal document, court order, guardianship papers, or medical orders that demonstrate this authority; and

(ii) For any restraint imposed, demonstration that the standards outlined in Section 4(h)(i) of this Chapter are met.

(h) The case manager shall reconvene the participant's plan of care team if any restraints are used in the previous calendar quarter. When convened under this Section, the team shall review all restraints for the previous quarter and develop a plan to reduce the number of restraints performed. On a quarterly basis, the case manager shall report data received from the provider concerning the number of restraints performed on the participant.

(i) The provider shall notify the case manager within one (1) business day of any use of an emergency restraint that is not written in a participant's individualized plan of care. A case manager who receives notice of restraint under this provision shall call a team meeting within two (2) weeks to discuss the incident and decide if the individualized plan of care shall be modified to include a crisis intervention protocol and a revised positive behavior support plan.

(j) Restraints shall only be performed by an individual trained and certified in restraint usage.

(k) Providers employing restraints shall:

(i) Adopt policies and procedures that:

(A) Identify the provider's chosen certifying entity consistent with subsection (l) of this Section;

(B) Specify the types of restraints that may be used by provider staff; and

(C) Establish provider-specific training requirements for staff.

(ii) Adhere to all state and federal statutes, rules, and regulations regarding the use of restraints.

(iii) Only utilize restraints approved by the provider's chosen certifying entity recognized in subsection (l) of this Section, unless the restraints are prohibited in subsection (d) of this Section.

(l) The provider and provider staff shall maintain certification, and provider shall require ongoing training for employees in de-escalation techniques, crisis prevention and intervention, and proper restraint usage from entities certified to conduct the training, such as Crisis Prevention Intervention (CPI), MANDT, or other entity approved by the Division.

(m) Restraints shall only be used in emergency circumstances to ensure the immediate physical safety of the participant, a provider staff member, or other persons, and when less restrictive positive behavior supports have been determined to be ineffective. Providers shall only use restraints when the risk of injury without restraint is greater than the risk associated with the restraint. Restraints may include, but are not limited to, the following:

(i) A chemical restraint, which is any drug that is administered to manage a participant's behavior in a way that reduces the safety risk to the participant or others, has the temporary effect of restricting the participant's freedom of movement, and is not a standard treatment for the participant's medical or psychiatric condition.

(A) A chemical restraint shall not be used unless ordered by a licensed medical professional chosen by the participant or any legally authorized representative(s), and administered by a person licensed to administer the medication.

(B) Standing orders for chemical restraints are prohibited, except when deemed necessary to prevent extreme reoccurring behavior by a participant's plan of care team and limited to one (1) month. A standing order shall include clarification on the circumstances of its usage by the licensed medical professional.

(C) If a provider uses three (3) or more chemical restraints on a participant within a consecutive six (6) month period, the participant's plan of care team shall arrange for the participant to see his or her treating medical professional for a formal medical review in case the treatment plan needs to change. The participant's plan of care team shall meet to determine if the positive behavior support plan or crisis intervention protocol needs to change.

The formal medical review shall be documented in the participant's file with the restraining provider and the case manager. If it is determined that the treatment plan or individualized plan of care will not be changed, then the case manager shall document the reasons it is not being changed in the individualized plan of care.

(D) Chemical restraints shall not be used on persons under the age of eighteen (18).

(ii) A mechanical restraint, which is any device attached or adjacent to a participant's body that he or she cannot easily move or remove that restricts freedom of movement or normal access to the body.

(A) Mechanical restraints shall only be used under the direct supervision of a licensed medical professional for the purpose of medical treatment procedures when compliance is deemed necessary to protect the health of the participant.

(B) Mechanical restraints shall not be used on persons under the age of eighteen (18).

(iii) A physical restraint, which is the application of physical force without the use of any device, for the purpose of limiting the free movement of a participant's body. Physical restraint does not include briefly holding a participant, without undue force, in order to calm or comfort him or her, or holding a participant's hand to safely escort him or her from one area to another.

(n) Seclusion is the involuntary confinement of a participant alone in a room or an area from which the participant is physically prevented from leaving. Seclusion is prohibited, and may result in sanctions, including the repayment of funds for waiver services.

(o) A provider using restraints shall:

(i) Maintain internal documentation to track and analyze each use of a restraint, its antecedents, reason(s) for the restraint, the participant's reaction to the restraint, and actions that may make future restraints unnecessary;

(ii) Implement additional supports with the participant in an effort to minimize restraints;

(iii) Use appropriate de-escalation techniques to redirect or mitigate a behavior before restraints occur;

(iv) Address and correct staff using restraints incorrectly;

(v) If an injury occurs as a result of a restraint, conduct staff retraining within five (5) business days if the injury being detected;

(vi) Hold a debriefing meeting with the participant, legally authorized representative, and case manager as soon as practicable after an incident to discuss the use of the restraint. Legally authorized representatives may be part of the participant's debrief discussion either by phone or in person;

(vii) Within five (5) business days of the event, provide case managers with a copy of the provider's completed internal tracking form, or notify the case manager that the electronic form is available for viewing;

(viii) Send a copy of the completed internal tracking form to the legally authorized representative within five (5) business days or notify the legally authorized representative that the electronic form is available for viewing;

(ix) Submit a critical incident report to the Division for each instance when a restraint is used, as outlined in Section 20(b) of this Chapter; and

(x) Regularly collect and review all available data regarding the use of restraints and work to reduce their duration and frequency, and eliminate their occurrence.

(p) The case manager shall follow-up on each incident within two (2) business days of notification of the incident to ensure the participant is safe and uninjured, ensure the participant's restraint protocol and positive behavior support plan were implemented appropriately, and verify that documentation demonstrates that less restrictive intervention techniques were used prior to the use of restraint. The case manager shall also report any suspected non-compliance to the Division**.**

(q) The Division may request a team meeting with the provider, case manager, and legally authorized representative to review any incident of restraint performed by a provider or provider staff.

(r) Restraints shall not be used for the following purposes:

(i) For the convenience of the provider;

(ii) To coerce, discipline, force compliance, or retaliate against a participant; or

(iii) As a substitute for a habilitation program or in quantities that interfere with services, treatment, or habilitation.

(s) The following restraints are prohibited:

(i) A restraint that is contraindicated by the person's medical or psychological condition;

(ii) A restraint procedure or device that obstructs a person's airway or

constricts the person's ability to breathe;

(iii) A supine or prone restraint including, but not limited to, restraining a person on the floor, in a bed, in any form of reclined chair, or using any other horizontal flat surface; and

(iv) Any physical, mechanical, or chemical restraint not provided for in this section.

(t) Any violation of subsection (r) or (s) may result in immediate sanctions of the provider.

(u) Any restraint shall be time-limited and removed immediately when the participant no longer presents a risk of immediate harm to self or others.

**Section 19. THIS SECTION RESERVED FOR FUTURE RULEMAKING.**

**Section 20. Notification of Incident Process.**

(a) Providers shall report the following incidents involving waiver participants to the Division, the Department of Family Services, Protection & Advocacy System, Inc., the case manager, legally authorized representative(s), and law enforcement immediately after assuring the health and safety of the participant and other individuals:

(i) Suspected abuse as defined by W.S. 35-20-102 or W.S. 14-3-202;

(ii) Suspected self-abuse;

(iii) Suspected neglect as defined in W.S. 35-20-102 or W.S. 14-3-202;

(iv) Suspected self-neglect as defined W.S. 35-20-102;

(v) Suspected abandonment as defined in W.S. 35-20-102;

(vi) Suspected exploitation as defined in W.S. 35-20-102;

(vii) Suspected intimidation as defined by W.S. 35-20-102;

(viii) Sexual abuse as defined in W.S. 35-20-102; and

(ix) Death.

(b) Providers shall report the following incidents to the Division, Protection & Advocacy System, Inc., the case manager, and legally authorized representative(s) within one (1) business day:

(i) Police involvement, such as arrests of participants or the participant's direct care provider, while they are providing services, or questioning of participants by law enforcement;

(ii) Any use of restraint;

(iii) Any use of seclusion;

(iv) Injuries caused by restraints;

(v) Serious injury to the participant;

(vi) Elopement;

(vii) Medication errors that result in emergency medical attention; and

(viii) Medical or behavioral admission and emergency room visits that are not scheduled medical visits.

(c) Providers shall report the following medication errors to the Division, the case manager, and legally authorized representative(s) within three (3) business days:

(i) Wrong medication;

(ii) Wrong dosage;

(iii) Missed medication;

(iv) Wrong participant;

(v) Wrong route; and

(vi) Wrong time, which is any deviation from the accepted standard time frame for the medication assistance.

(d) In addition to provisions of subsection (a) and (b) of this Section, if, at any time, a significant risk to a waiver participant's health and safety is identified, the provider shall report the incident to the Division.

(e) Providers shall have incident reporting policies and procedures that include the requirements of this Section and shall maintain internal incident reports for all incidents identified in this Section.

(i) Providers shall review internal incident data including the people involved in the incident, the preceding events, follow-up conducted, causes of reoccurring critical incidents, other trends, actions taken to prevent similar incidents from reoccurring, evaluation of

actions taken, education and training of personnel, and internal and external reporting requirements.

(ii) Providers shall provide access of internal incident data to case managers within five (5) business days.

(f) Providers shall comply with Division or other agency requests for additional information relating to any reported incident.

**Section 21. Complaint Process.**

(a) A provider or provider employee who has a reasonable suspicion that a participant's health or safety is in jeopardy shall immediately contact the Division, Protection & Advocacy Systems, Inc., and other governmental agencies, such as law enforcement or DFS to report incidents or concerns.

(b) A provider shall have policies and procedures for handling complaints, including:

(i) How it will attempt to resolve the complaint;

(ii) How it will document actions, follow-up, and resolution of the complaint;

(iii) How and when information shall be shared with the complainant, legally authorized representative, and the case manager; and

(iv) How the complainant will be informed of the process to file a formal complaint with the Division.

(c) Complaints may be filed with the Division in writing or verbally. If a provider files a complaint, the complaint shall be submitted in writing unless the complaint involves a participant whose health or safety is in jeopardy. Upon receipt of a complaint from any person, the Division shall:

(i) Send written notification to the complainant, within fifteen (15) business days, that the complaint has been received. The notification shall address:

(A) Anticipated timeframes for completing the follow-up and resolution of a complaint; and

(B) The authority for taking actions.

(ii) Send written notification to the provider, within fifteen (15) business days, when a complaint involving that provider is received, unless the complaint involves significant health, safety, or rights concerns, which require an unannounced on-site visit. In these cases, the Division shall provide written documentation to the provider at the time of the on-site visit that

indicates a complaint has been received, the nature of the complaint, and that complaint follow-up is being conducted.

(iii) Within fifteen (15) business days of complaint resolution, send written notification to the complainant that the complaint has been resolved.

(iv) Within fifteen (15) business days of the complaint resolution, submit a written report to the provider(s) that are the subject of the complaint summarizing the results of the complaint findings. The report may include findings, recommendations, and timeframes to address the recommendations through a corrective action plan. If the complaint involves a specific participant, the report will also be sent to the participant and legally authorized representative.

(d) Accredited providers shall adhere to the current accreditation requirements for complaints or grievances.

(e) A provider's failure to submit and successfully implement an approved corrective action plan, as outlined in Section 29 of this Chapter, may result in sanctions per Section 30 of this Chapter.

**Section 22. Transition Process.**

(a) The participant or legally authorized representative may choose to change any provider at any time and for any reason.

(b) A provider who is terminating services with a participant shall notify the participant and the Division in writing at least thirty (30) calendar days prior to ending services, unless the Division approves a shorter transition period in advance. Failure to provide services during this thirty (30) calendar day period shall be considered abandonment of services and may result in decertification of the provider.

(c) When a participant or legally authorized representative chooses to change providers, they shall inform the case manager of the decision. The case manager shall notify the provider of a participant's or legally authorized representative's decision to discontinue services within three (3) business days.

(d) When a transition is requested, the case manager shall notify the Division of the request for change within three (3) business days of the request.

(i) If the participant or legally authorized representative requests a change of case manager, the case manager shall review choice and make provider lists available to the participant and legally authorized representative.

(ii) If the participant or legally authorized representative requests a change of a provider other than the case manager, the case manager shall review choice and provider lists with the participant or legally authorized representative.

(e) When a transition occurs, the case manager shall complete the transition checklist(s) as required by the Division, and schedule a plan of care team meeting.

(i) Notify all current and new providers, the participant, legally authorized representative, and the Division at least two (2) weeks prior to the meeting.

(ii) Team meetings may be scheduled sooner than two (2) weeks due to an emergency situation. The case manager shall notify the Division of any emergency requiring a faster transition schedule.

(f) After the transition meeting, the case manager shall modify the participant's individualized plan of care.

(i) If a revised individualized plan of care is required, the case manager shall complete the revised plan and submit it to the Division at least thirty (30) calendar days before the new provider is scheduled to begin providing services.

(ii) If the individualized plan of care only requires minor modification, the case manager shall complete and submit plan of care modifications to the Division at least seven (7) business days prior to the scheduled start date of the new services.

(g) All providers on the individualized plan of care shall share pertinent information with the case manager and the plan of care team in a timely manner.

(h) If a community living services provider requires a participant to move to another service setting, the participant shall be given the opportunity to choose from all available options, without limitation to that provider's settings.

(i) The participant may choose from other setting options that are appropriate for the participant, which may include a new provider.

(ii) The provider shall notify the participant, family, case manager, and any legally authorized representative of the move at least thirty (30) calendar days in advance so the participant can exercise the choice to find a new residence or provider.

(i) It is the responsibility of the case manager to ensure providers have received training on all participant information, including health and safety, behavioral concerns, and the individualized plan of care.

**Section 23. Notice of Costs to the Participant.**

(a) The provider shall develop and implement a system to notify participants and legally authorized representatives of any associated cost to the participant for a service or item, and the terms of payment.

(b) Written notice shall be given to the participant before initiation of service and before any change. Providers shall allow participants and their legally authorized representative adequate time to review the notice before the participant chooses services from the provider, or before the changes are implemented.

(c) A provider's cost notice shall specify that participants will not be charged for services or items that are covered through other funding sources. This includes, but is not limited to, items necessary to provide habilitation and transportation related to habilitation. The cost notice shall also identify:

(i) Who is responsible for replacement or compensation when the participants' personal items are damaged or missing; and

(ii) How participants will be compensated when staff, guests, or other participants in service, who do not reside in the location (i.e., respite), utilize the environment and eat food paid for by participants.

(d) Providers shall not charge participants for changes to the provider's staffing, service settings, or services, if the change is required by state or federal law.

**Section 24. Participant Funds and Personal Property**.

(a) Standards in this Section apply to any provider who takes responsibility for the funds or personal property of a participant. This includes:

(i) Serving as representative payee;

(ii) Managing the funds of the participant;

(iii) Receiving benefits or funds on behalf of the participant; or

(iv) Temporarily safeguarding funds or personal property for the participant.

(b) The provider shall develop and implement written policies and procedures to identify and detail the system used to protect participant's funds and property. These policies and procedures shall be communicated to the participant or legally authorized representative, including:

(i) How the participant or any legally authorized representative will give informed consent for the expenditure of funds;

(ii) How the participant or legally authorized representative may access the records of the funds;

(iii) How funds are segregated for accounting and reporting purposes to the participant, legally authorized representative, and regulatory agencies, such as Social Security Administration or the Division of Healthcare Financing;

(iv) Safeguards used to ensure that funds are used for the designated and appropriate purposes;

(v) If interest is accrued, how interest is credited to the accounts of the participant;

(vi) How service fees are charged for managing funds; and

(vii) How the person's funds or personal property will be replaced or recouped in the event of theft or an unexplainable disappearance at the provider service setting, or during the provider's provision of services.

(c) Providers shall not use or allow participant funds or personal property to be used:

(i) As a reward or punishment, unless specified in the individualized plan of care as a restriction of rights that complies with the requirements in this Chapter and is approved by the participant and legally authorized representative;

(ii) As payment for damages, unless otherwise specified in the lease or other written agreement, evidence shows the charge is appropriate, the rationale is documented, and the participant or legally authorized representative gives written informed consent to make restitution for damages;

(iii) As payment for damages when the damage is the result of lack of appropriate supervision;

(iv) To purchase inventory or services for the provider; or

(v) As a loan to the provider or the provider's employees.

(d) Participant funds shall not be comingled with provider business accounts or monies.

**Section 25. Additional Standards for Providers that Require National Accreditation**.

(a) Providers who are certified in Adult Day, Case Management, Community Living, Community Support, Companion, or Supported Employment Services shall receive and maintain national accreditation in the accreditation areas specific to the service being provided if the

services listed in this subsection and delivered by the provider collectively equal or exceed $150,000 per calendar year.

(b) Providers shall obtain accreditation in the area applicable to each service within eighteen (18) months of qualifying under this provision. The eighteen (18) month clock begins on the date the accreditation criteria are met.

(c) Provider accreditation options include the Council on Quality and Leadership (CQL) and CARF International. Regardless of the accreditation attained, all references to accredited providers in this rule apply to the provider.

(d) The Division shall decertify a provider who fails to obtain or maintain accreditation.

(e) If a provider fails to obtain or maintain accreditation, a transition plan shall be implemented for each participant who is leaving the provider's services.

(i) Each waiver participant shall be relocated to a different provider within ninety (90) days of the date the Division receives confirmation that the provider did not receive accreditation. If a provider fails to obtain or maintain accreditation, the Division shall complete an immediate site survey and onsite assessment.

(ii) The provider's decertification date shall begin ninety (90) days from the date of written notice from the accrediting entity that the provider did not receive accreditation.

(f) An accredited provider shall submit all national accreditation report documents to the Division within thirty (30) days of receiving the report documents from the accrediting entity.

**Section 26. Mortality Review.**

(a) The Division shall review deaths of participants receiving waiver services.

(b) Providers shall submit information requested by the Division. This may include, but is not limited to:

(i) Copies of documentation of services;

(ii) Copies of incident reports; and

(iii) Copies of any health related records, including assessments, results of licensed medical professional's office visits, and hospital visits.

(c) The Division may make provider specific recommendations or systemic recommendations.

**Section 27. Initial Provider Certification.**

(a) An individual or entity may apply to become a provider by completing the Division's initial provider certification process and all required trainings. The applicant shall supply evidence that the applicant meets the qualifications for each service in which the applicant is seeking waiver certification.

(b) The Division shall only certify one provider per physical location.

(c) The Division shall not certify any person or entity as a waiver provider if:

(i) The person or entity has an open or pending corrective action plan with the Division;

(ii) The person or entity has an open case with the Medicaid Fraud Control Unit; or

(iii) The person has not successfully passed a background screening as provided in Section 14 of this Chapter.

(d) The Division may refuse to certify an entity that has an officer, administrator, or board member who was previously sanctioned by the Division. This refusal shall apply for a period of two (2) years from the date the person was sanctioned. The Division may also refuse to certify such person related to his or her involvement in any open or pending corrective action plan, or Medicaid Fraud Control Unit case until after the two (2) year period.

(e) A person who has been convicted of Medicaid fraud shall not be certified.

(f) The Division shall refuse to certify or shall subsequently decertify a provider applicant who fails to disclose any convictions in a court of law on the Division's provider application or organization's application.

(g) Falsifications of statements or documents, or any concealment of material fact may result in a denial of certification, decertification, or referral for criminal prosecution.

(h) The Division shall initially certify a new provider or provider agency providing any service for one (1) year. The provider must complete a provider certification renewal at the end of the first year to continue providing services

(i) A person or entity may dispute an adverse action related to provider initial certification by a request for an administrative hearing, which will be administered pursuant to Chapter 4 of the Department of Health's Medicaid Rules.

**Section 28. Provider Certification Renewal.**

(a) The Division shall notify all providers that their waiver certification is expiring at least ninety (90) calendar days prior to the certification expiration date. The notification shall detail requirements that the provider shall meet in order to renew their certification.

(b) The Division shall renew a provider certification at least once every three years. Based on the services provided, an on-site visit may be required. If an on-site visit is required, the Division shall provide notification to the provider at least thirty (30) calendar days prior to the visit.

(c) Provider certification renewal includes a Division review of the provider's evidence of compliance with state and federal regulations for home and community based services, and a review of the provider's self-assessment of compliance. For providers who offer services in a setting they own, operate, or lease, the Division shall also review the provider's self-inspection of service settings and a current inspection report from an outside entity.

(d) At any time, the Division shall conduct an on-site visit when a concern is identified during a complaint, incident report, or internal referral, if there is an indication the provider is not complying with state or federal rules and regulation, or at the Division's discretion.

(e) Providers may sign a form verifying that they do not provide services in their home or a provider-owned, leased, or operated setting. The Division will not conduct on-site evaluations for providers signing these forms, but may verify the accuracy of these statements. Falsification of these forms may result in sanctions.

(f) The Division does not require an on-site visit for a case manager, specialized equipment, or environmental modification certification renewal.

(g) Providers shall submit verification that they have met all applicable certification renewal requirements to the Division at least forty-five (45) calendar days prior to their certification expiration date.

(h) If a provider fails to submit the applicable certification renewal requirements to the Division as described in subsection (g) of this Section, the Division shall notify the provider in writing of the expiration of the certification.

(i) If the provider does not meet the certification renewal requirements within twenty (20) calendar days of the certification expiration, the Division shall begin the decertification process.

(ii) The provider shall be notified in writing through certified mail that their certification has expired.

(i) During any certification renewal, the Division shall review provider certification requirements and compliance with all home and community based regulations, then complete a written report, including a statement of the recommendations that shall be addressed within thirty (30) calendar days in order to maintain certification.

(i) The Division may approve a certification period for up to three (3) years depending on deficiencies noted during the certification renewal process.

(ii) The Division may approve the certification for a period of less than one (1) year if deficiencies are identified that seriously affect the health, safety, welfare, rights, or habilitation of a participant, or if the provider has otherwise substantially failed to comply with the rules and standards applicable to the services they are providing.

(iii) The Division may deny the certification.

(j) A provider may dispute an adverse action related to renewal of certification by a request for an administrative hearing, which will be administered pursuant to Chapter 4 of the Department of Health's Medicaid Rules.

**Section 29. Corrective Action Plan Requirements.**

(a) The Division shall, to the extent practicable and consistent with the provisions of applicable law, seek the cooperation of providers in obtaining compliance with these standards. The Division may provide technical assistance to providers to help them voluntarily comply with any applicable provision of these rules.

(b) The Division may attempt to resolve any suspected noncompliance with this Chapter through a corrective action plan.

(c) Corrective action plans shall address each area of suspected non-compliance to the Division's satisfaction. This includes identifying the suspected noncompliance area, action steps needed to address the area of noncompliance, the people in the organization responsible for each action item, due dates, and dates of completion for each recommendation.

(d) Corrective action plans may also include a recommendation for specialized training for the provider organization or individual employees. Specialized training may include, but is not limited to, training on positioning, feeding protocols, positive behavior supports, person-centered planning, or trauma-informed care.

(e) Suspected non-compliance that relates to the immediate health, safety, welfare, or rights of participants, shall be addressed immediately after the situation is discovered. Providers addressing suspected non-compliance under this section shall be given fifteen (15) business days from the date of the report issued by the Division to submit a corrective action plan.

(f) If a corrective action plan is not submitted and implemented to address all areas of suspected non-compliance, the Division may impose sanctions as warranted in Section 30 of this Chapter.

(g) The Division shall notify the provider in writing within thirty (30) business days after receipt of the provider's corrective action plan regarding the approval or rejection of the plan.

(i) If a corrective action plan is rejected, the provider shall receive notification in writing of the reasons for the rejection, and shall submit a revised plan within ten (10) business days from the notification of the written rejection from the Division.

(ii) The Division shall notify the provider in writing within thirty (30) business days after receipt of the provider's revised corrective action plan regarding the approval or rejection of the plan.

(iii) If the revised corrective action plan is rejected, the provider shall have ten (10) business days from the notification of rejection to submit an acceptable corrective action plan, or the Division may proceed with the sanctioning process as outlined in Section 30 of this Chapter.

(h) The provider shall complete appropriate follow-up monitoring to assure that the actions identified in their corrective action plan have been completed within the specified time frame(s) and, at the discretion of the Division, submit a monthly status report to the Division in the form and manner required by the Division until all action items have been satisfactorily completed. If the Division does not receive the monthly status report from the provider, the Division may proceed with the sanctioning process as outlined in Section 30 of this Chapter.

(i) The Division may complete follow-up or review additional items during the provider's certification renewal process to assure the provider has fully implemented and evaluated the corrective action plan, and that participants remain safe during the implementation.

**Section 30. Sanctions.**

(a) Sanctions shall be imposed in accordance with the provisions of Chapter 16 of the Department of Health's Medicaid Rules.

(b) Notwithstanding the provisions of Section 29 of this Chapter, the Division may impose sanctions or revoke provider certification for any violation of these rules.

(c) If the Division revokes a provider's certification or suspends a national provider identification number, the provider shall submit transition plans to the Division detailing the transition of each participant to other settings within twenty (20) calendar days of the date that the sanction is deemed final.

(i) The transition plans shall not be implemented until approved by the Division.

(ii) The transition plans shall be implemented and participants shall move to different certified providers or receive non-waiver supports and services from persons approved by the participants or any legally authorized representative(s) within ninety (90) calendar days of the date the Division informed the provider of the revocation of certification.

(iii) Transition plans shall adhere to the requirements in Section 22 of this Chapter.

(d) A provider who has had their certification revoked under this Section shall not provide waiver services.

(e) A provider may dispute a sanction under this Section or any other adverse action, including those related to certification or renewal of certification, by a request for an administrative hearing, which will be administered pursuant to Chapter 4 of the Department of Health's Medicaid Rules.

**Section 31. Relative Providers.**

(a) The Division shall allow a participant's relative, as defined in Section 3 of this Chapter, to become a certified waiver provider and receive reimbursement for services provided to the related participant.

(b) A participant's legally authorized representative shall not directly or indirectly receive reimbursement for providing waiver services for their ward, except as indicated in this Section. Direct or indirect reimbursement shall include, but is not limited to, providing direct services for, or serving as the owner or officer of, a provider organization, residing in a provider owned service setting, or being married to a person providing waiver services to the participant.

(c) A participant's spouse may receive direct or indirect reimbursement only if they present the Division with a certified copy of a court order establishing another party as the legally authorized representative of the participant.

(d) To provide waiver services to a related participant, the relative provider shall:

(i) Form a Limited Liability Company (LLC) or other corporation; and

(ii) Maintain provider certification in accordance with this chapter.

(e) A relative provider, spouse, or legally authorized representative shall not be hired to provide services through self-direction.

(f) Services that may be furnished by a relative provider are identified in the Comprehensive and Supports Waiver Index, which is incorporated by reference.

(g) If a relative provider or legally authorized representative is providing personal care to his or her ward, the individualized plan of care shall be developed and monitored by a case manager without a conflict of interest.

(h) If the relative provider is not providing services in the best interest of the participant, the case manager shall work with the participant, appropriate team members, and the Division as needed to choose other providers as appropriate and modify the individualized plan of care to better suit the needs of the participant.

(i) Payment to a relative provider specified in subsections (f) and (g) of this Section shall only be made when the service provided is not a function that the relative would normally provide for the individual without charge as a matter of course in the usual relationship among family members, and the service would otherwise need to be provided by a qualified provider.

(j) A relative who provides services either as an owner, employee, or officer of a provider or who intends to provide services to a related waiver participant shall disclose the relationship in the participant's team meeting and acknowledge and address the safeguards set forth in documentation required by the Division.

(k) If a provider permits the hiring of a legally authorized representative of a participant receiving services from the provider, or if a provider permits the hiring of relatives of provider employees working for the organization, the provider shall have a written policy on how it addresses potential conflicts that arise from these relationships and how the conflict of interest is mitigated. The policy shall be shared with the participant and legally authorized representative(s).

**Section 32. Interpretation of Chapter**.

(a) The order in which the provisions of this Chapter appear is not to be construed to mean that any one provision is more or less important than any other provision.

(b) The text of this Chapter shall control the titles of its various provisions.

**Section 33. Superseding Effect**. This Chapter supersedes all prior rules or policy statements issued by the Division, including provider manuals and provider bulletins, which are inconsistent with this Chapter.

**Section 34. Severability**. If any portion of this Chapter is found invalid or unenforceable, the remainder shall continue in full force and effect.

**Section 35. Incorporation by Reference.**

(a) For any code, standard, rule, or regulation incorporated by reference in these rules:

(i) The Department has determined that incorporation of the full text in these rules would be cumbersome or inefficient given the length or nature of the rules;

(ii) The incorporation by reference does not include any later amendments or editions of the incorporated matter beyond the applicable date identified in subsection (b) of this section; and

(iii) The incorporated code, standard, rule, or regulation is maintained at the Department and is available for public inspection and copying at cost at the same location.

(b) Each code, rule, or regulation incorporated by referenced in these rules is further identified as follows:

(i) Referenced in Section 2 of this Chapter is Title XIX of the Social Security Act, 42 C.F.R. Part 441, Subpart G, incorporated as of the effective date of this Chapter and can be found at http://www.ecfr.gov.

(ii) Referenced in Sections 2 and 9 of this Chapter is Wyoming Medicaid's State Plan, incorporated as of the effective date of this Chapter and can be found at http://www.health.wyo.gov/healthcarefin/medicaid/spa.

(iii) Referenced in Sections 2 and 11 of this Chapter is Wyoming's Comprehensive and Supports Waiver Applications, incorporated as of the effective date of this Chapter and can be found at https://health.wyo.gov/behavioralhealth/dd/bhd-public-notices/.

(iv) Referenced in Sections 2, 6, 8, and 31 of this Chapter is Wyoming's Comprehensive and Supports Waiver Service Index, incorporated as of the effective date of this Chapter and can be found at https://health.wyo.gov/behavioralhealth/dd/servicesandrates/.

(v) Referenced in Section 7 of this Chapter is W.S. 35-2-607, incorporated as of the effective date of this Chapter and can be found at https://legisweb.state.wy.us/.

(vi) Referenced in Section 8 of this Chapter is W.S. 40-21-107, incorporated as of the effective date of this Chapter and can be found at https://legisweb.state.wy.us/.

(vii) Referenced in Section 13 of this Chapter is W.S. 1-21-1201 through -1211, incorporated as of the effective date of this Chapter and can be found at https://legisweb.state.wy.us/.

(viii) Referenced in Section 14 of this Chapter is Title 6 of the Wyoming Statutes Annotated, incorporated as of the effective date of this Chapter and can be found at https://legisweb.state.wy.us/.

(ix) Referenced in Section 20 of this Chapter is W.S. 35-20-102, incorporated as of the effective date of this Chapter and can be found at https://legisweb.state.wy.us/.

(x) Referenced in Section 20 of this Chapter is W.S. 14-3-202, incorporated as of the effective date of this Chapter and can be found at https://legisweb.state.wy.us/.

## CHAPTER 45

## DD WAIVER PROVIDER STANDARDS, CERTIFICATION, AND SANCTIONS

**Section 1**. **Authority.** This Chapter is promulgated by the Department of Health pursuant to Wyoming Statute ~~§~~ 9-2-102 and the Wyoming Medical Assistance and Services Act at W~~.yoming~~ S~~.tatutes~~ ~~§§~~ 42-4-101 through -121.

**Section 2. Purpose and Applicability.**

(a) This Chapter was adopted to govern certification of providers under the Wyoming Medicaid Supports Waiver and Comprehensive Waiver (hereinafter collectively referred to as the "DD Waivers").

(b) This Chapter, in addition to Chapters 44 and 46 of the Wyoming Medicaid Rules, shall govern services and provider requirements of the DD Waivers.

(c) The ~~Behavioral Health~~ Division of Healthcare Financing, hereinafter referred to as the "Division," may issue ~~P~~provider ~~M~~manuals and ~~P~~provider ~~B~~bulletins to providers or other affected parties to interpret the provisions of this Chapter. Such ~~P~~provider ~~M~~manuals and ~~P~~provider ~~B~~bulletins shall be consistent with and reflect the rule provision's policies, as revised in this Chapter. The provisions contained in ~~P~~provider ~~M~~manuals or ~~P~~provider ~~B~~bulletins shall be subordinate to the provisions of this Chapter.

(d) ~~(i)~~ Wyoming's currently approved Centers for Medicare and Medicaid Services (CMS) Comprehensive and Supports Waiver Applications and the Comprehensive and Supports Waiver Service Index apply to this Chapter.

(e) ~~(d)~~ The requirements of Title XIX of the Social Security Act, 42 C.F.R., Part 441, Subpart G and the Medicaid State Plan apply to this Chapter.

**Section 3. General Provisions.**

(a) ~~Terminology.~~ Except as otherwise specified in Chapter 1 of the Department of Health's Medicaid Rules, or as defined in this Section, the terminology used in this Chapter is the standard terminology and has the standard meaning used in accounting, health care, Medicaid, and Medicare.

~~(b) Definitions.~~

(b) ~~(i)~~ "Case ~~M~~manager" means an individual who provides case management services, as ~~defined~~ established in ~~Chapter 45,~~ Section 9 of this Chapter.

(c) "Corrective Action Plan", referred to previously as a quality improvement plan, means a step by step plan of action developed by the provider to achieve targeted outcomes for resolution of identified errors in an effort to eliminate repeated deficient practices.

(d) ~~(ii)~~ "Elopement" means the unexpected or unauthorized absence of a participant

for more than is approved in the participant's individualized plan of care when that person is receiving waiver services, or the unexpected or unauthorized absence of any duration of a participant whose absence constitutes an immediate danger to themselves or others. This could be an unexpected participant action, which may not be intentional and may be due to wandering that is secondary to dementia.

(e) ~~(iii)~~ "Licensed Medical Professional" means a medical professional licensed to practice in the State of Wyoming and authorized to prescribe medication.

(f) ~~(iv)~~ "Relative" means a participant's biological, step, or adoptive parent(s). ~~or adoptive parent(s) or stepparent(s).~~

**Section 4. Rights of Participants Receiving Services.**

(a) Each participant receiving services has the same legal rights and responsibilities guaranteed to all other U.S. citizens under the United States and Wyoming constitutions and federal and state laws.

(b) Participant rights shall not be modified or suspended except in accordance with state or federal law and this Chapter. A participant's right to dignity and respect, to be free from coercion, and to receive services in settings that are physically accessible to the participant shall not be limited or restricted.

(c) The participant, the participant's legally authorized representative(s), the participant's case manager, and the Division shall be informed in writing of the grounds for the denial or limitation of rights. Such notice shall be written in plain language and shall include a statement that the participant may choose an alternative provider, if the participant or legally authorized representative disagrees with the denial or limitation. If the Division disallows a limitation of a right in an individualized plan of care, this decision will apply to any provider offering services to the participant. Rights restrictions shall constitute a material change to the individualized plan of care. The following participant rights shall not be denied or limited, except for the purpose of an identified health or safety need, which shall be included in the participant's individualized plan of care:

(i) The right to privacy~~, dignity, and respect~~;

(ii) The right to freedom from ~~coercion or~~ restraint;

(iii) The right to ~~P~~privacy in their sleeping or living quarters;

(iv) The right to ~~S~~sleeping and living quarters that have entrance doors that can be locked ~~lockable~~ by the individual, with only appropriate staff having keys to doors;

(v) If ~~I~~individuals ~~sharing~~ share sleeping quarters, ~~have a choice of~~ the right to choose roommates in that setting, and choose with whom and where they live;

(vi) Freedom to furnish and decorate their sleeping or living quarters within the lease or other agreement;

(vii) Freedom and support to control their own schedules and activities;

(viii) Freedom and support to have access to food at any time;

(ix) ~~The ability~~ Freedom to have visitors of their choosing at any time, and associate with people of their choosing;

(x) ~~The ability~~ Freedom to communicate with people of their choosing;

(xi) Freedom to keep and use their personal possessions and property;

(xii) Control over how they spend their personal resources;

~~(xiii) All settings shall be physically accessible to the participant individual;~~

(xiii) ~~(xiv)~~ The right to access the community; and

(xiv) ~~(xv)~~ The right to make and receive telephone calls.

~~(A)~~ No person shall limit a participant's right to make calls to Protection & Advocacy, or state and federal oversight or protection agencies as protected by 42 U.S.C. 10841(1)(M), such as the Division or Department of Family Services.

(d) A participant's right to be free from physical, mechanical, and chemical restraints shall not be denied or limited unless a court, the participant, or the participant's legally authorized representative authorizes the denial or limitation in writing. The request shall be accompanied by letters from a licensed medical and behavioral professional that detail medical and psychological contraindications that may be associated with a restraint.

(i) Such denial or limitation shall be included in the participant's individualized plan of care, ~~and~~ shall address how other less restrictive interventions will be used prior to a restraint, and shall detail the manner in which a restraint may be used pursuant to Section 18 of this Chapter.

(ii) The authorizing document shall be made part of the participant's individualized plan of care.

(e) Procedural requirements regarding rights. A provider that ~~provides~~ offers direct services shall have and implement policies and procedures that ensure:

(i) Except as identified in this section, participants have the opportunity to maximize their rights and responsibilities;

(ii) ~~All p~~Participants have the right to refuse services and shall not be disciplined or charged with a monetary fee for refusing ~~H~~home and ~~C~~community ~~B~~based ~~W~~waiver services;

(iii) ~~Each p~~Participants ~~served~~, parents of a minor, ~~or~~ and legally authorized representatives ~~is~~ are informed of the participant's rights and responsibilities;

(A) The information shall be given at the time of entry to direct care and case management services, annually thereafter, and when significant changes occur; and

(B) The information shall be provided in a manner that is easily understood, given verbally and in writing, in the native language of the participant or legally authorized representative(s), or through other modes of communication necessary for understanding~~.~~;

(iv) Participants are supported in exercising their rights while receiving waiver services;

(v) Rights shall not be treated as privileges or things that should be earned; and

(vi) Retaliation against a participant's services and supports due to the participant, family members, or legally authorized representatives advocating on behalf of the participant or initiating a complaint with an outside agency, is prohibited.

(f) Providers shall not request or require participants to waive or limit their rights as a condition of receiving service.

(g) Providers shall not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any individual who exercises any right established by, or for participation in any process provided in, these rules or the Wyoming Medical Assistance and Services Act.

(h) When rights restrictions are deemed necessary, the individualized plan of care shall include a rights restriction protocol that ~~shall include~~ addresses the ~~following:~~

~~(i) The~~ reasons for the rights restriction(s), including the legal document, court order, guardianship papers, or medical order, that allows a person other than the participant to authorize a restriction to be imposed.

(i) ~~(ii)~~ For any rights restriction imposed, the following items shall be addressed and documented in the individualized plan of care ~~as follows~~:

(A) ~~Identify~~ Identification of the specific and individualized assessed need;

(B) Documentation of the positive interventions and supports used prior to any modifications to the individualized plan of care;

(C) Documentation of less intrusive methods of meeting the need that have been tried but did not work;

(D) ~~Include a~~A clear description of the condition that is directly proportionate to the specific assessed need;

(E) ~~Include~~ A system of regular data collection and review ~~of data~~ to measure the ongoing effectiveness of the modification;

(F) ~~Include e~~Established time limits for periodic reviews, not to exceed six (6) months, to determine if the modification is still necessary or can be terminated;

(G) ~~Include the i~~Informed consent of the individual; and

(H) ~~Include an a~~Assurance that interventions and supports will cause no harm to the individual.

(ii) ~~(iii)~~ In addition to the items mentioned ~~above~~ in this Section, the individualized plan of care shall address how the team will work to restore any right described in this Section that has been limited or denied.

**Section 5. Provider Qualifications for Each Waiver Service**.

(a) All individual waiver providers, subcontractors, and provider employees ~~providing~~ offering direct services to waiver participants shall ~~complete and maintain~~ meet the following requirements unless otherwise specified in this ~~s~~Section:

(i) Be eighteen (18) years or older;

(ii) Be certified by the Division to provide the indicated service;

(iii) Maintain current CPR and First Aid Certification, which includes hands-on training from a trainer certified with a curriculum consistent with training standards set forth by the American Heart Association or the American Red Cross;

(iv) Have a valid email address, internet access, and the means to upload documentation into a Division designated portal; and

(v) If assisting with medications, maintain a current certificate in medication assistance training offered through the Division.

(b) A provider shall also meet the following specific requirements for the service in which they want to receive and maintain certification:

(i) Behavioral Support Services. A provider of Behavioral Support Services shall have either:

(A) A Master's Degree and be a Board Certified Behavior Analyst~~,~~; or

(B) A current license to practice from the Wyoming Board of Psychology.

(ii) Case Management.

(A) All providers of case management services shall have one (1) of the following:

(I) A Master's degree from an accredited college or university in one (1) of the following related human service fields:

(1.) Counseling;

(2.) Education;

(3.) Gerontology;

(4.) Human Services;

(5.) Nursing;

(6.) Psychology;

(7.) Rehabilitation;

(8.) Social Work;

(9.) Sociology; or

(10.) A related degree, as approved by the Division.

(II) A Bachelor's degree in one (1) of the related fields from subsection (I) above from an accredited college or university, and one (1) year work experience as a case manager or in a related human services field.

(III) An Associate's degree in a related field from subsection (I) above from an accredited college, and four (4) years of work experience as a case manager or in a related human services field.

(B) A case manager shall obtain and maintain his or her own National Provider Identifier (NPI) number for case management services through the Medicaid enrollment process.

(C) A case manager shall obtain and provide evidence of eight (8) hours of continued education relating to the delivery of case management services during each year of certification.

(D) A provider agency certified to provide case management services shall:

(I) Identify a back-up case manager from the list of Division certified case managers for each participant, and have policies and procedures for backup case management for each person's caseload, which include a process for how and when the case manager will notify the plan of care team that the backup case manager should be the primary

contact. Case managers shall meet with their designated backup to review all participant cases on a quarterly basis. The review shall be documented in case notes.

(II) Document on the individualized plan of care that they have no conflict of interest with the participant or family.

(III) Meet all of the following conflict of interest requirements~~:~~.

(1.) The case management agency and any managing employee shall not own, operate, be employed by, or have a financial interest in or financial relationship with any other person or entity providing services to a participant~~;~~.

(2.) The case management agency may be certified in other waiver services, but shall not provide case management services to any participant to whom they are providing any other waiver services, including self-directed services~~;~~.

(3.) The owner, operator, or managing employee of a case management agency shall not be related within the third degree by blood or marriage to the owner, operator, or managing employee of any other waiver service provider on the participant's individualized plan of care~~;~~.

~~a.~~ A relationship within the third degree includes the spouse; biological, step, or adoptive parent; mother, father, brother, or sister-in-law; biological, step, or adoptive child; biological, step, or adoptive sibling; grand or great grand-parent or child; or aunt, uncle, niece, or nephew.

(4.) Any employee of a guardianship agency shall not provide case management to any participant who is receiving any services from the guardianship agency.~~; and~~

(5.) The case management agency shall not:

a. Employ case managers that are related to the participant, the participant's guardian, or a legally authorized representative, within the third degree, served by the agency. If the case management agency is a sole proprietor, the case manager shall not be related to the participant, the participant's guardian, or a legally authorized representative, within the third degree, served by the agency;

b. Make financial or health-related decisions on behalf of the participant receiving services from that agency, including but not limited to a guardian, representative payee, power of attorney, or conservator; or

c. Provide case management services to, or live in the same residence of, any provider on a participant's individualized plan of care in which they provide case management services.

(E) ~~(IV)~~ If a rural area of the State does not have a case manager without a conflict of interest for a participant, the participant or legally authorized representative

may request to have a case manager with a conflict. If the Division confirms that there are no other case managers available in the region or a nearby region to provide case management, then the conflicted case manager may be approved on an annual basis. A third party entity without a conflict shall be involved in the participant's team to mediate, advocate for the participant as needed, and address unresolved grievances for any conflicts that are approved.

(F) ~~(V)~~ All case managers shall notify the provider of a participant's or legally authorized representative's decision to discontinue services within three (3) business days.

(iii) Child Habilitation. A Child Habilitation provider, if operating a day care while also providing child habilitation services, shall follow the Department of Family Services licensing rules in addition to meeting the Medicaid waiver provider rules.

(iv) Cognitive Retraining. A Cognitive Retraining provider shall:

(A) Be certified in Cognitive Retraining from an accredited institution of higher learning; ~~or~~

(B) Be a certified Brain Injury Specialist through the Brain Injury Association of America; or

(C) Be a licensed professional with one year of acquired brain injury training or Bachelor's degree in related field and three (3) years of experience in working with acquired brain injuries.

(v) Dietician. A Dietician provider or provider staff shall have a license to provide dietician services by the Wyoming Dietetics Board and a National Provider Identifier (NPI).

(vi) Environmental Modification. Environmental Modification providers shall have all applicable building, construction, and engineer license and certifications that may be required to work as a contractor ~~in~~ at the location where services will be provided. Employees do not have to be certified in CPR or First aid, complete a background check, or have participant specific training. The provider shall report critical incidents as defined in Section 20.

~~(vii) Independent Support Broker. An Independent Support Broker shall complete a required training and pass a competency based test from the Division prior to providing the service and have either:~~

~~(A) One (1) year of experience in the field of ID/DD or ABI and a Bachelor's degree, Master's degree or Doctoral degree, or~~

~~(B) Two (2) years or 48 credit hours of college and two (2) years of experience in the field of DD/ID or ABI.~~

(vii) ~~(viii)~~ Individual Habilitation Training. Within one (1) year of being certified in this service, and annually thereafter, the provider or staff providing the service shall

successfully complete at least eight (8) hours of continued education in any of the following areas: specific disabilities or diagnosed conditions relating to the population served, writing measurable objectives, gathering and using data to develop better training programs, or training modules posted by the Division.

(viii) ~~(ix)~~ Homemaker. A provider of Homemaker services shall be at least eighteen (18) years old but does not have to be certified in CPR and First Aid.

(ix) ~~(x)~~ Occupational Therapy. An Occupational Therapy provider or provider staff shall have a current license to practice occupational therapy by the Wyoming Board of Occupational Therapy and a National Provider Identifier (NPI).

(x) ~~(xi)~~ Physical Therapy. A Physical Therapy provider or provider staff shall have a current license to practice physical therapy by the Wyoming Board of Physical Therapy and a NPI.

~~(xi) Prevocational. Within one (1) year of certification in prevocational services, a provider shall have one (1) staff person certified in a supported employment curriculum approved by the Division and be available to train direct care staff on exploring employment interests, working on job readiness skills, or other employment related activities with participants.~~

(xi) ~~(xiii)~~ Skilled Nursing. A skilled nursing provider or provider staff shall be licensed to practice nursing by the Wyoming Board of Nursing, and have a current NPI.

(xii) ~~(xiv)~~ Special Family Habilitation Home. A Special Family Habilitation Home provider shall be at least 21 years of age.

(xiii) ~~(xv)~~ Specialized Equipment. A Specialized Equipment provider shall have the applicable license or certification for the type of equipment purchased, and does not have to be certified in CPR or First Aid.

(xiv) ~~(xvi)~~ Speech, Hearing, and Language Services. A Speech, Hearing, and Language Service provider or provider staff shall have a current license to practice Speech, Hearing and Language Services by the Wyoming Board of Speech Pathology and Audiology, and have a current NPI.

~~(xv) Supported Employment and Supported Employment Follow Along. A Supported Employment provider shall, within one (1) year of becoming certified in employment services, have one (1) employee that is certified in a supported employment curriculum approved by the Division, and be able to train direct care staff on working with participants to explore employment interests, work on readiness skills, or participate in other employment related activities.~~

(xv) ~~(xviii)~~ Transportation. A Transportation provider shall have a current, valid driver's license; automobile insurance; and additional liability insurance for transporting people for business purposes.

**Section 6. Standards for all Providers.**

(a) Consistent with the provisions of this chapter, providers shall:

(i) Protect participants from abuse, neglect, mistreatment, intimidation, and exploitation;

(ii) Treat participants with consideration, respect, and dignity;

(iii) Honor participants' preferences, interests, and goals;

(iv) Provide participants with daily opportunities to make choices and participate in decision making;

(v) ~~Provide and access~~ Facilitate activities that are meaningful and functional for each participant;

(vi) Direct services toward maximizing the growth and development of each participant for maximum community participation and citizenship;

(vii) Provide services in the most appropriate, least restrictive, most integrated environment;

(viii) Encourage participants to express their wishes, desires, and needs;

(ix) Protect and promote the health, safety, and well-being of each participant;

(x) Design services to meet the needs of all participants served by the provider; and

(xi) Establish and implement written policies and procedures that:

(A) Are available to staff, participants, legally authorized representatives and, upon request, the general public;

(B) Are updated or revised as needed by rule or policy changes;

(C) Are reviewed at least annually with employees; and

(D) Describe the provider's operation and how systems are set up to meet participants' needs.

(b) Before providing services to a participant, the provider shall gather and review referral information regarding the participant so, to the greatest extent possible, the provider is aware of the participant's preferences, strengths, and needs. The provider shall use this information to:

(i) Make a determination as to whether the provider is capable of providing services to meet the participant's needs;

(ii) Consider the safety of all participants who the provider serves in the decision to accept new participants to services or the location for the services; and

(iii) Consider whether the provider has the capacity, commitment, and resources necessary to provide supports to the participant served.

~~(iv)~~ The provider shall not serve a participant if the provider cannot reasonably assure the participant, legally authorized representative, and case manager that it has the ability to meet the participant's needs.

(c) The provider shall orient, train, and manage staff with the skills necessary to meet the needs of participants in their services, and be able to respond to emergencies.

(d) The provider shall facilitate opportunities for all participants to receive services consistent with the needs and preferences of the participant.

(e) The provider shall develop a process for detecting and preventing abuse, neglect, exploitation, and intimidation, and handling allegations of abuse, neglect, exploitation, and intimidation in accordance with state and federal statutes and rules.

(f) The provider shall, at all times, maintain documentation to demonstrate sufficient staff provide services, supports, and supervision to meet the needs of each participant per the participant's individualized plan of care.

(g) The provider shall implement reasonable and appropriate policies and procedures to comply with the standards, specifications, and requirements of this ~~c~~Chapter and the Comprehensive and Supports Waiver Service Index, which is incorporated by reference. Compliance with this provision does not permit or excuse a violation of any standard, specification, or requirement of this chapter. A provider may change its policies or procedures at any time, provided that the changes are documented, implemented, and maintained in accordance with the standards, specifications, and requirements of these rules.

(h) Any person who provides a service for which a license, certification, registration, or other credential is required shall hold the current license, certification, registration, or credential in accordance with applicable state laws. The license holder shall notify the Division if the license, certification, registration, or credential is revoked, within ten (10) business days. The provider shall maintain documentation of the staff credentials.

(i) If the Division receives information that the provider no longer meets the qualifications for a service for which the provider is certified, the Division shall send notice to the provider within five (5) business days regarding this missing qualification and the applicable sanction. If the missing qualification is not obtained within the timeframe given by the Division, the provider is disqualified from providing such waiver service(s).

(j) ~~(h)~~ Providers that subcontract for services shall be responsible for assuring that the subcontractors meet all applicable requirements, qualifications, and standards for the services being provided. Failure of a provider who subcontracts to assure that the subcontractor meets all

applicable requirements and standards may result in revocation of the provider's certification pursuant to Section 30 of this Chapter.

**Section 7. Provider Recordkeeping and Data Collection.**

(a) The provider shall collect and maintain data, records, and information as necessary to provide services.

(b) The provider shall develop and maintain a record keeping system that includes a separate record for each participant served.

(c) The provider shall develop and implement a systematic organization of records to ensure permanency, accuracy, completeness, and easy retrieval of information.

(d) The provider shall develop a process relating to retention, safe storage, and safe destruction of the participant's records to ensure retention of necessary information and to protect confidentiality of records. The provider shall retain all records relating to the participant and the provision of services in accordance with Chapter 3 of the Department of Health's Medicaid Rules.~~for at least six (6) years after the end of the fiscal year during which services were provided.~~

(e) If there are changes in ownership of the provider agency, complete and accurate copies of all participant records shall be transferred to the participant's newly chosen provider. Before dissolution of any provider agency, the provider shall follow Medicaid disenrollment procedures and notify the Division in writing of the location and secure storage of any remaining participant records.

(f) The provider shall establish and implement policies that govern access to, duplication, dissemination, and release of information from the participant's record, which are consistent with applicable state and federal laws.

(g) Except as otherwise provided by law, the provider shall obtain a written authorization from the participant or the participant's legally authorized representative for the release of participant information that identifies or can readily be associated with the identity of a participant. The authorization shall comply with the requirements for hospital records identified in W.~~yoming~~ S.~~tatute~~ ~~§~~ 35-2-607.

(h) Providers shall make all records maintained or controlled by the provider available upon request to ~~the~~ Division ~~S~~staff, representatives from the State or Federal Medicaid programs, or the Medicaid Fraud Control Unit, without prior written authorization, consent, or other form of release.

(i) The provider shall specify the method and frequency for obtaining authorizations for medical treatment and consents.

(j) The provider shall ensure that all record entries are dated, legible, and clearly identify the person making the entry.

**Section 8. Documentation Standards**.

(a) In addition to the requirements of Chapter 3~~, Provider Participation,~~ of the ~~Wyoming~~ Department of Health's Medicaid Rules, the following provisions shall apply to the documentation of services, and medical and financial records, including information regarding dates of services, diagnoses, services furnished, and claims affected by this Chapter.

(b) A provider shall complete all required documentation, including the required signatures, before or at the time the provider submits a claim.

(i) Documentation prepared or completed after the submission of a claim is prohibited. The ~~Department~~ Division shall deem the documentation to be insufficient to substantiate the claim, and Medicaid funds shall be withheld or recovered.

(ii) Documentation shall not be altered in any way once billing is submitted, unless the participant or legally authorized representative requests an amendment to the documentation in accordance with the patient privacy rules in the Health Insurance Portability and Accountability Act of 1996.

(c) A provider shall document services either electronically or in writing.

(d) Electronic documentation shall capture all data required by subsection (e) of this Section, shall ~~and~~ include electronic signatures and automatic date stamps pursuant to ~~Wyoming Statute~~ W.S. ~~§~~ 40-21-107, and shall have automated tracking of all attempts to alter or delete information that was previously entered.

(i) Electronic records shall not be altered or deleted prior to submission of payment unless incorrect, and the purpose of the correction shall be captured in the electronic documentation system.

(ii) If anyone other than the employee who provided the service completes electronic documentation for the purpose of claims submission, the provider of the service shall separately maintain all written or electronic service documentation to support the claim.

(iii) A provider shall make a participant's electronic case file, specific to the case manager's caseload, available to a case manager in the electronic record in order to comply with the required documentation reviews and service unit utilization specified in this Chapter.

(iv) Case management monthly documentation in the Electronic Medicaid Waiver System (EMWS), or its successor, once marked as final and submitted to the Division in the web portal, meets the requirements for an electronic signature and date stamp. These records cannot be altered once the case manager bills for the service provided.

(e) For written documentation, each physical page of documentation shall include:

(i) The f~~F~~ull legal name of the participant;

(ii) The i~~I~~ndividualized plan of care start date for the participant;

(iii) The n~~N~~ame~~, type,~~ and billing code of the service provided; and

(iv) A l~~L~~egible signature of each person performing a service, if initials are being used for documentation purposes.

(f) ~~For written documentation, t~~The following information shall be included each time a service is documented:

(i) The l~~L~~ocation of services;

(ii) The d~~D~~ate of service, including year, month, and day;

(iii) The t~~T~~ime services begin~~, and time services~~ and end, using either AM and PM or military time, ~~and documenting per~~ with documentation for each calendar day, even when services ~~are provided over~~ span a period longer than one calendar day;

(iv) An i~~I~~nitial or signature of the person performing the service; and

(v) A detailed description of services provided that:

(A) Consists of a personalized list of tasks or activities that describe a typical day, week, or month for a participant, in which the participant and legally authorized representative has provided input;

(B) Supports recommendations from assessments by therapists, licensed medical professionals, psychologists, and other professionals in a manner that prevents the provision of unnecessary or inappropriate services and supports;

(C) Reflects the participant's desires and goals; and

(D) Includes specific objectives for habilitation services, support needs, and health and safety needs.

(g) ~~Documentation for d~~Different services shall be documented on separate forms and shall be clearly ~~be~~ separated by time in and out, service name, documentation of services provided, signature of staff providing services, and printed name of staff providing the service.

(h) A provider shall not bill for the provision of more than one direct service for the same participant at the same time unless the participant's approved individualized plan of care identifies the need for more than one (1) direct service to be provided at the same time.

(i) A provider staff member shall not bill for the provision of more than one direct service for different participants at the same time.

(j) A provider shall not round up total service time to the next unit, except as outlined in the Skilled Nursing section of the Comprehensive and Supports Waiver Service Index.

(k) Documentation of services shall be legible, retrieved easily upon request, complete, and unaltered. If hand written, documentation shall be completed in permanent ink.

(l) Services shall meet the service definitions outlined in the Comprehensive and Supports Waiver Service Index, and be provided pursuant to a participant's individualized plan of care.

(m) For all direct care waiver services, the participant shall be in attendance in the service in order for the provider to bill for services.

(n) The provider shall make service documentation for services rendered available to the case manager each month by the tenth ($10^{th}$) business day of the month following the date that the services were rendered. If services are not delivered during a month, the provider shall report the zero (0) units used to the case manager by the tenth ($10^{th}$) business day of the following month.

(i) Failure to make documentation available by the tenth ($10^{th}$) business day of the month may result in a corrective action plan or sanctioning.

(ii) The case manager shall give written notification of noncompliance to the provider with a copy submitted to the Behavioral Health Division. Chronic failure to make documentation available may result in provider sanctions.

(o) The provider shall make unit billing information for services rendered available to the case manager by the tenth ($10^{th}$) business day of the month after unit billing has been submitted for payment.

**Section 9. Case Management Services.**

(a) Case management is a mandatory service ~~to~~ for all participants enrolled on the waivers.

(b) Case ~~M~~managers shall complete all eligibility paperwork, as established under Chapter 46 of the Department of Health's Medicaid Rules, within ~~30~~ thirty (30) calendar days.

(c) A case manager shall use person-centered planning to understand the needs, preferences, goals, and desired accomplishments of the participant. The case manager shall coordinate and assist the participant in accessing all needed and available resources, such as natural, paid, and community support ~~available and needed~~. The case manager shall develop and monitor the implementation of an individualized plan of care.

(d) It is the case manager's responsibility to assure all information, including but not limited to guardianship paperwork and ~~maintain the current~~ physical and mailing addresses of the participant, ~~and~~ legally authorized representative(s), and other contacts is updated and accurate at all times.~~,~~ The case manager shall ~~and~~ update ~~any changes to~~ the Division and other providers of any changes.

(e) The case manager shall maintain a participant's file and service documentation~~:~~.

(i) The case manager shall assure information is disseminated to, and received by, the participant and appropriate parties involved in the participant's care or as authorized by a signed release of information by the participant or the participant's legally authorized representative(s)~~;~~.

(ii) The case manager shall arrange and coordinate eligibility for applicants, or waiver participants by providing:

(A) Targeted case management services to an applicant who is in the eligibility process for waiver services or awaiting a funding opportunity; and

(B) Services that include the coordination and gathering of information needed for initial and annual certification, clinical and financial eligibility, and the level of care determination.

(iii) The case manager shall p~~P~~rovide the participant and any legally authorized representative(s) with a list of all providers available in their community in order to allow the participant a choice of providers. To the extent that they are available, participant choice shall include any certified waiver provider, self-directed options, Medicaid State Plan services, and services offered by other state agencies, as well as community and natural supports.

(A) At least once every six (6) months, the case manager shall provide information to the participant or the legally authorized representative(s) on all available waiver services, including self-direction service delivery options. This may be done more frequently as requested by the participant or legally authorized representative(s).

(B) The case manager shall coordinate transition plans when the participant chooses to change, stop, or add providers to his or her individualized plan of care, or exit the waiver, as established under Section 22 of this Chapter.

(C) If the case manager chooses to discontinue providing services, the case manager shall give the participant, legally authorized representative(s), and Division thirty (30) calendar days written notice ~~of the change to the participant or legally authorized representative(s), and to the Division~~. The case manager shall continue to provide case management services for the thirty (30) calendar days, or until a new case manager is approved, whichever is first.

(iv) The case manager shall involve and assist the participant's ~~identified~~ plan of care team ~~members~~ with developing a person-centered individualized plan of care in accordance with this Chapter. The case manager shall assist the team with planning, budgeting, and prioritizing services for the participant using all available resources and the assigned individual budget amount.

(v) The case manager shall complete and submit the individualized plan of care, including all required components, in EMWS, or its successor, at least thirty (30) days before the intended plan start date.

(vi) If the participant chooses to self-direct services on the waiver, the case manager shall assist the participant in ~~finding a support broker when applicable,~~ modifying the individualized plan of care as needed, and monitoring the services of the Financial Management Service utilized by the participant ~~to self-direct~~ in accordance with the approved waiver.

(vii) The case manager shall ensure all providers on the participant's individualized plan of care sign off on the plan, receive a copy of the plan, receive team meeting notes, and complete participant specific training as required in Section 15(~~h~~g) of this Chapter. Documentation of participant specific training shall be available to the Division upon request.

(viii) The case manager shall monitor and evaluate the implementation of the participant's individualized plan of care, including a review of the type, scope, frequency, duration, and effectiveness of services, as well as the participant's satisfaction with the supports and services. On a quarterly basis, the case manager shall include this information in a report prescribed by the Division. ~~After the evaluation, the case manager shall:~~

(ix) ~~(A)~~ The case manager shall r~~R~~eport to the provider any concerns with provider implementation of the individualized plan of care, or concerns with the health and safety of a participant. ~~Significant~~ These concerns shall be reported to the Division through the incident reporting or complaint processes~~;~~.

(x) ~~(B)~~ The case manager shall s~~S~~end the Division and the provider or employer of record written notification of noncompliance with these rules, the health, safety, or rights of the participant specified in the individualized plan of care, or when documentation is not received by the tenth (10th) business day of the following month after services were provided~~;~~.

(xi) ~~(C)~~ The case manager shall s~~S~~ecurely store and retain all confidential provider documentation received from other providers for a participant's services for a twelve (12) month period from the month services were rendered~~,~~ and shall follow safe destruction policies as established under Section 7 of this Chapter, even if the participant changes case managers.~~; and~~

(xii) ~~(D)~~ The case manager shall d~~D~~ocument all monitoring and evaluation activities, follow-up on concerns and actions completed, and make appropriate changes to the individualized plan of care with team involvement, as needed.

(f) A case manager shall be the second-line monitor for participants receiving medications. Second-line monitoring ~~is conducted to~~ shall help to ensure a participant's medical needs are addressed and medication regimens are delivered in a manner that promotes the health, safety, and well-being of the participant. The case manager shall provide monitoring of, and review trends regarding, the usage of the participant's over-the-counter and prescription medications through a monthly review of medication assistance records and PRN medication usage records.

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

**Section 10. Individualized Plan of Care.**

(a) A ~~participant's~~ case manager shall convene ~~a participant's~~ the plan of care team to develop an individualized plan of care for each participant on his or her caseload, and base the plan on the results of the comprehensive assessment(s) and the person-centered planning process. The team shall ~~include~~ be comprised of persons who are knowledgeable about the participant and are qualified to assist in developing an individualized plan of care for that person, including: the participant; any legally authorized representative(s); the case manager; providers chosen by the participant; and any other advocate, family member, or entity chosen by the participant or the participant's legally authorized representative(s).

(b) The plan of care meeting shall be timely and occur at times and locations that are convenient for the participant.

(c) The ~~C~~case ~~M~~manager shall provide written notice of the plan of care meeting to all team members at least ~~thirty (30)~~ twenty (20) calendar days prior to the meeting.

(d) The individualized plan of care shall not exceed twelve (12) months and shall be developed in accordance with state and federal rules, which includes the submission of the complete individualized plan of care to the Division at least thirty (30) days prior to the plan start date. Corrections to the individualized plan of care required by the Division shall be submitted by the case manager within seven (7) business days of being issued.

(e) The individualized plan of care shall include ~~the provision of or describe the inability to provide~~:

(i) Necessary information and support to the participant to ensure that the participant directs the process to the maximum extent possible;

(ii) Services in a setting chosen by the participant from all service options available, including non-disability specific settings and alternate settings that were considered;

(iii) Opportunities for the participant to seek employment and work in competitive integrated settings;

(iv) Opportunities for the participant to engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid home and community-based services;

(v) Cultural and religious considerations;

(vi) Services based on the choices made by the participant regarding supports the participant receives and from whom;

(vii) What is important to the participant and for the participant;

(viii) Services provided in a manner reflecting personal preferences and ensuring health and welfare;

(ix) Services based on the participant's strengths and preferences;

(x) Any rights ~~or freedoms that are restricted~~ restrictions, including why the restriction is imposed, how the restriction is imposed, and the plan to restore the right to the fullest extent possible;

(xi) Both clinical and support needs;

(xii) Participant's desired outcomes;

(xiii) Risk factors and plans to minimize them;

(xiv) Individualized backup plans and strategies when needed;

(xv) Individuals important in supporting the participant, such as friends, family, professionals, specific staff or providers;

(xvi) Learning objectives for habilitation services that address the training activities, training methods, and the measurement used to gauge learning;

(xvii) Relevant protocols that have been updated within the past year;

(xviii) Informed consent of the participant or legally authorized representative in writing; and

(xix) Signatures of all providers listed in the individualized plan of care after the draft plan, as written, is completed by the team including participant's signature for informed consent.

(f) The individualized plan of care shall include information addressing a provider's inability to provide any of the supports outlined in subsection (e) of this Section.

(g) ~~(f)~~ The individualized plan of care shall be reviewed at least semi-annually, when the participant's circumstances or needs change significantly, or at the request of any team member. The plan shall be revised upon reassessment of functional need, as needs arise, and every twelve (12) months for a new plan year.

(h) ~~(g)~~ The individualized plan of care shall be written in plain language that is understandable to the participant, legally authorized representative(s), and persons serving the participant.

**Section 11. Rate Reimbursement Requirements.**

(a) Providers shall be reimbursed for services through the rate methodology established in the corresponding waiver agreement with CMS.

(b) Rates paid to providers for waiver services shall be less than or equal to the usual and customary rates for similar non-waiver services.

(i) The Department shall consult with waiver service providers, developmental disability waiver program participants and their families to gather information about reimbursement rates prior to calculating the new reimbursement rates.

(ii) If third party expertise is necessary, the Department shall follow a competitive bidding process to procure the services of an expert in the development of cost-based waiver program payments to assist with the development of new reimbursement rates for waiver providers.

(iii) The Department shall receive approval from CMS prior to the implementation of a new or modified reimbursement rate setting methodology.

(c) Upon request, providers shall submit the following information to the Division:

(i) Cost data;

(ii) Claims data; and

(iii) Participant needs assessment data.

(d) Providers shall participate in reasonable audits of the data submitted in subsection (c).

**Section 12. THIS SECTION RESERVED FOR FUTURE RULEMAKING**

**Section 13. Home and Community Based ~~Services~~ Standards for Waiver Services.**

(a) ~~All c~~Certified waiver providers ~~that provide~~ offering direct care services to participants in a provider owned or operated service setting ~~facility~~ ~~they own or lease~~ shall meet all applicable federal, state, city, county, and tribal health and safety code requirements. A ~~facility~~ service setting includes the provider's home, if services are routinely provided in that setting.

(b) ~~All c~~Certified waiver providers shall provide services that are home and community-based in nature, which means the service setting:

(i) Assists the participant to achieve success in the setting environment and supports full access to the greater community to the same degree as individuals not receiving Medicaid home and community based services (HCBS);

(ii) Is selected by the individual from options including non-disability specific settings;

(iii) Assists the participant to ~~self-~~advocate for him or herself, and participate in life-long learning opportunities;

(iv) Ensures an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint;

(v) Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including daily activities, recreational activities, physical environment, and with whom to interact;

(vi) Facilitates individual choice regarding services and supports and who provides them; and

(vii) Encourages individuals to have visitors of their choosing at any time.

(c) Settings that are not considered home and community-based include, but are not limited to:

(i) Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment;

(ii) Any setting that is in a building on the grounds of, or immediately adjacent to, a public institution; or

(iii) Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

(d) New provider owned or operated ~~residential~~ community living settings serving five (5) or more participants ~~will~~ shall not be certified.

~~(e) Provider facilities certified prior to the effective date of this rule shall continue to provide services in settings that do not meet this requirement, but shall begin transition to HCBS compliance by June 2021. Providers that do not start the transition process in good faith by June 2021 may be decertified.~~

(e) ~~(f)~~ Provider ~~facility~~ service setting inspections.

(i) For each location where services are provided to a participant, ~~except the participant's own home,~~ the provider shall ~~receive~~ obtain an ~~a facility~~ inspection of the service setting by an outside entity at least once every ~~thirty six (36)~~ twenty-four (24) months. The Division may require more frequent inspections if the Division suspects that the provider or employee's ~~facility~~ service setting would not pass the inspection.

(ii) The ~~facility~~ inspection of the service setting shall be completed by one or more of the following outside entities:

(A) A fire marshal or designee;

(B) A certified or licensed home or building inspector; or

(C) ~~Other~~ An appropriate contractor inspecting a part of the ~~facility~~ service setting within the scope of the contractor's license.

(iii) ~~Facility i~~Inspections of service settings required by this ~~s~~Section shall include verification that:

(A) All areas are free of fire and safety hazards, including, but not limited to, all living and service areas, as well as the garage, attic, and basement areas; and

(B) The ~~facility~~ service setting is free of any other significant health or safety concerns, including structural concerns, wiring problems, plumbing problems, and any major system concerns.

(iv) ~~Facility i~~Inspections of service settings shall include a written report that describes the items ~~checked~~ inspected and recommendations to address areas of deficiencies.

(v) If the ~~facility~~ inspection of the service setting identifies deficiencies, the provider shall remediate deficiencies within thirty (30) calendar days. If deficiencies cannot be corrected within thirty (30) calendar days, a written plan on how deficiencies will be remediated, including the anticipated date of completion, shall be completed within thirty (30) calendar days of the initial report, and available to the Division upon request.

(A) The written plan ~~should~~ shall address all identified deficiencies and the intended completion dates.

(B) The Division may request additional corrective actions or proof of ~~corrected problems~~ corrections made, based on the inspector's report.

(C) ~~No s~~Services shall not be provided in a ~~facility~~ setting that does not pass the initial inspection until all deficiencies have been corrected.

(vi) External inspections shall be required on all new locations before services are provided in the new location.

(A) The provider shall notify the Division of the new location at least thirty (30) calendar days before the location is to be used to provide services.

(B) The provider shall not provide services in the new location until the Division has reviewed the external inspection report and has verified that all recommendations have been addressed. The Division shall complete an on-site visit within six (6) months.

(vii) Providers that are not required to have ~~a home or facility~~ an inspection of the home or service setting shall sign a form designated by the Division to verify they are not providing services in a~~ny~~ provider-owned or leased ~~facility~~ service setting.

(viii) Except as described in subsection (a) of this Section, p~~P~~roviders shall not provide services in a ~~facility~~ service setting that is owned or leased by the provider or an employee, which has not had a current inspection completed. The Division may sanction or decertify any provider or self-directed employee ~~when~~ if they are subsequently found to be providing services in a ~~facility~~ service setting owned or leased by the provider or employee, which has not previously passed inspection.

(f) ~~(g)~~ Self-Inspections. A provider ~~providing~~ offering services in a ~~facility~~ service

setting they own or lease shall complete an annual self-inspection of the ~~facility~~ service setting to verify that the provider is in compliance with this ~~s~~Section.

(g) ~~(h)~~ Emergency plans.

(i) Providers shall have written emergency plans and procedures for:

(A) Fires;

(B) Bomb threats;

(C) Natural disasters, including but not limited to earthquakes, blizzards, floods, tornadoes, wildfires;

(D) Power and other utility failures;

(E) Medical~~/behavioral~~ emergencies~~/missing person~~;

(F) Missing person;

(G) Provider incapacity;

(H) ~~(F)~~ Safety during violent or other threatening situations;

(I) Staffing shortages due to other emergency situations;

(J) ~~(G)~~ Vehicle emergencies~~y~~; and

(K) ~~(H)~~ If applicable, h~~H~~ow the provider is able to care for or provide supervision to both participants and any children under the age of 12 or other individuals requiring support and supervision.

~~(I) Providers shall notify the Division in writing within seven (7) calendar days if additional individuals move into the home or have the intent of staying in the home for a period longer than one month.~~

(ii) The emergency plans shall include a contingency plan that assures that there is a continuation of essential services when emergencies occur.

(iii) ~~If the provider is providing 24 hour services, t~~The provider shall document the review of all applicable emergency plans, with staff and participants, at least once every twelve (12) months on ~~each~~ routine shifts. The documentation shall include:

(A) Written identification of concerns noted during the review of plans;

(B) Written documentation of follow-up to concerns noted during the review of plans; and

(C) Evidence of one fire drill, including an evacuation of the premises.

~~(iv) If provider is not providing 24 hour services, the provider shall document the review of all applicable emergency plans, with staff and participants, during normal working hours at least once every twelve (12) months, on each shift. The documentation shall include:~~

~~(A) Written identification of concerns noted during the review of plans;~~

~~(B) Written documentation of follow-up to concerns noted during the review of plans; and~~

~~(C) Evidence of one fire drill, including an evacuation of the premises.~~

(h) ~~(i)~~ Other service standards. All service settings owned or controlled by a provider shall meet the following requirements:

(i) In ~~residential~~ community living service and day service settings~~facilities~~, the provider shall ensure participants have access to food at all times, and provide nutritious meal and snack options. Providers shall not require a regimented meal schedule except as outlined in subsection ~~(o)~~ (n) of this Section.

(ii) Raw and prepared food, if removed from the container or package in which it was originally packaged, shall be stored in clean, covered, dated, and labeled containers. Fruit and vegetable produce may remain unmarked unless partially prepared or used.

(iii) All food shall be served in a clean and sanitary manner.

(iv) Floors and floor coverings shall be maintained in good repair, with the exception of incidental stains natural to the life of the carpet, and shall not be visibly soiled, malodorous, or damaged.

(v) ~~The w~~Walls, wall coverings, and ceilings shall be maintained in good repair and shall not be visibly soiled or damaged.

(vi) All doors, windows, and other exits to the outside shall be reasonably protected against the entrance of insects and rodents, and shall be maintained in good repair.

(vii) All windows shall be free of cracks or breaks.

(viii) All medications, chemicals, poisons, ~~or~~ and household cleaners shall be secured in a manner that minimizes the risk of improper use or harm to individuals in the setting.

(ix) All restrooms shall contain trash receptacles, towels, hand cleanser~~s~~, and toilet tissue at all times.

(x) ~~Toilet facilities~~ Restrooms shall be kept clean and sanitary, and maintained in good repair.

(xi) The overall condition of the home or ~~facility~~ service setting shall be maintained in a clean, uncluttered, sanitary, and healthful manner that does not impede mobility or jeopardize a participant's health or safety, and allows physical access.

(xii) Providers shall not use video monitors in participant bedrooms or bathrooms. Other forms of remote monitoring, remote support, or sensors may be used where appropriate, and shall be documented in the participant's individualized plan of care.

(A) The consent of participants who share living quarters and may be affected shall be obtained prior to the implementation of remote support or monitoring.

(B) Consent shall be documented in each participant's individualized plan of care, which is verified by the plan of care team.

(xiii) A provider ~~facility~~ service setting with a private water supply shall have ~~a bacterial test~~ testing conducted every three (3) years to demonstrate that the water is safe to drink. ~~, and t~~The written results shall be submitted to the Division within thirty (30) calendar days of receiving test results.

(xiv) Providers shall ensure that all participants residing in a provider owned or leased ~~facility~~ service setting have:

(A) A lease or residency agreement for the location in which they are agreeing to reside. The lease or agreement shall be signed by the participant or legally authorized representative, and the provider. The lease or agreement shall allow the same responsibilities and protections from eviction as all tenants under landlord tenant law of the state, as established under W. S. 1-21-1201 through -1211, the county, and the city where the ~~facility~~ service setting is located. A participant shall not be asked to leave ~~their~~ his or her residence on a regular basis to accommodate the provider;

(B) Freedom and support to control their schedules and activities;

(C) ~~The right~~ Freedom to access the community;

(D) Freedom to furnish and decorate their sleeping and living units within the lease or other agreement;

(E) A private bedroom with no more than one (1) person to a bedroom unless a more preferred situation is identified in his or her individualized plan of care and one (1) of the following criteria is met:

(I) The participant is under two (2) years of age;

(II) The services provided are episodic;

(III) The arrangement is determined medically necessary; or

(IV) The participants request to share a bedroom.

(F) An individual bed, unless the participant~~s are legally related~~ is married, or joint sleeping accommodations are specifically requested by the participant, and specified in the ~~approved~~ individualized plan of care;

(G) Access to appropriate egress and a lockable entrance, which can be unlocked by the participant. No devices shall be used that prohibit a participant's entry or exit from the bedroom;

(H) A secure place for personal belongings, which the participant may freely access;

(I) A key or other type of access to a lock for the housing unit, the participant's bedroom, and any form of locked storage where the participant's personal belongings are kept, with only appropriate staff having keys to doors; and

(J) Other appropriate sleeping quarters as necessary to meet health and safety needs for an emergency placement, as long as the sleeping area allows for personal privacy and immediate egress.

(I) Emergency placement, due to situations defined in Chapter 46, Section 1~~2~~4, shall be limited to one week. A participant may request additional emergency placement on a week-by-week basis if the emergency continues and affirmative steps to secure alternative permanent placement are not successful.

(II) Following emergency placement, the participant shall be permitted to transfer to permanent housing. If the provider is no longer able to serve the participant in permanent housing, the case manager will present the participant with options to transition to other certified providers.

(K) Providers shall notify the Division in writing within seven (7) calendar days if additional individuals move into the home or have the intent of staying in the home for a period longer than one month.

(xv) Written policies to address health, safety, and rights. ~~when:~~ Providers shall share policies with participants and the legally authorized representative before the participant formally chooses the provider. Print information shall be written in plain language. Policies shall include:

(A) ~~(I)~~ A smoking policy that assures protection of the health of the participant, if ~~Any~~ occupants or visitors of the home smoke;~~, a policy on smoking that assures protection of health of the participant.~~

(B) ~~(II)~~ A pet policy that includes verification that pets have current vaccinations, if ~~Any~~ occupants or visitors have pets; and~~, a plan to protect participant, including verification that the pets are current with vaccinations.~~

(C) ~~(III)~~ A weapons policy that includes the requirements that weapons are stored in a locked cabinet or inaccessible location, and ammunition is stored separately from firearms, if ~~Any~~ occupants or visitors have weapons in the home~~, a policy on weapons that shall include the requirements that weapons are stored in a locked cabinet or in an inaccessible location and that, for firearms, ammunition is stored in a separate location from the firearm~~.

~~(IV) Providers shall share policies with participants before the participant formally chooses the provider.~~

(i) ~~(j)~~ The provider may be required to provide written verification of their organization's ability to provide support and supervision to children under the age of twelve (12) or other participants requiring support and supervision who are in the care and responsibility of the provider. This may include, but is not limited to, licensure by the Department of Family Services or other appropriate state agency.

(j) ~~(k)~~ Unless otherwise directed by the participant's licensed medical professional, or is otherwise indicated in the individualized plan of care, ~~residential~~ community living service providers shall ensure each participant receives a medical evaluation every twelve (12) months.

(k) ~~(l)~~ Each provider shall identify, in writing, the potential conflicts of interest among employees, other service providers on the participant's plan, relatives to participants, or any legally authorized representative(s), and address how a conflict of interest shall be mitigated. The provider shall share this information with ~~any~~ potential participants and legally authorized representative(s) before the provider is chosen to provide services.

(l) ~~(m)~~ Any provider that is transporting participants shall comply with all applicable federal, state, county, and city laws and requirements including, but not limited to, vehicle and driver licensing and insurance, and shall:

(i) Maintain vehicles in good repair;

(ii) Keep and replenish first aid supplies in the vehicle; and

(iii) Conduct quarterly self-inspections or have the vehicle inspected by a mechanic to ensure that the vehicle is operational, safe, and in good repair.

(m) ~~(n)~~ Each provider certified to provide employment services, including supported employment and group supported employment services, shall ensure that:

(i) The participant is involved in making informed employment related decisions;

(ii) The participant is linked to services and community resources that enable them to achieve their employment objectives;

(iii) The participant is given information on local job opportunities; and

(iv) The participant's satisfaction with employment services is assessed on a regular basis.

(n) ~~(o)~~ Settings that include any ~~modification~~ restriction to a participant's right to food, or a non-regimented meal schedule imposed by a provider, shall be ordered by the participant's attending medical professional with evidence in the individualized plan of care that details the assessed need for the order and the protocols that shall be followed.

(o) ~~(p) Settings that include any restriction to a~~ A participant's right to visitors, communication, privacy, or other standard in this Section may only be restricted as documented in an approved individualized plan of care with the restriction being time-limited and following the requirements listed in Section 4 of this Chapter.

**Section 14. Background Check Requirements**.

(a) All persons providing waiver services including: managers, supervisors, direct care staff, participant employees hired through self-direction, and any other person who may have unsupervised access to participants shall complete and pass a background screening as referenced in this section. Persons who do not successfully pass a background screening shall not supervise, provide, or bill for waiver services, or otherwise have unsupervised access to participants on behalf of a provider.

(b) Certified providers, their employees, and all legal entities supervising, providing, or billing for waiver services shall also pass and maintain documentation of successful Department of Family Services Central Registry screening and an Office of Inspector General Exclusion Database screening. Entities that do not successfully pass these screenings shall be denied certification or terminated.

~~(c) Any person or entity that subsequently fails to pass a renewed background screening shall not supervise, provide, or bill for waiver services following a failed background screening.~~

(c) ~~(d)~~ Any provider or participant who employs an individual or entity to supervise, provide, or bill for waiver services who has not completed all required background checks may be subject to sanctions under these rules.

(d) ~~(e)~~ Providers and self-direction employees shall show evidence of current background screenings for all required persons as part of the provider or employee's ~~recertification~~ certification renewal.

(e) ~~(f)~~ A successful background screening shall include:

(i) A Wyoming Department of Family Services Central Registry Screening, which shows that the individual is not listed on the Central Registry.

(ii) A United States Department of Health and Human Services, Office of Inspector General's Exclusions Database search result, which shows that the individual or entity is not currently excluded.

(iii) A state and national fingerprinted criminal history record check which shows that the individual has not been convicted, plead guilty, no contest to, or does not have a pending deferred prosecution for:

(A) An Offense Against the Person, including:

(I) Homicide (~~Wyo. Stat. Ann.~~W.S. ~~§§~~ 6-2-101~~ et seq.~~)

(II) Kidnapping (~~Wyo. Stat. Ann~~W.S. ~~§§~~ 6-2-201~~ et seq.~~)

(III) Sexual assault (~~Wyo. Stat. Ann~~W.S. ~~§§~~ 6-2-301~~ et seq.~~)

(IV) Robbery and blackmail (~~Wyo. Stat. Ann~~W.S. ~~§§~~ 6-2-401~~ et seq.~~)

(V) Assault and battery (~~Wyo. Stat. Ann~~W.S. ~~§§~~ 6-2-501~~ et seq.~~), ~~and~~

(VI) Human trafficking (W.S. 6-2-701), and

(VII) ~~(VI)~~ Similar laws of any other state or the United States relating to these crimes.

(B) An Offense Against Morals, Decency and Family including:

(I) Bigamy (~~Wyo. Stat. Ann~~W.S. ~~§§~~ 6-4-401)

(II) Incest (~~Wyo. Stat. Ann.~~W.S. ~~§§~~ 6-4-402)

(III) Abandoning or endangering children (~~Wyo. Stat. Ann~~W.S. ~~§§~~ 6-4-403)

(IV) Violation of order of protection (~~Wyo. Stat. Ann.~~W.S. ~~§§~~ 6-4-404)

(V) Endangering children; controlled substances (~~Wyo. Stat. Ann.~~W.S. ~~§§~~ 6-4-405), and

(VI) Similar laws of any other state or the United States relating to these crimes.

~~(g) No person ages eighteen (18) or older shall provide waiver services, or have unsupervised access to a waiver participant, unless the Department of Family Services and Office of Inspector General screenings come back with no findings and the state and national criminal history screenings are in process.~~

(f) ~~(h)~~ At the discretion of the provider or employer of record, an ~~An~~ individual ~~provider~~ staff member may provide unsupervised services on a provisional basis to a participant who is ~~ages~~ ~~18~~ eighteen (18) years or older following the submission of the background screening, as long as disqualifying crimes or relevant criminal records are not disclosed on the application, until individual provider staff are cleared through successful background screenings. ~~a successful Department of Family Services and Office of Inspector General screening while the state and national criminal history screenings are pending.~~

(g) ~~(i)~~ Persons who do not successfully pass the criminal history screenings listed in subsection (~~f~~e) of this Section shall not be left unsupervised in the vicinity of any participant, except as provided by subsection (~~h~~f) of this Section.

(h) ~~(j)~~ Notwithstanding subsection (~~h~~f) of this Section, staff shall not provide any services to participants ages seventeen (17) or younger until all successful background screenings listed in subsection (~~f~~e) of this Section have come back with no findings.

(i) ~~(k)~~ Each individual eighteen (18) years of age or older who is living in a provider's home where services are provided, or staying in the home for a period longer than one (1) month, shall pass a background check as listed in subsection (~~f~~e) of this Section. An Office of Inspector General check is not required.

(i) Waiver participants receiving services in this location are not required to complete a background screening.

(ii) Providers shall not employ or permit individuals registered as a sexual offender to stay in the home. This requirement does not apply to waiver participants.

(j) ~~(l)~~ If a criminal history screening does not include a disposition of a charge, or if an individual is charged with an offense listed in subsection (~~f~~e)(iii) of this Section, the individual shall not have any unsupervised access or provide billable services to participants until the provider is able to provide proof of a successful background check.

(k) ~~(m)~~ Volunteers and individuals under the age of eighteen (18) shall be under the direct supervision of an adult who has passed a background check. Individuals convicted of a sexual offense are not permitted as volunteers.

(l) ~~(n)~~ Background screenings shall not be transferred from one provider entity to another.

(m) ~~(o)~~ The background screening notification shall not be altered in any manner, including the crossing out of names or use of whiteout. If altered, the ~~release forms~~ screening notification shall be determined null and void.

(n) The Division shall require subsequent background screenings as outlined in this subsection. Any person who fails to pass a subsequent background screening shall not supervise, provide, or bill for waiver services.

(i) Any individual required to receive a background screening under this Section shall undergo subsequent background screenings every five (5) years.

(ii) Providers and any person with an ownership or control interest or who is an agent or managing employee of the provider shall undergo subsequent monthly Office of Inspector General Database screenings.

(o) ~~(p)~~ The Division may request a background screening at the Division's expense as part of an investigation.

**Section 15. Provider Training Standards.**

(a) In addition to the other training standards in this Chapter and the Wyoming Medicaid rules, providers shall ensure that employees, including management staff responsible for providing supports and services to participants, ~~are qualified to provide waiver services by receiving~~ receive training in the areas specified in this Section prior to working unsupervised with participants in services.

(b) Staff responsible for providing direct services shall receive participant specific training ~~under the guidance of~~ from a trained staff member prior to working alone with participants.

(c) The provider shall maintain documentation that staff are qualified to provide waiver services through evidence of completed trainings, including ~~when it~~ the date training was completed, who ~~provided~~ conducted the training, and how the employee demonstrated understanding. The provider shall ensure that training is ~~performed~~ conducted by persons with expertise in the topic area, who are qualified by education, training, and experience, and maintain complete verification of such.

(d) All persons qualified to provide waiver services shall complete training in the following areas ~~within one month of an employee's hire or provider certification date~~ prior to delivering services. Providers may choose to develop their own training modules for employees or use Division modules, as long as the provider covers the key elements of each topic specified in the Division module with Division approval. General training topics include:

(i) Participant choice;

(ii) The rights of participants in accordance with state and federal laws, and any rights restrictions for each participant with whom a person works;

~~(A) Providers of only environmental modification services, specialized equipment, or homemaker services are exempt from this training requirement.~~

(iii) Confidentiality;

(iv) Dignity and respect;

(v) Preventing, recognizing and reporting abuse, neglect, intimidation, exploitation, and all other categories listed on the Division's Notification of Incident form;

(vi) Responding to injury, illness, and emergencies;

(vii) Billing and documentation of services;

(viii) Releases of information;

(ix) Grievance and complaint procedures for participants, legally authorized representatives, provider employees, and community members; and

(x) Implementing and documenting participant objectives and progress on objectives.

(e) To verify each provider and provider staff meets the qualification standards, evidence of a completed training summary or test of each training topic shall be retained in the employer's files.

(f) One representative from the provider agency shall receive training on the provider ~~re~~certification renewal process.

~~(g) Any person who provides a service for which a license, certification, registration, or other credential is required shall hold the current license, certification, registration, or credential in accordance with applicable state laws. The provider shall maintain documentation of the staff credentials.~~

(g) ~~(h)~~ Participant specific training.

(i) Each provider and provider staff shall receive participant specific training prior to the individualized plan of care start date. Impacted staff shall receive participant specific training prior to changes to the individualized plan of care.

(ii) All case managers shall train one employee from each provider on the individualized plan of care. The provider shall ensure that all other employees of the provider receive plan of care training. The case manager and the participant or any legally authorized representative(s) may request verification of the provider's participant specific training. Training shall occur before the individualized plan of care start date and before each employee provides services.

(iii) A provider of waiver services shall be trained on any specific assistive technology devices, disabilities, diagnoses, or medical or risk conditions as necessary for the participants served by the provider. This training shall be unique to, and meet the needs of, the participant.

(h) ~~(i)~~ Documentation of participant specific training and general training shall include:

(i) The date of the training;

(ii) The name, signature, and title of the trainer;

(iii) The name and signature of the person receiving the training; ~~and~~

(iv) A detailed agenda of the training topic(s), including the method of training; and~~.~~

(v) How the person receiving training demonstrated understanding.

**Section 16. THIS SECTION RESERVED FOR FUTURE RULEMAKING**

**Section 17. Positive Behavior Supports.**

(a) ~~Treatment and h~~Habilitation services shall be designed to maximize the potential of the participant. Services shall be provided in the setting that is the least restrictive for the participant.

(b) Participants shall have a positive behavior support plan in place if restraints are outlined in their individualized plan of care.

(c) A participant with a challenging behavior identified by the plan of care team shall have a current functional behavioral analysis conducted within the last year to ~~learn~~ identify what the person is trying to communicate through the behavior(s), to identify the function or possible purpose for the behavior(s), to explore antecedents and contributing factors to behaviors, and to review and describe potentially positive behavioral supports and interventions in order to develop a positive behavior support plan.

(i) Challenging behaviors may include actions by the participant that constitute a threat to the person's immediate health and safety, the health and safety of others in the environment, a persistent pattern of behaviors that inhibit the participant's functioning in public places and integration within the community, or uncontrolled symptoms of a physical or mental condition.

(ii) The functional behavioral analysis shall include data compiled regarding all challenging behaviors exhibited, and be utilized to develop the positive behavior support plan used by the provider during the provision of waiver services.

(iii) A provider or provider staff knowledgeable of the participant shall complete the functional behavior analysis, which shall include input from the team, participant, and any legally authorized representative(s).

(d) A positive behavior support plan, based upon a current functional behavioral analysis, shall be developed for a participant in order for ~~employees~~ providers working with the

person to understand and recognize the communication and behaviors exhibited by the person. The positive behavior support plan shall describe agreed upon supports to assist the participant using proven support techniques and non-restrictive interventions. At a minimum, a positive behavior support plan shall:

(i) Include the components of the template provided on the Department's website.

(ii) Maintain the dignity, respect, and value~~s~~ of the participant;

(iii) Use a person-centered approach with the participant involved in the development of the plan on a level appropriate for that person;

(iv) Aim to minimize the use of restraints;

~~(A) If restraints are used then the positive behavior support plan has failed, and must be reviewed to possibly add or modify the service environment or behavioral interventions;~~

(v) Be specific and easily understood, so direct care employees can implement it appropriately and consistently;

(vi) ~~Be approved by verification of~~ Include a signature ~~by~~ of the participant or ~~any~~ legally authorized representative(s), which verifies ~~through~~ informed consent;

~~(A) As part of the informed consent process, education shall be given by the provider to the participant and any legally authorized representative(s);~~

~~(B) This education shall include information about positive behavior supports that may be used and the risks and benefits of any supplemental plan for the use of a restraint or prescribed psychoactive medication if the positive behavior support plan fails.~~

(vii) Define the antecedents and the targeted behavior(s) that need to be replaced or reduced;

(viii) List positive behavioral supports that assist the participant in replacing targeted or challenging behaviors with appropriate replacement behaviors;

(ix) Provide protocols for providers and provider employees to recognize emerging targeted behaviors, and determine the appropriate interventions to implement positive behavioral supports;

(x) Provide protocols, which focus on positive interventions that are deemed least restrictive and most effective, for employees to use when targeted behaviors take place;

(xi) Reference the protocol ~~in the plan,~~ for the use of any PRN medication that may be a part of the positive behavior support plan, as recommended by the treating medical

professional and can be requested by the participant to help manage stress, anxiety, or behaviors~~. The use of a PRN for this purpose shall comply with Section 19(b) of this Chapter~~;

(xii) Be reviewed every six (6) months by the provider(s) and the case manager to assess the effectiveness of the plan, or more frequently if needed;

(xiii) Include specific guidelines for tracking and analyzing the antecedents related to the occurrence of a targeted behavior, the actual behavior(s) displayed, and the results of positive behavioral interventions; and

(xiv) Be included as a formal component of the individualized plan of care.

(e) A provider employee implementing a positive behavior support plan shall receive participant specific training on the positive behavior support plan, and on specific positive de-escalation techniques and interventions, before they begin working with the participant.

(f) The case manager shall educate the participant and legally authorized representative about positive behavior supports that may be used, and the risks and benefits of any supplemental plan for the use of restraint or prescribed psychoactive medication if the positive behavior support plan fails.

(g) If restraints are used or law enforcement is contacted due to a behavioral emergency, the positive behavior support plan has failed and must be reviewed to possibly add or modify the service environment or behavioral interventions.

**Section 18. Restraint Standards.**

(a) Restraint includes physical, chemical, and mechanical restraints, as further defined in this Section.

(b) The entire plan of care team shall agree to the use of restraints, confirmed with a signature from the participant, legally authorized representative, and all providers involved, and be consistent with this Section.

(c) When the use of positive behavior supports is not effective in modifying or changing a participant's challenging behavior, the participant's plan of care team may implement a restraint protocol to supplement the positive behavior support plan, subject to the provisions of this Section.

(d) Providers shall not use aversive techniques to modify a person's behavior. Aversive techniques include any intervention that causes pain, harm, discomfort, or social humiliation for the purpose of modifying or reducing a behavior.

(e) A provider serving more than five (5) participants with restraints in their plans ~~are~~ is required to have one (1) employee complete training on positive behavior supports through any program approved by the Division. An additional employee shall be certified for every ten (10) additional participants with restraints in their plan.

(f) The plan of care team shall review the participant's plan thoroughly to ensure the individualized plan of care is not so restrictive that it repeatedly provokes behaviors that lead to the use of restraints.

(g) When restraints are deemed necessary, the individualized plan of care shall include a restraint protocol that includes ~~the following~~:

(i) If a person other than the participant authorizes the use of restraint, the legal document, court order, guardianship papers, or medical orders that demonstrate this authority; and ~~shall be provided.~~

(ii) For any restraint imposed, demonstration that the standards outlined in Section 4(h)(~~i~~ii) of this Chapter ~~shall~~ are ~~be~~ met.

(h) The case manager shall reconvene the participant's plan of care team if any restraints are used in the previous calendar quarter. When convened under this ~~s~~Section, the team shall review all restraints for the previous quarter and ~~make plans for reducing~~ develop a plan to reduce the number of restraints performed. On a quarterly basis, the case manager shall report data received from the provider concerning the number of restraints performed on the participant.

(i) The provider shall notify the case manager within one (1) business day of any use of an emergency restraint that is not written in a participant's individualized plan of care. A case manager who receives notice of restraint under this provision shall call a team meeting within two (2) weeks to discuss the incident and decide if the individualized plan of care shall be modified to include a crisis intervention protocol and a revised positive behavior support plan.

(j) Restraints shall only be performed by an individual trained and certified in restraint usage.

(k) Providers employing restraints shall:

(i) Adopt policies and procedures that:

(A) Identify the provider's chosen certifying entity consistent with subsection (l) of this Section;

(B) Specify the types of restraints that may be used by provider staff; and

(C) Establish provider-specific training requirements for staff.

(ii) Adhere to all state and federal statutes, rules, and regulations regarding the use of restraints.

(iii) Only utilize restraints approved by the provider's chosen certifying entity recognized in subsection (l) of this Section, unless the restraints are prohibited in subsection (d) of this Section.

(l) The provider and provider staff shall maintain certification, and provider shall require ongoing training for employees in de-escalation techniques, crisis prevention and intervention, and proper restraint usage from entities certified to conduct the training, such as Crisis Prevention Intervention (CPI), MANDT, or other entity approved by the Division.

(m) Restraints shall only be used in emergency circumstances to ensure the immediate physical safety of the participant, a provider staff member, or other persons, and when less restrictive positive behavior supports have been determined to be ineffective. Providers shall only use restraints when the risk of injury without restraint is greater than the risk associated with the restraint. Restraints may include, but are not limited to, the following:

(i) A chemical restraint, which is any drug that is administered to manage a participant's behavior in a way that reduces the safety risk to the participant or others, has the temporary effect of restricting the participant's freedom of movement, and is not a standard treatment for the participant's medical or psychiatric condition.

(A) A chemical restraint shall not be used unless ordered by a licensed medical professional chosen by the participant or any legally authorized representative(s), and administered by a person licensed to administer the medication.

(B) Standing orders for chemical restraints are prohibited, except when deemed necessary to prevent extreme reoccurring behavior by a participant's plan of care team and limited to one (1) month. A standing order shall include clarification on the circumstances of its usage by the licensed medical professional.

(C) If a provider uses three (3) or more ~~instances of a~~ chemical restraints on a participant within a consecutive six (6) month period, the participant's plan of care team shall arrange for the participant to see his or her treating medical professional for a formal medical review in case the treatment plan needs to change. The participant's plan of care team shall meet to determine if the positive behavior support plan or crisis intervention protocol needs to change. The formal medical review shall be documented in the participant's file with the restraining provider and the case manager. If it is determined that the treatment plan or individualized plan of care will not be changed, then the case manager shall document the reasons it is not being changed in the individualized plan of care.

(D) Chemical restraints shall not be used on persons under the age of ~~18~~ eighteen (18).

(ii) A mechanical restraint, which is any device attached or adjacent to a participant's body that he or she cannot easily move or remove that restricts freedom of movement or normal access to the body.

(A) Mechanical restraints shall only be used under the direct supervision of a licensed medical professional for the purpose of medical treatment procedures when compliance is deemed necessary to protect the health of the participant.

(B) Mechanical restraints shall not be used on persons under the age of ~~18~~ eighteen (18).

(iii) A physical restraint, which is the application of physical force without the use of any device, for the purpose~~s~~ of limiting the free movement of a participant's body. Physical restraint does not include briefly holding a participant, without undue force, in order to calm or comfort him or her, or holding a participant's hand to safely escort him or her from one area to another.

(n) Seclusion is the involuntary confinement of a participant alone in a room or an area from which the participant is physically prevented from leaving. Seclusion is prohibited, and may result in sanctions, including the repayment of funds for waiver services ~~and other sanctions~~.

(o) A provider using restraints shall:

(i) Maintain internal documentation to track and analyze~~:~~ each use of a restraint, its antecedents, reason(s) for the restraint, the participant's reaction to the restraint, and actions that may make future restraints unnecessary;

(ii) Implement additional supports with the participant in an effort to minimize restraints;

(iii) Use appropriate de-escalation techniques to redirect or mitigate a behavior before restraints occur;

(iv) Address and correct staff using restraints incorrectly;

(v) If an injury occurs as a result of a restraint, conduct staff retraining within five (5) business days the injury being detected;

(vi) ~~(v)~~ Hold a debriefing meeting with the participant, legally authorized representative, and case manager as soon as practicable after an incident to discuss the use of the restraint. Legally authorized representatives may be part of the participant's debrief discussion either by phone or in person;

(vii) ~~(vi)~~ Within five (5) business days of the event, provide case managers with a copy of the provider's completed internal tracking form, or notify the case manager that the electronic form is available for viewing;

(viii) ~~(vii)~~ Send a copy of the completed internal tracking form to the legally authorized representative within five (5) business days or notify the legally authorized representative that the electronic form is available for viewing;

(ix) ~~(viii)~~ Submit a critical incident report to the Division for each instance when a restraint is used, as outlined in Section 20(b) of this Chapter; and

(x) ~~(ix)~~ Regularly collect and review all available data regarding the use of restraints and work to reduce their duration and frequency, and eliminate their occurrence.

(p) ~~(x)~~ The case manager shall follow-up on each incident within two (2) business

days of notification of the incident to ensure the participant is safe~~,~~ and uninjured, ~~and to~~ ensure the participant's restraint protocol~~,~~ and ~~participant's~~ positive behavior support plan ~~was~~ were implemented appropriately, and verify that documentation demonstrates that less restrictive intervention techniques were used prior to the use of restraint. The case manager shall also ~~review whether the items in this section were completed and~~ report any suspected non-compliance to the Division**.**

(q) ~~(xi)~~ The Division may request a~~n interdisciplinary~~ team meeting with the provider, case manager, and legally authorized representative to review any incident of restraint performed by a provider or provider staff.

(r) ~~(p)~~ Restraints shall not be used for the following purposes:~~. Violation of this provision may result in immediate sanctions of the provider:~~

(i) For the convenience of the provider;

(ii) To coerce, discipline, force compliance, or retaliate against a participant; or

(iii) As a substitute for a habilitation program or in quantities that interfere with services, treatment, or habilitation~~;~~.

(s) The following restraints are prohibited:

(i) ~~(iv)~~ A r~~R~~estraint that is contraindicated by the person's medical or psychological condition;

(ii) ~~(v)~~ A r~~R~~estraint procedure~~s~~ or device~~s~~ that obstruct~~s~~ a person's airway or constrict~~s~~ the person's ability to breathe;

(iii) ~~(vi) The use of any~~ A supine or prone restraint including, but not limited to, restraining a person on the floor, in a bed, in any form of reclined chair, or using any other horizontal flat surface; and

(iv) Any ~~use of~~ physical, mechanical, or chemical restraint not provided for in this ~~s~~Section.

(t) Any violation of subsection (r) or (s) may result in immediate sanctions of the provider.

(u) ~~(q)~~ Any restraint shall be time-limited and removed immediately when the participant no longer presents a risk of immediate harm to self or others.

**Section 19. THIS SECTION RESERVED FOR FUTURE RULEMAKING.**

**Section 20. Notification of Incident Process.**

(a) ~~A p~~Providers shall report the following ~~categories of critical~~ incidents involving waiver participants to the Division, the Department of Family Services, Protection & Advocacy System, Inc., the case manager, ~~any~~ legally authorized representative(s), and ~~to~~ law enforcement immediately after assuring the health and safety of the participant and other individuals:

(i) Suspected abuse as defined by ~~Wyo. Stat. Ann.~~W.S. ~~§~~ 35-20-102 or ~~Wyo. Stat. Ann.~~ W.S. ~~§~~ 14-3-202;

(ii) Suspected self-abuse;

(iii) Suspected neglect as defined in ~~Wyo. Stat. Ann.~~W.S. ~~§~~ 35-20-102 or ~~Wyo. Stat. Ann.~~ W.S. ~~§~~ 14-3-202;

(iv) Suspected self-neglect as defined ~~Wyo. Stat. Ann.~~W.S. ~~§~~ 35-20-102;

(v) Suspected abandonment as defined in ~~Wyo. Stat. Ann.~~W.S. ~~§~~ 35-20-102;

(vi) Suspected exploitation as defined in ~~Wyo. Stat. Ann.~~W.S. ~~§~~ 35-20-102;

(vii) Suspected intimidation as defined by ~~Wyo. Stat. Ann.~~W.S. ~~§~~ 35-20-102;

(viii) Sexual abuse as defined in ~~Wyo. Stat. Ann.~~W.S. ~~§~~ 35-20-102; and

(ix) Death.

(b) ~~All p~~Providers shall report the following ~~non-critical~~ incidents to the Division, Protection & Advocacy System, Inc., the case manager, and ~~any~~ legally authorized representative(s) within one (1) business day:

(i) Police involvement, such as arrests of participants or the participant's direct care provider, while they are providing services, or questioning of participants by law enforcement;

(ii) Any use of restraint;

(iii) Any use of seclusion;

(iv) Injuries caused by restraints;

(v) Serious injury to the participant;

(vi) Elopement~~,~~;

(vii) Medication errors that result in emergency medical attention; and~~,~~ ~~including:~~

~~(A) Wrong medication;~~

~~(B) Wrong dosage;~~

~~(C) Missed medication;~~

~~(D) Wrong participant;~~

~~(E) Wrong route; and~~

~~(F) Wrong Time, which is any deviation from the accepted standard time frame for the medication assistance; and~~

(viii) ~~(viii)~~ Medical or behavioral admission and ~~E~~emergency ~~R~~room visits that are not scheduled medical visits.

(c) Providers shall report the following medication errors to the Division, the case manager, and legally authorized representative(s) within three (3) business days:

(i) Wrong medication;

(ii) Wrong dosage;

(iii) Missed medication;

(iv) Wrong participant;

(v) Wrong route; and

(vi) Wrong time, which is any deviation from the accepted standard time frame for the medication assistance.

(d) ~~(c)~~ In addition to provisions of subsection (a) and (b) of this Section, if, at any time, a significant risk to a waiver participant's health and safety is ~~found~~ identified, the provider shall report the incident to the Division.

~~(d) Medication error reports that do not result in emergency medical attention shall be filed no later than three (3) business days after the event is discovered, in order to give the provider time to complete all follow-up listed in subsection (e) of this Section prior to reporting.~~

(e) Providers shall have incident reporting policies and procedures that include the requirements of this ~~s~~Section and shall maintain internal incident reports for all ~~critical and non-critical~~ incidents identified in this Section.

(i) Providers shall review internal incident data including the people involved in the incident, the preceding events, follow-up conducted, causes of reoccurring critical incidents, other trends, actions taken to prevent similar incidents from reoccurring, evaluation of actions taken, education and training of personnel, and internal and external reporting requirements.

(ii) Providers shall provide access of internal incident data to case managers within five (5) business days.

(f) ~~A p~~Providers shall comply with Division or other agency requests for additional information relating to any reported ~~critical or non-critical~~ incident.

**Section 21. Complaint Process.**

~~(a) All accredited providers shall adhere to the current accreditation requirements for complaints or grievances.~~

(a) ~~(b)~~ A provider ~~who~~ or provider employee who has a reasonable suspicion that ~~believes~~ a participant's health or safety is in jeopardy~~,~~ shall immediately contact the Division, Protection & Advocacy Systems, Inc., and other governmental agencies, such as law enforcement or DFS to report incidents or concerns.

(b) ~~(c)~~ A provider shall have policies and procedures for handling complaints, including:

(i) How it will attempt to resolve the complaint;

(ii) How it will document actions, follow-up, and resolution of the complaint;

(iii) How and when information shall be shared with the complainant, legally authorized representative, and the case manager; and

(iv) How the complainant will be informed of the process to file a formal complaint with the Division.

(c) ~~(d)~~ Complaints may be filed with the Division in writing or verbally. If a provider files a complaint, the complaint shall be submitted in writing unless the complaint involves a participant whose health or safety is in jeopardy. Upon receipt of a complaint from any person, the Division shall:

(i) ~~Notify~~ Send written notification to the complainant, within fifteen (15) business days, ~~in writing~~ that the complaint ~~is~~ has been received. The notification shall address:

(A) Anticipated timeframes for completing the follow-up and resolution of a complaint~~,~~; and

(B) The authority for taking actions.

(ii) ~~Notify~~ Send written notification to the provider, ~~in writing~~ within fifteen (15) business days, when a complaint involving that provider is received ~~involving that provider~~, unless the complaint involves significant health, safety, or rights concerns, which require an unannounced on-site visit. In these cases, the Division shall provide written documentation to the provider at the time of the on-site visit that indicates a complaint has been received, the nature of the complaint, and that complaint follow-up is being conducted.

(iii) Within fifteen (15) business days of complaint resolution, send written notification to ~~notify~~ the complainant ~~in writing~~ that the complaint has been resolved.

(iv) Within fifteen (15) business days of the complaint resolution, submit a written report to the provider(s) that are the subject of ~~involved in~~ the complaint summarizing the results of the complaint findings. The report may include findings, recommendations, and timeframes to address the recommendations through a corrective action plan. If the complaint involves a specific participant, the report will also be sent to the participant and legally authorized representative.

(d) Accredited providers shall adhere to the current accreditation requirements for complaints or grievances.

(e) ~~(v)~~ A provider's failure to ~~complete~~ submit and successfully implement an approved corrective action plan, as outlined in Section 29 of this Chapter, may result in sanctions per Section 30 of this Chapter.

**Section 22. Transition Process.**

(a) The participant or legally authorized representative may choose to change any provider at any time and for any reason.

(b) A provider who is terminating services with a participant shall notify ~~that~~ the participant and the Division in writing at least thirty (30) calendar days prior to ending services, unless the Division approves a shorter transition period in advance. Failure to provide services during this thirty (30) calendar day period shall be considered abandonment of services and may result in decertification of the provider.

(c) When a participant~~,~~ or ~~any~~ legally authorized representative~~,~~ chooses to change providers, they shall inform the ~~participant's~~ case manager of the decision. ~~All~~ The case manager~~s~~ shall notify the provider of a participant's or legally authorized representative's decision to discontinue services within three (3) business days.

(d) When a transition ~~occurs~~ is requested, the case manager shall~~:~~

~~(i) N~~notify the Division of the request for change within ~~five (5)~~ three (3) business days of the request~~.~~;

(i) ~~(A)~~ If the participant~~,~~ or ~~any~~ legally authorized representative~~,~~ requests a change of case manager, the case manager shall review choice and make provider lists available to the participant and legally authorized representative.

(ii) ~~(B)~~ If the participant or legally authorized representative requests a change of a provider other than the case manager, the case manager shall review choice and provider lists with the participant or legally authorized representative.

(e) ~~(ii)~~ When a transition occurs, the case manager shall ~~C~~complete the transition checklist(s) as required by the Division~~;~~ and schedule a plan of care team meeting.

(i) ~~(iii) Schedule individualized plan of care team meetings and n~~Notify all current and new providers, the participant, ~~any~~ legally authorized representative, and the Division at least two (2) weeks prior to the meeting.

(ii) Team meetings may be scheduled sooner than two (2) weeks due to an emergency situation. The c~~C~~ase manager~~s~~ shall notify the Division of any emergency requiring a faster transition schedule.~~; and~~

(f) ~~(iv)~~ After the transition meeting, the case manager shall ~~M~~modify the participant's individualized plan of care.

(i) ~~(A)~~ If a revised individualized plan of care is required, the case manager shall complete the revised plan and submit it to the Division at least thirty (30) calendar days before the new provider is scheduled to begin providing services.

(ii) ~~(B)~~ If the individualized plan of care only requires minor modification, the case manager shall complete and submit plan of care modifications to the Division at least seven (7) business days prior to the scheduled start date of the new services.

(g) ~~(e)~~ All providers on the individualized plan of care shall share pertinent information with the case manager and the ~~individualized~~ plan of care team in a timely manner.

(h) ~~(f)~~ If a community living services provider ~~providing residential services to a participant~~ requires a participant to move to another ~~residential location~~ service setting, the participant shall be given the opportunity to choose from all available options, without limitation to that provider's settings.

(i) The participant may choose from other setting options that are appropriate for the participant, which may include a new provider ~~or transitioning to supported living services~~.

(ii) The provider shall notify the participant, family, case manager, and any legally authorized representative of the move at least thirty (30) calendar days in advance so the participant can exercise the choice to find a new residence or provider.

(i) It is the responsibility of the case manager to ensure providers have received training on all participant information, including health and safety, behavioral concerns, and the individualized plan of care.

**Section 23. Notice of Costs to the Participant.**

(a) The provider shall develop and implement a system to notify participants and legally authorized representatives of any associated cost to the participant for a service or item, and the terms of payment.

(b) Written notice shall be given to the participant before initiation of service and before any change. Providers shall allow participants and their legally authorized representative

adequate time to review the notice before the participant chooses services from the provider, or before the changes are implemented.

(c) A provider's cost notice shall specify that participants will not be charged for services or items that are covered through other funding sources. This includes, but is not limited to, items necessary to provide habilitation and transportation related to habilitation. The cost notice shall also identify:

(i) Who is responsible for replacement or compensation when the participants' personal items are damaged or missing; and

(ii) How participants will be compensated when staff, guests, or other participants in service, who do not reside in the location (i.e., respite), utilize the environment and eat food paid for by participants.

(d) Providers shall not charge participants for changes to the provider's staffing, ~~facilities~~ service settings, or services, if the change is required by state or federal law.

**Section 24. Participant Funds and Personal Property**.

(a) Standards in this Section apply to any provider who takes responsibility for the funds or personal property of a participant. This includes:

(i) Serving as representative payee;

(ii) ~~Involvement in m~~Managing the funds of the participant;

(iii) Receiving benefits or funds on behalf of the participant; or

(iv) Temporarily safeguarding funds or personal property for the participant.

(b) The provider shall develop and implement written policies and procedures to identify and detail the system used to protect participant's funds and property. These policies and procedures shall be communicated to the participant or legally authorized representative, including:

(i) How the participant or any legally authorized representative will give informed consent for the expenditure of funds;

(ii) How the participant or legally authorized representative may access the records of the funds;

(iii) How funds are segregated for accounting and reporting purposes to the participant, legally authorized representative, and regulatory agencies, such as Social Security Administration or the Division of Healthcare Financing;

(iv) Safeguards used to ensure that funds are used for the designated and appropriate purposes;

(v) If interest is accrued, how interest is credited to the accounts of the participant;

(vi) How service fees are charged for managing funds; and

(vii) How the person's funds or personal property will be replaced or recouped in the event of theft or an unexplainable disappearance at the provider ~~facility~~ service setting, or during the provider's provision of services.

(c) Providers shall not use or allow participant funds or personal property to be used:

(i) As a reward or punishment, unless specified in the individualized plan of care as a restriction of rights that complies with the requirements in this Chapter and is approved by the participant and legally authorized representative;

(ii) As payment for damages, unless otherwise specified in the lease or other written agreement, ~~with~~ evidence ~~provided~~ show~~s~~ing the charge is appropriate ~~for the participant to make restitution~~, the rationale is documented, and the participant or legally authorized representative gives written informed consent to make restitution for damages;

(iii) As payment for damages when the damage is the result of lack of appropriate supervision;

(iv) To purchase inventory or services for the provider; or

(v) ~~On~~ As a loan to the provider or the provider's employees.

(d) Participant funds shall not be comingled with provider business accounts or monies.

**Section 25. Additional Standards for Providers that Require National Accreditation**.

(a) Providers who are certified in ~~Residential Services, Supported Living, Community Integration,~~ Adult Day ~~Services, Prevocational~~, Case Management, Community Living, Community Support, Companion, or ~~any~~ Supported Employment Service~~s~~ shall receive and maintain national accreditation in the accreditation areas specific to the service being provided if the services listed in this subsection and delivered by the provider collectively equal or exceed $150,000 per calendar year.~~:~~

~~(i) The provider is on the individualized plan of care for three (3) or more participants; and~~

~~(ii) The provider's total income for all billed waiver services equals or exceeds $125,000 collectively per calendar year.~~

(b) ~~(iii)~~ Providers shall obtain accreditation in the area applicable to each service within eighteen (18) months of qualifying under this provision. The eighteen (18) month clock begins on the date the accreditation criteria are met.

(c) ~~(b)~~ Provider accreditation options include the ~~Commission~~ Council on Quality and Leadership (CQL) and ~~or Commission on Accreditation of Rehabilitation Facilities (CARF)~~ CARF International. Regardless of the accreditation attained, all references to accredited providers in this rule apply to the provider.

(d) ~~(c)~~ The Division shall decertify a provider who fails to obtain or maintain accreditation.

(e) ~~(d)~~ If a provider fails to obtain or maintain accreditation, a transition plan shall be implemented for each participant who is leaving the provider's services.

(i) Each waiver participant shall be relocated to a different provider within ninety (90) days of the date the Division receives confirmation that the provider did not receive accreditation. If a provider fails to obtain or maintain accreditation, the Division shall complete an immediate site survey and onsite assessment.

(ii) The provider's decertification date shall begin ninety (90) days from the date of written notice from the accrediting entity that the provider did not receive accreditation.

(f) ~~(e)~~ An accredited provider shall submit all national accreditation report documents to the Division within thirty (30) days of receiving the report documents from the accrediting entity.

**Section 26. Mortality Review.**

(a) The Division shall review deaths of participants receiving waiver services.

(b) Providers shall ~~provide~~ submit information requested by the Division. This may include, but is not limited to:

(i) Copies of documentation of services;

(ii) Copies of incident reports; and

(iii) Copies of any health related records, including assessments, results of licensed medical professional's office visits, and hospital visits.

(c) The Division may make provider specific recommendations or systemic recommendations.

**Section 27. Initial Provider Certification.**

(a) An individual or entity may apply to become a provider by completing the Division's initial provider certification ~~packet~~ process and all required trainings. The applicant

shall supply evidence that the applicant meets the qualifications for each service in which the applicant is seeking waiver certification.

(b) The Division shall only certify one provider per physical location.

(c) The Division shall not certify any person or entity as a waiver provider if:

(i) The person or entity has an open or pending corrective action plan with the Division;~~, or~~

(ii) The person or entity has an~~y~~ open case~~s~~ with the Medicaid Fraud Control Unit; or~~.~~

(iii) The person has not successfully passed a background screening as provided in Section 14 of this Chapter.

(d) The Division may refuse to certify an entity that has an officer, administrator, or board member who was previously sanctioned by the Division. This refusal shall apply for a period of two (2) years from the date the person was sanctioned. The Division may also refuse to certify such person related to his or her involvement in any open or pending corrective action plan, or Medicaid Fraud Control Unit case until after the two (2) year period.

(e) A~~ny~~ person who has been convicted of Medicaid fraud shall not be certified.

(f) The Division shall refuse to certify or shall subsequently decertify a provider applicant who fails to disclose any convictions in a court of law on the Division's provider application or organization's application.

(g) ~~Any f~~Falsifications of statements~~,~~ or documents, or any concealment of material fact may result in a denial ~~or~~ of certification, decertification, or referral for criminal prosecution.

~~(h) If the Division receives information that the provider no longer meets the qualifications for each service for which the provider is certified, the Division will send notice to the provider within one (1) business day regarding this missing qualification and the applicable sanction. If the missing qualification is not obtained within the timeframe given by the Division, the provider will be disqualified from providing such waiver service(s).~~

(h) ~~(i)~~ The Division shall initially certify a new provider or provider agency providing any service for one (1) year. The provider must complete a provider certification renewal at the end of the first year to continue providing services

(i) ~~(j)~~ A person or entity may dispute an adverse action related to provider initial certification by a request for an administrative hearing, which will be administered pursuant to Chapter 4 of the Department of Health's Medicaid Rules.

**Section 28. Provider Certification Renewal.**

(a) The Division shall notify all providers that their waiver certification is expiring at least ninety (90) calendar days prior to the certification expiration date.
The ~~letter~~ notification shall detail requirements that the provider shall meet in order to renew their certification.

(b) The Division shall renew a provider certification at least once every three years. Based on the services provided, an on-site visit may be required. If an on-site visit is required, the Division shall provide notification to the provider at least thirty (30) calendar days prior to the visit.

(c) Provider certification renewal includes a Division review of the provider's evidence of compliance with state and federal regulations for home and community based services, and a review of the provider's self-assessment of compliance. For providers who ~~provide~~ offer services in a ~~facility~~ setting they ~~control~~ own, operate, or lease, the Division shall also review the provider's self-inspection of ~~facilities~~ service settings and a current inspection report from an outside entity.

~~(d) The Division will notify the provider of the certification renewal and site visit sixty (60) days prior to the evaluation.~~

(d) ~~(e)~~ At any time, the Division shall conduct an on-site visit when a concern is identified during a complaint, incident report, or internal referral, if there is an indication the provider is not complying with state or federal rules and regulation, or at the Division's discretion.

(e) ~~(f)~~ Providers may sign a form verifying that they do not provide services in their home or a provider-owned, leased, or ~~controlled facility~~ operated setting. The Division will not conduct on-site evaluations for providers signing these forms, but may verify the accuracy of these statements. Falsification of these forms may result in sanctions.

(f) ~~(g)~~ The Division does not require an on-site visit for a case manager, specialized equipment, or environmental modification certification renewal.

(g) ~~(h)~~ Providers shall submit verification that they have met all applicable certification renewal requirements to the Division at least forty-five (45) calendar days prior to their certification expiration date.

(h) ~~(i)~~ If a provider fails to submit the applicable certification renewal requirements to the Division as described ~~above~~ in subsection (g) of this Section, the Division shall notify the provider in writing of the expiration of the certification.

(i) ~~(A)~~ If the provider does not meet the certification renewal requirements within ~~fifteen (15)~~ twenty (20) calendar days of the certification expiration, the Division shall begin the decertification process.

(ii) ~~(B)~~ The provider shall be notified in writing through certified mail that their certification has expired.

(i) During any certification renewal, the Division shall review provider certification requirements and compliance with all home and community based regulations, then complete a written report, including a statement of the recommendations that shall be addressed within thirty (30) calendar days in order to maintain certification.

(i) The Division may approve a certification period for up to three (3) years depending on deficiencies noted during the certification renewal process.

(ii) The Division may approve the certification for a period of less than one (1) year~~,~~ if deficiencies are identified that seriously affect the health, safety, welfare, rights, or habilitation of a participant, or if the provider has otherwise substantially failed to comply with the rules and standards applicable to the services they are providing.

(iii) The Division may deny the certification.

(j) A provider may dispute an adverse action related to renewal of certification by a request for an administrative hearing, which will be administered pursuant to Chapter 4 of the Department of Health's Medicaid Rules.

**Section 29. Corrective Aaction Pplan Rrequirements.**

(a) The Division shall, to the extent practicable and consistent with the provisions of applicable law, seek the cooperation of providers in obtaining compliance with these standards. The Division may provide technical assistance to providers to help them voluntarily comply with any applicable provision of these rules.

(b) The Division may ~~also~~ attempt to resolve any suspected noncompliance with this ~~c~~Chapter through a corrective action plan.

(c) Corrective action plans shall address each area of suspected non-compliance to the Division's satisfaction. This includes identifying the suspected noncompliance area, action steps needed to address the area of noncompliance, the ~~responsible~~ people in the organization responsible for each action item, due dates, and dates of completion for each recommendation.

(d) Corrective action plans may also include a recommendation for specialized training for the provider organization or individual employees. Specialized training may include, but is not limited to, training on positioning, feeding protocols, positive behavior supports, person-centered planning, or trauma-informed care.

(e) Suspected non-compliance that relates to the immediate health, safety, welfare, or rights of participants, shall be addressed immediately after the situation is discovered. Providers addressing suspected non-compliance under this section shall be given fifteen (15) business days from the date of the report issued by the Division to submit a corrective action plan.

(f) If a corrective action plan is not submitted and implemented to address all areas of suspected non-compliance, the Division may impose sanctions as warranted in Section 30 of this Chapter.

(g) The Division shall notify the provider in writing within thirty (30) business days after receipt of the provider's corrective action plan regarding the approval or rejection of the plan.

(i) If a corrective action plan is rejected, the provider shall receive notification in writing of the reasons for the rejection, and ~~will~~ shall ~~be required to~~ submit a revised plan within ten (10) business days ~~of receipt of~~ from the notification of the written rejection from the Division.

(ii) The Division shall notify the provider in writing within thirty (30) business days after receipt of the provider's revised corrective action plan regarding the approval or rejection of the plan.

(iii) If the revised corrective action plan is rejected, the provider shall have ten (10) business days from the notification of rejection to submit an acceptable corrective action plan, or the Division may proceed with the sanctioning process as outlined in Section 30 of this Chapter.

(h) The provider shall complete appropriate follow-up monitoring to assure that the actions identified in their corrective action plan have been completed within the specified time frame(s) and, at the discretion of the Division, submit a monthly status report to the Division in the form and manner required by the Division until all action items have been satisfactorily completed. If the Division does not receive the monthly status report from the provider, the Division may proceed with the sanctioning process as outlined in Section 30 of this Chapter.

(i) The Division may complete follow-up ~~investigations~~ or review additional items during the provider's ~~recertification~~ certification renewal process to assure the provider has fully implemented and evaluated the corrective action plan, and that participants remain safe during the implementation.

**Section 30. Sanctions.**

(a) Sanctions shall be imposed in accordance with the provisions of Chapter 16 of the Department of Health's Medicaid Rules.

(b) Notwithstanding the provisions of Section 29 of this Chapter, the Division may impose sanctions or revoke provider certification for any violation of these rules.

(c) If the Division revokes a provider's certification or suspends a national provider identification number, the provider shall submit transition plans to the Division detailing the transition of each participant to other settings within ~~thirty (30)~~ twenty (20) calendar days of the date that the sanction is deemed final.

(i) The transition plans shall not be implemented until approved by the Division.

(ii) The transition plans shall be implemented and participants shall move to different certified providers or receive non-waiver supports and services from persons approved by the participants or any legally authorized representative(s) within ninety (90) calendar days of the date the Division informed the provider of the revocation of certification.

(iii) Transition plans shall adhere to the requirements in Section 22 of this Chapter.

(d) A provider who has had their certification revoked under this Section shall not provide waiver services.

(e) ~~(d)~~ A provider may dispute a sanction under this Section or any other adverse action, including those related to certification or renewal of certification, by a request for an administrative hearing, which will be administered pursuant to Chapter 4 of the Department of Health's Medicaid Rules.

**Section 31. Relative Providers.**

(a) The Division shall allow a participant's relative, as defined in Section 3 of this Chapter, to become a certified waiver provider and receive reimbursement for services provided to the related participant.

(b) A participant's legally authorized representative shall not directly or indirectly receive reimbursement for providing waiver services for their ward, except as indicated in this Section. Direct or indirect reimbursement shall include, but is not limited to, providing direct services ~~at~~ for, or serving as the owner or officer of, a provider organization ~~serving the ward~~, residing in a provider owned ~~facility~~ service setting ~~serving the ward~~, or being married to a person providing waiver services to the ~~ward~~ participant.

(c) A participant's spouse may receive direct or indirect reimbursement only if they present the Division with a certified copy of a court order establishing another party as the legally authorized representative of the participant.

(d) To provide waiver services to a related participant, the relative provider shall:

(i) Form a Limited Liability Company (LLC) or other corporation;~~,~~ and

(ii) Maintain provider certification in accordance with this chapter.

(e) ~~No parent, step-parent~~ A relative provider, spouse, or legally authorized representative shall not be hired to provide services through self-direction.

(f) Services that may be furnished by a relative provider are identified in the Comprehensive and Supports Waiver Index, which is incorporated by reference. ~~a relative provider may provide include residential habilitation and supported living for participants over the age of 18, personal care, specialized equipment, any supported employment service, prevocational services, and environmental modifications with the following limitations:~~

~~(i) For residential habilitation and supported living services, the relative shall not live in same residence as the participant.~~

~~(ii) Personal care services reimbursed to a relative provider shall not exceed four (4) hours per day, and can only be reimbursed if the provider lives in the same residence as the participant.~~

~~(iii) A provider who is the parent, stepparent, or legally authorized representative of a participant age zero through seventeen shall only be reimbursed for providing personal care services up to four (4) hours per day and for extraordinary care purposes only. No other waiver services are reimbursable.~~

~~(A) Extraordinary care personal care services shall align with the needs and supports specified in the individualized plan of care which demonstrate the need for extraordinary care; and~~

~~(B) The participant's Adaptive Behavior Quotient shall be 0.35 or lower on the Inventory for Client and Agency Planning (ICAP) assessment; and meet one of the following criteria:~~

~~(I) 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, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; or~~

~~(II) 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 licensed medical professional and the Behavioral Health Division.~~

(g) If a ~~parent, stepparent,~~ relative provider or legally authorized representative is providing personal care to his or her ward, the individualized plan of care shall be developed and monitored by a case manager without a conflict of interest.

(h) If the relative provider is not providing services in the best interest of the participant, the case manager shall work with the participant, appropriate team members, and the Division, as needed, to choose other providers as appropriate and modify the individualized plan of care to better suit the needs of the participant.

(i) Payment to a~~ny~~ relative provider specified in subsections (f) and (g) of this Section shall only be made when the service provided is not a function that the relative would normally provide for the individual without charge as a matter of course in the usual relationship among family members, and the service would otherwise need to be provided by a qualified provider.

(j) A~~ny~~ relative who provides services either as an owner, employee, or officer of a provider or who intends to provide services to a related waiver participant shall disclose the relationship in the participant's team meeting and acknowledge and address the safeguards set forth in documentation required by the Division.

(k) If a provider permits the hiring of a legally authorized representative of a participant receiving services from the provider, or if a provider permits the hiring of relatives of provider employees working for the organization, the provider shall have a written policy on

how it addresses potential conflicts that arise from these relationships and how the conflict of interest is mitigated. The policy shall be shared with the participant and legally authorized representative(s).

**Section 32. Interpretation of Chapter**.

(a) The order in which the provisions of this Chapter appear is not to be construed to mean that any one provision is more or less important than any other provision.

(b) The text of this Chapter shall control the titles of its various provisions.

**Section 33. Superseding Effect**. This Chapter supersedes all prior rules or policy statements issued by the Division, including ~~P~~provider ~~M~~manuals and ~~P~~provider ~~B~~bulletins, which are inconsistent with this Chapter.

**Section 34. Severability**. If any portion of this Chapter is found invalid or unenforceable, the remainder shall continue in full force and effect.

**Section 35. Incorporation by Reference.**

(a) For any code, standard, rule, or regulation incorporated by reference in these rules:

(i) The Department has determined that incorporation of the full text in these rules would be cumbersome or inefficient given the length or nature of the rules;

(ii) The incorporation by reference does not include any later amendments or editions of the incorporated matter beyond the applicable date identified in subsection (b) of this section; and

(iii) The incorporated code, standard, rule, or regulation is maintained at the Department and is available for public inspection and copying at cost at the same location.

(b) Each code, rule, or regulation incorporated by referenced in these rules is further identified as follows:

(i) Referenced in Section 2 of this Chapter is Title XIX of the Social Security Act, 42 C.F.R. Part 441, Subpart G, incorporated as of the effective date of this Chapter and can be found at http://www.ecfr.gov.

(ii) Referenced in Sections 2 and 9 of this Chapter is Wyoming Medicaid's State Plan, incorporated as of the effective date of this Chapter and can be found at http://www.health.wyo.gov/healthcarefin/medicaid/spa.

(iii) Referenced in Sections 2 and ~~8~~ 11 of this Chapter is Wyoming's Comprehensive and Supports Waiver Applications, incorporated as of the effective date of this Chapter and can be found at ~~https://health.wyo.gov/behavioralhealth/dd/waivers/~~ https://health.wyo.gov/behavioralhealth/dd/bhd-public-notices/.

(iv) Referenced in Sections 2, 6, 8, and 31 of this Chapter is Wyoming's Comprehensive and Supports Waiver Service Index, incorporated as of the effective date of this

Chapter and can be found at ~~https://www.health.wyo.gov/behavioralhealth/dd/comprehensive-support-waivers/~~ https://health.wyo.gov/behavioralhealth/dd/servicesandrates/.

(v) Referenced in Section 7 of this Chapter is ~~Wyoming Statute~~ W.S. ~~§~~ 35-2-607, incorporated as of the effective date of this Chapter and can be found at https://legisweb.state.wy.us/.

(vi) Referenced in Section 8 of this Chapter is ~~Wyoming Statute~~ W.S. ~~§~~ 40-21-107, incorporated as of the effective date of this Chapter and can be found at https://legisweb.state.wy.us/.

(vii) Referenced in Section 13 of this Chapter is W.S, ~~§~~ 1-21-1201 through -1211, incorporated as of the effective date of this Chapter and can be found at https://legisweb.state.wy.us/.

(viii) ~~(vi)~~ Referenced in Section 14 of this Chapter is Title 6 of the Wyoming Statutes Annotated, incorporated as of the effective date of this Chapter and can be found at https://legisweb.state.wy.us/.

(ix) ~~(vii)~~ Referenced in Section 20 of this Chapter is ~~Wyoming Statute~~ W.S. ~~§~~ 35-20-102, incorporated as of the effective date of this Chapter and can be found at https://legisweb.state.wy.us/.

(x) ~~(ix)~~ Referenced in Section 20 of this Chapter is ~~Wyoming Statute~~ W.S. ~~§~~ 14-3-202, incorporated as of the effective date of this Chapter and can be found at https://legisweb.state.wy.us/.

# CHAPTER 46

## MEDICAID SUPPORTS AND COMPREHENSIVE WAIVERS

**Section 1. Authority.** This Chapter is promulgated by the Department of Health pursuant to Wyoming Statute 9-2-102 and the Wyoming Medical Assistance and Services Act at W. S. 42-4-104 through -121.

**Section 2. Purpose and Applicability**.

(a) This Chapter shall apply to and govern Medicaid services provided under the Wyoming Medicaid Supports and Comprehensive Waivers.

(b) This Chapter, in addition to Chapters 44 and 45 of the Department of Health's Medicaid Rules, shall govern services and provider requirements of the Supports and Comprehensive Waivers.

(c) The Division of Healthcare Financing, hereinafter referred to as the "Division," may issue manuals and bulletins to providers or other affected parties to interpret the provisions of this Chapter. Such manuals and bulletins shall be consistent with and reflect the policies contained in this Chapter. The provisions contained in manuals and bulletins shall be subordinate to the provisions of this Chapter.

(d) Wyoming's currently approved Centers for Medicare and Medicaid Services (CMS) Comprehensive and Supports Waiver Applications and the Comprehensive and Supports Waiver Index apply to this Chapter.

(e) The requirements of Title XIX of the Social Security Act, 42 C.F.R Part 441, Subpart G and the Medicaid State Plan apply to this Chapter.

**Section 3. General Provisions**.

(a) Except as otherwise specified in Chapter 1 of the Department of Health's Medicaid Rules, or as defined in this Section, the terminology used in this Chapter is standard terminology and has the standard meaning used in accounting, health care, Medicaid, and Medicare.

(b) "Case manager" means an individual who provides case management services, as established in Chapter 45, Section 9.

(c) "Level of Service score" means a participant's support needs for various parts of their everyday routine and their level of independence, which are tied to a Level of Service score ranging from 1 (lowest level of support) to 6 (highest level of support). The Level of Service scores are based on comprehensive assessments that determine an individual's level of functioning related to behavioral and health factors, and identify essential staffing and support requirements.

(d) "Relative" means a participant's biological, step, or adoptive parent(s).

**Section 4. Eligibility Requirements**.

(a) Eligibility under this Chapter is limited to persons who complete the application process and who meet the requirements for clinical and financial eligibility established under this Section. An individual is not eligible for the Wyoming Medicaid Supports Waiver unless the individual meets the following criteria:

(i) The individual satisfies the citizenship, residency, and financial eligibility requirements established in Chapter 18 of the Department of Health's Medicaid Rules;

(ii) The individual qualifies for the relevant institutional level of care pursuant to Section 6 of this Chapter;

(iii) The individual has received a clinical eligibility diagnosis pursuant to Section 7 of this Chapter; and

(iv) The individual has received a qualifying Inventory for Client and Agency Planning (ICAP) score pursuant to Section 8 of this Chapter.

(b) An individual is not eligible for the Wyoming Medicaid Comprehensive Waiver unless the individual meets the following criteria:

(i) The individual meets the eligibility criteria pursuant to subsection (a) of this Section;

(ii) The individual has assessed service needs in excess of the established cost limit on the Supports Waiver; and

(iii) The individual meets one of the following:

(A) The emergency criteria as approved by the Extraordinary Care Committee (ECC); or

(B) The criteria for reserved capacity as specified in Section 13(f) or (g) of this Chapter.

(c) Diagnoses and assessments used to meet initial clinical eligibility shall be accurate and shall be completed within the past five (5) years. Any assessment or reassessment for eligibility is subject to review by the Division before acceptance, and may require additional evidence or verification.

(d) Case managers shall complete all eligibility paperwork within thirty (30) calendar days of being selected. Submitted paperwork shall be reviewed by the Division within thirty (30) calendar days of receipt.

**Section 5. Loss of Eligibility**

(a) The Division shall determine a participant has lost eligibility for waiver services when the participant:

(i) Does not meet clinical eligibility;

(ii) Does not meet financial eligibility; or

(iii) Changes residence to another state.

(b) The Division may terminate a participant's eligibility when the participant:

(i) Voluntarily does not receive waiver services for three (3) consecutive months;

(ii) Is in a nursing home, hospital, residential treatment facility, in-patient hospice, institution, or ICF/IID for thirty (30) or more consecutive calendar days;

(iii) Is in an out-of-state placement or residence for six (6) consecutive months or resides out of state for six (6) consecutive months; or

(iv) Chooses another waiver outside of the Comprehensive or Supports waiver.

(c) If the participant is determined not to be eligible for services due to one of the criteria in subsection (b) of this Section, the participant or the participant's legally authorized representative shall be notified in writing within fifteen (15) calendar days.

(d) The Division shall notify an applicant, participant, or legally authorized representative, in writing, of the determination of clinical ineligibility or loss of clinical eligibility within fifteen (15) calendar days of the determination or loss.

(i) Upon written notification of ineligibility, the applicant, participant, or legally authorized representative may submit, in writing, a request for reconsideration within thirty (30) calendar days of the notice of ineligibility, which shall include the reasons why the participant should still be considered eligible for the services.

(ii) If the participant requests reconsideration, the Division Administrator or Designee shall review the request and make a final determination, in writing, within thirty (30) calendar days of the request. A participant who is aggrieved or adversely affected by a reconsideration decision may also request an administrative hearing within thirty (30) calendar days following the adverse reconsideration decision.

(iii) Requests for an administrative hearing will be administered pursuant to Chapter 4 of the Department of Health's Medicaid Rules.

(iv) Services to a participant determined not to meet clinical eligibility requirements shall be terminated no more than forty-five (45) calendar days after the determination is made.

(e) Wyoming Medicaid shall send written notification of financial ineligibility.

(f) An applicant who is determined ineligible, or a participant whose eligibility is terminated under this Section, may reapply at any time.

**Section 6. Institutional Level of Care Requirements**

(a) An individual with a developmental or intellectual disability diagnosis is not eligible for waiver services pursuant to Section 4 of this Chapter unless the individual qualifies for an intermediate care facility for individuals with an intellectual or developmental disability (ICF/IID) level of care, as measured by the LT-104 assessment.

(b) An individual with an acquired brain injury diagnosis is not eligible for waiver services pursuant to Section 4 of this Chapter unless the individual qualifies for a nursing facility level of care, as measured by the LT-101 assessment.

**Section 7. Clinical Eligibility Diagnoses**

(a) An individual is not eligible for waiver services pursuant to Section 4 of this Chapter unless the individual meets one of the following clinical eligibility diagnoses:

(i) A diagnosis of an intellectual disability, as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM 5), which is incorporated by reference, and is determined by a Medicaid enrolled psychiatrist, neurologist, or clinical psychologist who is licensed in Wyoming and is free of conflicts with other providers chosen by the participant.

(A) The diagnosis shall be verified in a written and signed psychological evaluation that is submitted to the Division.

(B) The psychological evaluation shall reflect adaptive behavior scores as determined through a standard measurement of adaptive behavior using a validated test of adaptive functioning such as the most current form of the Vineland Adaptive Behavior Scales or Adaptive Behavior Assessment System.

(C) A child applicant who takes an Intelligence Quotient test shall meet a qualifying clinical diagnosis like an adult. A child too young to complete an Intelligence Quotient test may meet the criteria of a developmental disability as described in subsection (a)(i)(B) through medical records of a related condition using a standardized test of development, such as the Bayley Scales of Infant and Toddler Development or other similar instrument.

(ii) A developmental disability or a related condition determined by a Medicaid enrolled licensed medical professional, neurologist, or clinical psychologist who is licensed in Wyoming and is free of conflicts with other providers chosen by the participant.

(A) Determination shall include verification in medical records and a written psychological evaluation, which includes assessment scores. The evaluation or records shall be submitted to the Division and shall identify a severe, chronic disability, which:

(I) Manifested before the person turned age twenty-two;

(II) Reflects the need for a combination and sequence of special services, which are lifelong or of extended duration;

(III) Is attributable to a cognitive or physical impairment, other than mental illness;

(IV) Is likely to continue indefinitely; and

(V) Results in substantial functional limitations in three (3) or more of the following major life activity areas: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.

(B) Individuals with a diagnosis of Autism Spectrum Disorder (ASD) shall submit a current autism evaluation accepted by the Division, which demonstrates the diagnosis of ASD. The autism evaluation shall be completed by a Medicaid enrolled psychiatrist, neurologist, or clinical psychologist who is licensed in Wyoming and is free of conflicts with other providers chosen by the participant.

(iii) An Acquired Brain Injury (ABI), as defined by Chapter 1 of the Department of Health's Medicaid Rules. An individual with an ABI shall:

(A) Be between the ages of twenty-one (21) and sixty-four (64); and

(B) Have received a qualifying score on at least one of the evaluations accepted by the Division, which shall be completed by a Medicaid enrolled psychiatrist, neurologist, or clinical psychologist who is licensed in Wyoming and is free of conflicts with other providers chosen by the participant. Accepted evaluations, which shall be submitted to the Division to confirm the diagnosis, include:

(I) A score of 42 or more on the Mayo Portland Adaptability Inventory (MPAI);

(II) A score of 40 or less on the most current version of the California Verbal Learning Test Trials 1-5 T; or

(III) A score of 4 or more on the Supervision Rating Scale.

(b) A participant shall be reassessed for clinical eligibility at least annually or more frequently should a change in circumstances occur, which requires a participant to receive a higher level of services or support to ensure the participant's health, safety, and welfare.

(i) A subsequent psychological evaluation, which shall be approved by the Division prior to scheduling, must be necessary due to the participant's change in condition or as determined by the Division.

(ii) A subsequent neuropsychological evaluation, which shall be approved by the Division prior to scheduling, shall be performed every five (5) years.

(iii) Psychological and neuropsychological reassessments shall be completed by a Medicaid enrolled psychiatrist, neurologist, or clinical psychologist who is licensed in Wyoming and is free of conflicts with other providers chosen by the participant.

**Section 8. Inventory for Client and Agency Planning Assessment**

(a) An individual is not eligible for waiver services pursuant to Section 4 of this Chapter unless the individual receives a qualifying Inventory for Client and Agency Planning (ICAP) assessment score for the individual's age.

(i) If an individual is age zero (0) through one (1), the adaptive behavior quotient shall be .50 or below.

(ii) If an individual is age two (2) through five (5):

(A) The ICAP service score shall be between 30 and 44, depending on age; or

(B) The adaptive behavior quotient shall be .50 or below.

(iii) If an individual is age six (6) through twenty (20):

(A) The ICAP service score shall be between 48 and 70, depending on age; or

(B) The adaptive behavior quotient shall be .70 or below.

(iv) If an individual is age twenty-one (21) or older:

(A) The ICAP service score shall be 70 or less; or

(B) The individual shall have a functional limitation in at least three (3) of the following ICAP areas: self-care, language, learning/cognition, mobility, self-direction, or independent living.

(b) The ICAP assessment shall be administered by the Division's designee, and shall be completed every five (5) years, or more frequently at the option of the Division, to provide continued verification that the participant meets waiver clinical eligibility.

**Section 9. Statewide Data Registry.** All individuals who have been determined eligible for waiver services shall be included in the statewide data registry used by the Division for planning, monitoring, and analysis for the waiver system. Information in the registry is

considered confidential and will not be released without proper authorization, or otherwise as required by law. Providers shall submit data on programs, participant outcomes, costs, and other information as required by the Division.

**Section 10. Waiver Services, Service Requirements, and Restrictions.**

(a) Waiver services specified in the individualized plan of care shall be based on the participant's assessed needs; meet the service definition(s); be considered medically or functionally necessary; align with the participant's preferences for services, supports, and providers; and be prioritized based on the availability of funding in the participant's individual budget amount.

(b) Services shall have prior authorization before being provided to a participant.

(c) Waiver services shall support and assist the participant in acquiring, retaining, and improving the skills necessary for the individual to function with as much independence as possible, exercise choice and self-management, and participate in the rights and responsibilities of community membership.

(d) The individualized plan of care shall reflect the services and actual units that providers agree to provide over the plan year. The individualized plan of care shall also include details regarding the specific support, settings, times of day, and activities requiring more support than others.

(e) Providers shall not serve children under age eighteen (18) and adults at the same time unless authorized in writing by the Division.

(f) Waiver services shall not be used to duplicate the same service or a similar service that is available to the participant through one of the following programs:

(i) Section 110 of the Rehabilitation Act of 1973;

(ii) Section 504 of the Rehabilitation Act of 1973;

(iii) Individuals with Disabilities Education Act (IDEA) (20 U.S.C. 1401 et seq.); or

(iv) Medicaid State Plan.

(g) Participants may request an exemption from subsection (f) by submitting a third party liability form as part of the participant's individualized plan of care. This form shall document that the service is not available through another program or agency to meet the individual participant's assessed needs. Exemptions may be granted at the direction of the Division.

(h) Routine transportation for activities provided during the service is included in the reimbursement rate for the service regardless of the number of trips. The provider shall not charge a participant separately for transportation during these waiver activities unless the special activity is outside of the participant's community or normal routine.

(i) Participants receiving levels three (3) through six (6) community living services may receive up to an average of thirty-five (35) hours of day services per week, which include adult day, community support, and companion services.

(j) Waiver services are outlined in the Comprehensive and Supports Waiver Service Index, which is incorporated by reference.

**Section 11. Waiver Cost Limits and Individual Budget Amounts.**

(a) The allocation of Medicaid waiver funds that may be available to a participant to purchase services shall be based on his or her assessed needs.

(b) Eligible individuals shall be assigned a Level of Service score.

(c) Participants enrolled in the Supports Waiver shall be assigned a designated budget amount outlined in the most current Supports Waiver application, which is incorporated by reference. Transition to the Comprehensive Waiver shall only occur as funding and a slot on the Comprehensive Waiver becomes available.

(d) Participants shall meet criteria outlined in Section 4(d) of this Chapter to be eligible for Comprehensive Waiver Services.

(i) Participants enrolled on the Comprehensive Waiver shall be assigned an individual budget amount based on the following factors:

(A) Functional and medical assessments;

(B) The participant's age group;

(C) The participant's living situation;

(D) The participant's need for a higher level of services;

(E) An amount for annual case management services; and

(F) Any temporary or permanent increase or decrease as determined by the ECC.

(ii) The factors in subsection (d)(i) determine the participant's Level of Service score in order to plan for appropriate services and supports.

(iii) A participant's individual budget amount on the Comprehensive Waiver shall not exceed the institutional cost limit specified in the most current Comprehensive Waiver application approved by CMS, which is incorporated by reference. A participant who needs services in excess of this amount shall have the individualized plan of care and budget approved by the ECC.

(e) Waiver services shall align with the Level of Service scoring rubric associated with the person's Level of Service score. The scoring rubric is outlined in the Comprehensive and Supports Waiver Service Index, which is incorporated by reference.

**Section 12. Self-Directed Service Delivery.**

(a) The services that may be self-directed are outlined in the Comprehensive and Supports Waiver Service Index, which is incorporated by reference.

(b) At least once a year, each participant's case manager shall provide the participant or legally authorized representative information regarding the option to self-direct waiver services. Information shall include requirements of the employer of record, not limited to:

(i) Hiring, firing, and training staff;

(ii) Setting staff work schedules; and

(iii) Monitoring and working within the participant's individual budget amount.

(c) Self-Directed services are available to a participant who:

(i) Lives in his or her own private residence or the home of a family member; or

(ii) Resides in other living arrangements where services, regardless of funding source, are furnished to three (3) or fewer persons unrelated to the proprietor.

(d) To self-direct waiver services, the participant or legally authorized representative or other designee shall act as the Employer of Record and use a Financial Management Service on contract with the Division.

(e) A participant shall only self-direct services if the Financial Management Service contractor has open slots for new people to enroll, based upon the contracted capacity.

(f) The Financial Management Service shall assist the participant in being the Employer of Record.

(g) The Division shall provide the recommended wage ranges for all self-directed services.

(h) The Employer of Record shall be responsible to recruit, hire, schedule, evaluate, and supervise self-directed employees. The Employer of Record shall have the budgetary authority to negotiate and set wages and payment terms for all services received.

(i) The Employer of Record shall hire employees to provide waiver services, and work with the Financial Management Service to determine that the potential employee meets the general and specific provider standards for the service being provided. A provider who has had their certification revoked under Chapter 45 of the Department of Health's Medicaid Rules shall not provide self-directed services.

(j) Consistent with the service definitions as outlined in the Comprehensive and Supports Waiver Service Index, which is incorporated by reference, the Employer of Record shall work with the employee hired through self-direction to determine the specific tasks to be completed during the provision of services, the employee's schedule, and how to document services and report documentation and timesheets to the Employer and Financial Management Service. The Employer of Record shall ensure documentation is available to the case manager by the tenth ($10^{th}$) business day of the month following the month in which services were provided.

(k) When the Employer of Record and the employee have reached agreement on the services, schedule, and rate, the Financial Management Service shall track the rate and services authorized and ensure the employee wages are paid in accordance with state and federal laws.

(l) Employees hired through self-direction shall document services provided in accordance with Chapter 45 and the agreed upon manner between the Financial Management Service and the Employer of Record. The Employer of Record shall maintain documentation in accordance with the Department of Health's Medicaid Rules.

(m) The Employer of Record, with assistance from the case manager as needed, shall review employee documentation of the services provided and the employee timesheets to ensure accuracy with the type, scope, amount, frequency, and duration of services agreed upon in the individualized plan of care.

(n) A participant or legally authorized representative may choose to voluntarily terminate self-direction at any time during the plan year and shall work with the case manager to transition to other available services or providers. The case manager shall disenroll the participant from the Financial Management Service within thirty (30) calendar days of notification that the participant chooses to terminate self-direction services.

(o) A participant may be involuntarily terminated from the use of self-direction if:

(i) The participant or Employer of Record is found to misuse waiver funds;

(ii) The participant's health and welfare needs are not adequately being met;

(iii) The participant exceeds the budget amount for self-directed services identified in the individualized plan of care;

(iv) The Division, the Division of Healthcare Financing, or the Medicaid Fraud Control Unit identifies situations involving the commission of fraudulent or criminal activity associated with the self-direction of services; or

(v) The participant chooses not to receive self-directed services for ninety (90) calendar days after active enrollment begins.

(p) A participant who is involuntarily terminated from this service under subsection (o) shall receive written notice from the Division and may request an administrative hearing as provided in Chapter 4 of the Department of Health's Medicaid Rules.

**Section 13. Wait List Process.**

(a) The Division shall maintain a Supports Waiver wait list to add additional participants as funding is appropriated and as approved by CMS.

(b) The Division shall prioritize eligible individuals on the Supports Waiver wait list on a first come, first serve basis. Funding opportunities shall be given to the person who has waited the longest for services, based on the date that the individual was determined eligible.

(c) Before being added to the Supports Waiver wait list, the individual shall be determined eligible as specified in Section 4 of this Chapter.

(d) For people with the same date of eligibility, the Division shall use the date that the Case Manager Selection form was received by the Division to determine which individual shall receive the next funding opportunity.

(e) The Level of Service score and individual budget amount shall be determined for each individual on the wait list. An eligible individual who needs services in excess of the Supports Waiver may request placement on the Comprehensive Waiver, and may be placed on the Comprehensive Waiver wait list, if a funding opportunity is not available. Preference on the Comprehensive Waiver wait list is given to individuals with a Level of Service score of four (4) or higher.

(f) The Comprehensive Waiver shall reserve capacity each year for eligible individuals who have resided in a Wyoming institution, such as an ICF/IID, nursing home, Psychiatric Residential Treatment Facility, residential treatment facility, BOCES, or an inpatient psychiatric hospital, and who have been:

(i) In residence at the institution;

(ii) On a Division wait list; or

(iii) On a Division waiver prior to being institutionalized.

(g) The Comprehensive and Supports Waivers shall reserve capacity each year for qualifying dependents of active military service members who have been assigned to serve in Wyoming, or who are retiring or separating from active duty military service and intend to reside in Wyoming within eighteen (18) months.

(h) If additional capacity is available after the Comprehensive Waiver makes the required reservations under subsections (f) and (g) of this Section, the Comprehensive Waiver may reserve capacity for other individuals transitioning out of institutional services upon the request of the individual.

**Section 14. Emergency Waiver Services.**

(a) An emergency case involves an eligible person who requires immediate action or has an urgent need for waiver services, including placement in the least restrictive and most appropriate environment necessary to maintain the person's vital functions because of one of the following criteria:

(i) An immediate threat, or a high probability of immediate danger to the life, health, property, or environment of the eligible person or another individual because of the eligible person's medical, mental health, or behavioral condition.

(ii) A loss of the person's primary caregiver due to death, incapacitation, critical medical condition, or inability to provide continuous care. A caregiver is defined as any person, agency, or other entity responsible for the care, both physical and supervisory, of a person because of:

(A) A family relationship;

(B) Voluntary assumption of responsibility for care;

(C) Court ordered responsibility or placement;

(D) Rendering services in a residential program;

(E) Rendering services in an institution or in a community-based program; or

(F) Acceptance of a legal obligation or responsibility of care to the person.

(iii) Homelessness, which means a situation where, for a period of thirty (30) days, a person lacks access to an adequate residence with appropriate resources to meet his or her support and supervision needs, and without such support, there is evidence of serious harm to the person's life or health.

(iv) A case involving a person removed from the home by an appropriate agency due to abuse, neglect, abandonment, exploitation, or self-neglect.

(v) A residential service request for a waiver participant or a person on the wait list not receiving 24-hour residential services, whose health or safety is at significant risk due to extraordinary needs that cannot be met in the current living arrangement because of one of following criteria:

(A) A substantial threat to a person's life or health that is either corroborated by the Department of Family Services, Protection & Advocacy System, Inc., or law enforcement;

(B) A situation where the person's health condition or significant and frequently occurring behavioral challenges pose a substantial threat to the person's own life or health, or to others in the home;

(C) A situation where the person's critical medical condition requires ongoing twenty-four (24) hour support and supervision to maintain the person's health and safety that cannot be met in the current living situation; or

(D) The loss of the eligible person's primary caregiver due to death, incapacitation, critical medical condition, or inability to provide continuous care.

(b) Any person who requests that the Division consider an emergency case shall be directed to work with the person's chosen case manager, the Division, and other community resources to review options for emergency services. The case manager shall submit the request for emergency services on behalf of the person.

(c) Emergency cases shall be referred to the ECC pursuant to Section 15 of this Chapter.

(d) An individual who has not been deemed eligible for waiver services may complete the eligibility process and request emergency services. No emergency services may be provided to ineligible persons.

(e) Emergency placement in waiver services shall not be made as an alternative to incarceration or jail.

**Section 15. Extraordinary Care Committee**.

(a) The ECC shall be composed of a Division waiver manager, a Medicaid manager, the Participant Support Specialist presenting the case, and a representative from the Department's fiscal unit. When appropriate, the ECC may also include the Division's licensed psychiatrist, the Medicaid Medical Director, the Division's registered nurse, or a behavioral specialist. Members may also consult other specialists in the field as appropriate.

(b) The ECC shall only approve additional funds for participant cases if funding is available in the Division's waiver budget appropriation.

(c) The ECC shall review:

(i) Emergency cases as defined by Section 14 of this Chapter;

(ii) Extraordinary cases that include a significant change in service need due to the onset of a behavioral or medical condition or injury including:

(A) A temporary change in circumstances, which requires a higher level of service or support to ensure the health, safety, and welfare of the participant;

(B) Temporary funding increases under Section 11(d) of this Chapter;

(C) Concerns about a Level of Service score; or

(D) Requests requiring ECC approval under these Rules; and

(iii) Other supplemental requests as defined in the Comprehensive and Supports Service Index, which is incorporated by reference.

(d) Emergency cases can arise for a person who is eligible for covered services but is on the wait list, or for participants currently receiving Comprehensive or Supports waiver services who may be determined to be in an emergency situation pursuant to Section 14(a) of this Chapter.

(e) The ECC shall have the authority to approve, partially approve, or deny a submitted funding request for any person deemed eligible for a waiver operated by the Division.

(f) Before submission, the participant's plan of care team shall meet and come to a consensus that an ECC request is necessary and other support or resource options have been explored. The case manager shall ensure the request contains evidence of, but not limited to:

(i) Written statements or reports from the other state or regional agencies that support the emergency case including specific incidents, notes related to the type of condition or injury, witnesses, follow-up, treatment summaries, and any documented accounts of events by witnesses;

(ii) Documentation of other approaches or supports that have been attempted;

(iii) Written statements from a credentialed professional related to the area of concern, explaining the significant change in the participant's functioning limitations that result in an assessed need for additional supports or services and how the person's life or health is in jeopardy without such supports and services;

(iv) Evidence that the person does not qualify for funding or services through any other agency that would alleviate the emergency situation; and

(v) For persons requesting services or supports due to homelessness, evidence that:

(A) Either:

(I) Other community resources, such as a victim's shelter, or other temporary residence are not available or appropriate; or

(II) Other community resources are insufficient to meet the person's immediate health and safety needs, and there is evidence of immediate and serious harm to the person's life or health; and

(B) Due to other conditions of the emergency or the person's condition, waiver services would be the necessary and appropriate intervention.

(g) A request may be made by the participant's plan of care team if they can demonstrate that a participant's Level of Service score does not reflect the participant's assessed need.

(h) A request shall be submitted on the form provided by the Division, and accompanied by additional information that the participant and the participant's plan of care team does not see adequately captured in the ICAP or in the information stored electronically by the Division.

(i) ECC requests that do not meet the criteria outlined in subsection (f) of this Section shall not be considered by the ECC.

(j) The ECC may request additional assessments, referrals, or outside consultation. The additional assessments and information may result in a level of service score increase, decrease, or no change. If the participant or plan of care team declines the additional requests, the ECC request shall be denied.

(k) Decisions of the ECC shall be by majority vote and issued in writing within twenty (20) business days of the ECC review.

(l) In cases of a tie vote among members, the Section Administrator or his/her designee shall issue the final vote.

(m) The Section Administrator or his/her designee may approve time limited funding while the ECC is rendering a final decision.

(n) An eligible individual denied services under this section may request administrative review of that decision pursuant to Chapter 4 of the Department of Health's Medicaid Rules.

**Section 16. Prohibited Use of Waiver Funds**.

(a) The following services are not eligible for waiver services reimbursement:

(i) The care of individuals residing in a hospital, nursing facility, ICF/IID, or other institutional placement;

(ii) Wavier services provided by:

(A) A spouse of the participant, if the spouse is also the participant's legally authorized representative;

(B) A legally authorized representative of a participant who is eighteen (18) years of age or older; or

(C) An owner or officer of a provider organization if the organization is serving a participant for whom they are the legally authorized representative;

(iii) Room and board, except when provided as part of respite in a facility, other than a private residence, approved by Medicaid;

(iv) Services currently covered under the Medicaid State Plan;

(v) Services to an individual if it is reasonably expected that the cost of these services would exceed the institutional cost limit specified in the most current Comprehensive Waiver application approved by CMS, which is incorporated by reference; or

(vi) Service settings reimbursed by another state agency, such as the Department of Family Services or Department of Education.

(b) No direct service that is the responsibility of the school system shall be authorized as a waiver service. The Division shall not authorize direct waiver services for the hours the child is attending school or in a vocational program.

(i) Regular school hours and days apply for a child who receives home schooling or an adjusted school day.

(ii) Waiver services may be used if an individualized educational plan identifies specific times when the school system shall not cover services for the individual.

(c) Any individual eligible for funding for specialized services under the Developmental Disabilities Services Act shall apply for and accept any federal Medicaid benefits

for which they may be eligible and benefits from other funding sources within the Department; the Department of Education, specifically including the Department of Workforce Services and Division of Vocational Rehabilitation; and other agencies to the maximum extent possible.

**Section 17. Denial of Funding for Waiver Services.**

(a) The Division may deny or revoke authorization for waiver services for any of the following reasons:

(i) The individual fails to meet waiver eligibility criteria as established in Section 5;

(ii) The eligible individual has not met emergency criteria and no other waiver funding opportunities are available;

(iii) The individual or legally authorized representative has not consented to waiver services;

(iv) The individual or legally authorized representative has chosen to receive ICF/IID or nursing facility services;

(v) The individual, his or her legally authorized representative, or other person on his or her behalf has not supplied needed information;

(vi) The participant's needs are not being met through waiver services;

(vii) The individualized plan of care has not been implemented;

(viii) The legislature has not appropriated sufficient fiscal resources to fund all services for all persons determined eligible for waiver services;

(ix) Funding for requested waiver services is available as a similar service from other sources, such as a school district or the Division of Vocational Rehabilitation;

(x) The eligible individual or legally authorized representative has failed to apply for, and accept any federal Medicaid benefits for which she or he may be eligible, or benefits from other funding sources within the Department of Health, the Department of Education, Department of Workforce Services, or other agencies to the maximum extent possible.

(xi) The eligible individual or legally authorized representative has not signed documentation required by the Department;

(xii) The eligible individual or legally authorized representative has failed to cooperate with, or refused the services funded by the Division; or

(xiii) The individual could receive educational services during a regular or adjusted school day, through the end of the school year in which the individual turns twenty-one (21) years old.

**Section 18. Interpretation of Chapter.**

(a) The order in which the provisions of this Chapter appear is not to be construed to mean that any one provision is more or less important than any other provision.

(b) The text of this Chapter shall control the titles of its various provisions

**Section 19. Superseding Effect.** This Chapter supersedes all prior rules or policy statements issued by the Division, including provider manuals and provider bulletins, which are inconsistent with this Chapter.

**Section 20. Severability**. If any portion of this Chapter is found to be invalid or unenforceable, the remainder shall continue in full force and effect.

**Section 21. Incorporation by Reference.**

(a) For any code, standard, rule, or regulation incorporated by reference in these rules:

(i) The Department has determined that incorporation of the full text in these rules would be cumbersome or inefficient given the length or nature of the rules;

(ii) The incorporation by reference does not include any later amendments or editions of the incorporated matter beyond the applicable date identified in subsection (b) of this Section; and

(iii) The incorporated code, standard, rule, or regulation is maintained at the Department and is available for public inspection and copying at cost at the same location.

(b) Each code, rule, or regulation incorporated by reference in these rules is further identified as follows:

(i) Referenced in Section 2 of this Chapter is Title XIX of the Social Security Act, 42 C.F.R. Part 441, Subpart G, incorporated as of the effective date of this Chapter and can be found at http://www.ecfr.gov.

(ii) Referenced in Section 2 and 10 of this Chapter is Wyoming Medicaid's State Plan, incorporated as of the effective date of this Chapter and can be found at http://www.health.wyo.gov/healthcarefin/medicaid/spa.

(iii) Referenced in Section 2, 11, and 16 of this Chapter is Wyoming's Comprehensive and Supports Waiver Applications, incorporated as of the effective date of this Chapter and can be found at https://health.wyo.gov/behavioralhealth/dd/bhd-public-notices/.

(iv) Referenced in Section 2, 10, 11, 12, and 15 of this Chapter is Wyoming's Comprehensive and Supports Waiver Service Index, incorporated as of the effective date of this Chapter and can be found at https://www.health.wyo.gov/behavioralhealth/dd/servicesandrates/.

(v) Referenced in Section 4 of this Chapter is the Diagnostic and Statistical Manual of Mental Disorders (DSM 5), incorporated as of the effective date of this Chapter and can be found at American Psychiatric Association Publishing, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209.

(vi) Referenced in Sections 10 and 11 of this Chapter is Section 110 of the Rehabilitation Act of 1973, incorporated as of the effective date of this Chapter and can be found at https://www.ssa.gov/.

(vii) Referenced in Sections 10 and 11 of this Chapter is Section 504 of the Rehabilitation Act of 1973, incorporated as of the effective date of this Chapter and can be found at https://www.ssa.gov/.

(viii) Referenced in Sections 10 and 11 of this Chapter is the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. 1401 *et seq.*), incorporated as of the effective date of this Chapter and can be found at https://www.ssa.gov/.

# CHAPTER 46

## MEDICAID SUPPORTS AND COMPREHENSIVE WAIVERS

**Section 1. Authority.** This Chapter is promulgated by the Department of Health pursuant to Wyoming Statute ~~§~~ 9-2-102 and the Wyoming Medical Assistance and Services Act at W~~.yoming~~ S~~.tatutes~~ ~~§§~~ 42-4-104 through ~~-~~121.

**Section 2. Purpose and Applicability**.

(a) This Chapter shall apply to and govern Medicaid services provided under the Wyoming Medicaid Supports and Comprehensive Waivers.

(b) This Chapter, in addition to Chapters 44 and 45 of the Department of Health's Medicaid Rules, shall govern services and provider requirements of the Supports and Comprehensive Waivers.

(c) The ~~Behavioral Health~~ Division of Healthcare Financing, hereinafter referred to as the "Division," may issue manuals and bulletins to providers or other affected parties to interpret the provisions of this Chapter. Such manuals and bulletins shall be consistent with and reflect the policies contained in this Chapter. The provisions contained in manuals and bulletins shall be subordinate to the provisions of this Chapter.

(d) ~~(i)~~ Wyoming's currently approved Centers for Medicare and Medicaid Services (CMS) Comprehensive and Supports Waiver Applications and the Comprehensive and Supports Waiver Index apply to this Chapter.

(e) ~~(d)~~ The requirements of Title XIX of the Social Security Act, 42 C.F.R Part 441, Subpart G and the Medicaid State Plan apply to this Chapter.

**Section 3. General Provisions**.

(a) ~~Terminology.~~ Except as otherwise specified in Chapter 1 of the Department of Health's Medicaid Rules, or as defined in this Section, the terminology used in this Chapter is standard terminology and has the standard meaning used in accounting, health care, Medicaid, and Medicare.

~~(b) Definitions.~~

(b) ~~(i)~~ "Case ~~M~~manager" means an individual who provides case management services~~,~~ as ~~defined~~ established in Chapter 45, Section 9.

(c) ~~(ii)~~ "Level of Service score" means a participant's support needs for various parts of their everyday routine and their level of independence, which are tied to a Level of Service score ranging from 1 (~~least~~ lowest level of support) to 6 (highest level of support). The Level of Service scores are based on comprehensive assessments that determine an individual's level of functioning related to behavioral and health factors, and identify essential staffing and support requirements.

(d) ~~(iii)~~ "Relative" means a participant's biological, step, or adoptive parent(s) ~~or stepparent(s)~~.

~~(c) This Chapter establishes a person-centered approach to determining the support needs of participants in the individualized plan of care and to assign the individual budget amount. Developing community connections, increasing independence, natural supports, self-direction, and employment opportunities are essential components of the Supports and Comprehensive Waivers.~~

~~(d) The Supports Waiver provides eligible participants supportive services so the person may remain in the place he or she currently lives, as funding is available.~~

~~(e) Objectives. In conjunction with the methodology listed in this Section, the Supports and Comprehensive Waivers shall meet the following objectives:~~

~~(i) Provide an array of services, including a continuum of support and employment offerings, to serve participants in the least restrictive and most appropriate environment;~~

~~(ii) Provide participants increased opportunities for community involvement;~~

~~(iii) Allow the opportunity to self-direct services;~~

~~(iv) Set and achieve targeted outcomes for each participant served; and~~

~~(v) Monitor and enhance continuous improvement strategies to improve service delivery for participants.~~

**~~Section 4. Philosophy.~~**

~~(a) All persons possess inalienable rights under the Constitutions of the United States and the State of Wyoming. Persons with developmental disabilities also possess the rights outlined in the Developmental Disabilities Assistance and Bill of Rights Act of 2000, 42 U.S.C. §15001.~~

~~(b) It is the philosophy of the Division to develop reasonable and enforceable rules for the provision of services to individuals with developmental disabilities, acquired brain injury injuries, and related conditions in community settings in lieu of unnecessary institutionalization. This philosophy is mandated in the Supreme Court ruling on *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999).~~

~~(c) This Chapter is designed not only to support the philosophy of home and community-based services, but also to protect the health, welfare, and safety of waiver participants.~~

**Section ~~5~~4. ~~Assessment and~~ Eligibility Requirements**.

(a) Eligibility under this Chapter is limited to persons who complete the application process and who meet the ~~following~~ requirements for clinical and financial eligibility established under this Section. ~~In order to be~~ An individual is not eligible for the Wyoming Medicaid Supports Waiver ~~or Wyoming Medicaid Comprehensive Waiver, an individual shall~~ unless the individual meets ~~all of~~ the following criteria:

(i) ~~All~~ The individual satisfies the citizenship, residency, and financial eligibility requirements established in Chapter 18 of the Department of Health's Medicaid Rules;

(ii) The individual qualifies for the relevant institutional level of care pursuant to Section 6 of this Chapter;~~Institutional level of care:~~

~~(A) For an individual with a developmental or intellectual disability diagnosis, an intermediate care facility for individuals with an intellectual or developmental disability (ICF/IID) level of care, as measured by the LT-104; or~~

~~(B) For an individual with an acquired brain injury diagnosis, a nursing facility level of care, as measured by the LT-101; and~~

(iii) The individual has received a clinical eligibility diagnosis pursuant to Section 7 of this Chapter; and ~~One of the following clinical eligibility diagnoses:~~

~~(A) A diagnosis of an intellectual disability, as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which is incorporated by reference. The diagnosis shall:~~

~~(I) Be determined by a Medicaid enrolled clinical psychologist who is independent from the provider of waiver services and currently licensed in Wyoming,~~

~~(II) Be verified in a written and signed psychological evaluation,~~

~~(III) Reflect adaptive behavior scores as determined through standard measurement of adaptive behavior using a validated test of adaptive functioning such as the most current forms of the Vineland Adaptive Behavior Scales or Adaptive Behavior Assessment System, and~~

~~(IV) For a child applicant who is old enough to take an Intelligence Quotient test, meet a qualifying clinical diagnosis like an adult. A child too young to complete an Intelligence Quotient test may meet the criteria of a developmental disability as described in subsection (B) through medical records of a related condition using a standardized test of development, such as the Bayley Scales of Infant and Toddler Development or other similar instrument.~~

~~(B) A developmental disability or a related condition determined by a physician or independent psychologist currently licensed in Wyoming, with verification in medical records or a written psychological evaluation, which includes assessment scores. The evaluation or records shall identify a severe, chronic disability, which:~~

~~(I) Manifested before the person turned age twenty-two;~~

~~(II) Reflects the need for a combination and sequence of special services which are lifelong or of extended duration;~~

~~(III) Is attributable to a mental or physical impairment, other than mental illness;~~

~~(IV) Is likely to continue indefinitely;~~

~~(V) Results in substantial functional limitations in three (3) or more of the following major life activity areas: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and~~

~~(IV) For those with a diagnosis of Autism Spectrum Disorder, a current autism evaluation and shall be completed.~~

~~(C) An Acquired Brain Injury (ABI), as defined by Chapter 1 of the Wyoming Medicaid Rules and meets the following criteria:~~

~~(I) Is between the ages of twenty-one (21) and sixty-four (64), and~~

~~(II) Meets at least one of the following evaluations to confirm the diagnosis:~~

~~(1.) A score of 42 or more on the Mayo Portland Adaptability Inventory (MPAI),~~

~~(2.) A score of 40 or less on the most current version of the California Verbal Learning Test Trials 1-5 T, or~~

~~(3.) A score of 4 or more on the Supervision Rating Scale.~~

(iv) The individual has received a qualifying Inventory for Client and Agency Planning (ICAP) score pursuant to Section 8 of this Chapter. ~~If clinical eligibility is met, qualify on the Inventory for Client and Agency Planning (ICAP) assessment, as administered by the Division's designee, with one of the following:~~

~~(A) If age twenty-one (21) or older,~~

~~(I) A service score of 70 or less; or~~

~~(II) At least three (3) significant functional limitations listed in the following sections of the ICAP: Personal Living domain, Social/Communication domain,~~

~~Community Living domain, a diagnosis of an intellectual disability, or is non-ambulatory without assistance.~~

~~(B) If age two (2) through twenty (20) with an ICAP service score between 30 and 70, respectively depending on age.~~

~~(C) If age twenty (20) or below, the age-adjusted ICAP service score shall be higher than the ICAP service score for his or her actual age and meet eligibility based on their Adaptive Behavior Quotient (ABQ):~~

~~(I) For ages zero (0) through five (5), an adaptive behavior quotient of .50 or below; and~~

~~(II) For individuals age six (6) through twenty (20), an adaptive behavior quotient of .70 or below.~~

(b) An individual is not eligible for the Wyoming Medicaid Comprehensive Waiver unless the individual meets the following criteria:

(i) The individual meets the eligibility criteria pursuant to subsection (a) of this Section;

(ii) The individual has assessed service needs in excess of the established cost limit on the Supports Waiver; and

(iii) The individual meets one of the following:

(A) The emergency criteria as approved by the Extraordinary Care Committee (ECC); or

(B) The criteria for reserved capacity as specified in Section 13(f) or (g) of this Chapter.

(c) ~~(b)~~ Diagnoses and assessments used to meet initial clinical eligibility shall be accurate and shall be completed within the past five (5) years. Any assessment or reassessment for eligibility is subject to review by the Division before acceptance, and may require additional evidence or verification.

(d) ~~(c)~~ Case managers shall complete all eligibility paperwork within thirty (30) calendar days of being selected. Submitted paperwork shall be reviewed by the Division within thirty (30) calendar days of receipt.

~~(c) To be eligible for participation in the Comprehensive Waiver, an individual shall:~~

(iv) ~~Meet the clinical eligibility specified in this section and have a qualifying ICAP assessment;~~

(v) ~~Have assessed service needs in excess of the established cost limit on the Supports Waiver; and~~

(vi) ~~Meet one of the following:~~

(C) ~~The emergency criteria as approved by the Extraordinary Care Committee (ECC); or~~

(D) ~~The criteria for reserved capacity as specified in Section 11(f) or (g) of this Chapter.~~

~~(e)~~ ~~Reassessments.~~

~~(i)~~ ~~A participant shall be reassessed for clinical eligibility at least annually or more frequently should a change in circumstances occur, which requires a participant to receive a higher level of services or support to ensure the participant's health, safety, and welfare.~~

~~(A)~~ ~~A subsequent psychological evaluation shall be prior authorized and be necessary due to the participant's change in condition or as determined by the Division.~~

~~(B)~~ ~~Psychological reassessments shall be conducted by an entity without a conflict of interest to the providers chosen by the participant or legally authorized representative.~~

~~(i)~~ ~~The ICAP assessment shall be completed every five (5) years, or more frequently at the option of the Division, to provide continued verification that the participant meets waiver clinical eligibility.~~

~~(ii)~~ ~~The Division may require other assessments to determine budget amounts or service authorization.~~

~~(f)~~ ~~Loss of eligibility.~~

~~(a)~~ ~~A participant shall be determined to have lost eligibility when the participant:~~

~~(A)~~ ~~Does not meet clinical eligibility when re-assessed;~~

~~(B)~~ ~~Does not meet financial eligibility; or~~

~~(C)~~ ~~Changes residence to another state.~~

~~(b)~~ ~~The Division may terminate a participant's eligibility when the participant:~~

~~(A)~~ ~~Voluntarily does not receive any waiver services for three (3) consecutive months;~~

~~(B)~~ ~~Is in a nursing home, hospital, residential treatment facility, in-patient hospice, institution, or ICF/ID for thirty (30) or more calendar days;~~

~~(C) Is in an out-of-state placement or residence for six (6) consecutive months or resides out of state for six (6) consecutive months; or~~

~~(D) Chooses another waiver outside of the Comprehensive or Supports waiver.~~

~~(c) If the participant is determined not to be eligible for services due to one of the criteria in subsection (ii) of this Section, the participant or the participant's legally authorized representative shall be notified in writing within fifteen (15) calendar days.~~

~~(d) Notice of Ineligibility or Loss of Eligibility~~

~~(i) The Division shall notify an applicant or participant, or legally authorized representative, in writing, of the determination of clinical ineligibility or termination of clinical eligibility within fifteen (15) calendar days of the determination or termination.~~

~~(A) Upon written notification of ineligibility in the case of an applicant, or the loss of clinical eligibility in the case of a participant, the applicant, participant, or legally authorized representative may submit, in writing, a request for reconsideration within thirty (30) calendar days of the notice of ineligibility or loss of eligibility, which shall include the reasons why the participant should still be considered eligible for the services.~~

~~(B) If the participant requests reconsideration, the Division Administrator or Designee shall review this written request and make a final determination in writing within thirty (30) calendar days of the request. A participant who is aggrieved or adversely affected by a reconsideration decision may also request a hearing within thirty (30) calendar days following the adverse reconsideration decision.~~

~~(C) Requests for an administrative will be administered pursuant to Chapter 4 of the Department of Health's Medicaid Rules.~~

~~(D) Services to a participant determined not to meet clinical eligibility requirements shall be terminated no more than forty-five (45) calendar days after the determination is made.~~

~~(ii) Upon notification from Wyoming Medicaid, the Division shall notify the applicant, participant, or legally authorized representative, in writing, of termination of financial eligibility within fifteen (15) calendar days.~~

~~(e) An applicant who is determined ineligible, or a participant whose eligibility is terminated under this Section, may reapply at any time.~~

**Section 5. Loss of Eligibility**

(a) The Division shall determine a participant has lost eligibility for waiver services when the participant:

(i) Does not meet clinical eligibility;

(ii) Does not meet financial eligibility; or

(iii) Changes residence to another state.

(b) The Division may terminate a participant's eligibility when the participant:

(i) Voluntarily does not receive waiver services for three (3) consecutive months;

(ii) Is in a nursing home, hospital, residential treatment facility, in-patient hospice, institution, or ICF/IID for thirty (30) or more consecutive calendar days;

(iii) Is in an out-of-state placement or residence for six (6) consecutive months or resides out of state for six (6) consecutive months; or

(iv) Chooses another waiver outside of the Comprehensive or Supports waiver.

(c) If the participant is determined not to be eligible for services due to one of the criteria in subsection (b) of this Section, the participant or the participant's legally authorized representative shall be notified in writing within fifteen (15) calendar days.

(d) The Division shall notify an applicant, participant, or legally authorized representative, in writing, of the determination of clinical ineligibility or loss of clinical eligibility within fifteen (15) calendar days of the determination or loss.

(i) Upon written notification of ineligibility, the applicant, participant, or legally authorized representative may submit, in writing, a request for reconsideration within thirty (30) calendar days of the notice of ineligibility, which shall include the reasons why the participant should still be considered eligible for the services.

(ii) If the participant requests reconsideration, the Division Administrator or Designee shall review the request and make a final determination, in writing, within thirty (30) calendar days of the request. A participant who is aggrieved or adversely affected by a reconsideration decision may also request an administrative hearing within thirty (30) calendar days following the adverse reconsideration decision.

(iii) Requests for an administrative hearing will be administered pursuant to Chapter 4 of the Department of Health's Medicaid Rules.

(iv) Services to a participant determined not to meet clinical eligibility requirements shall be terminated no more than forty-five (45) calendar days after the determination is made.

(e) Wyoming Medicaid shall send written notification of financial ineligibility.

(f) An applicant who is determined ineligible, or a participant whose eligibility is terminated under this Section, may reapply at any time.

**Section 6. Institutional Level of Care Requirements**

(a) An individual with a developmental or intellectual disability diagnosis is not eligible for waiver services pursuant to Section 4 of this Chapter unless the individual qualifies for an intermediate care facility for individuals with an intellectual or developmental disability (ICF/IID) level of care, as measured by the LT-104 assessment.

(b) An individual with an acquired brain injury diagnosis is not eligible for waiver services pursuant to Section 4 of this Chapter unless the individual qualifies for a nursing facility level of care, as measured by the LT-101 assessment.

**Section 7. Clinical Eligibility Diagnoses**

(a) An individual is not eligible for waiver services pursuant to Section 4 of this Chapter unless the individual meets one of the following clinical eligibility diagnoses:

(i) A diagnosis of an intellectual disability, as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM 5), which is incorporated by reference, and is determined by a Medicaid enrolled psychiatrist, neurologist, or clinical psychologist who is licensed in Wyoming and is free of conflicts with other providers chosen by the participant.

(A) The diagnosis shall be verified in a written and signed psychological evaluation that is submitted to the Division.

(B) The psychological evaluation shall reflect adaptive behavior scores as determined through a standard measurement of adaptive behavior using a validated test of adaptive functioning such as the most current form of the Vineland Adaptive Behavior Scales or Adaptive Behavior Assessment System.

(C) A child applicant who takes an Intelligence Quotient test shall meet a qualifying clinical diagnosis like an adult. A child too young to complete an Intelligence Quotient test may meet the criteria of a developmental disability as described in subsection (a)(i)(B) through medical records of a related condition using a standardized test of development, such as the Bayley Scales of Infant and Toddler Development or other similar instrument.

(ii) A developmental disability or a related condition determined by a Medicaid enrolled licensed medical professional, neurologist, or clinical psychologist who is licensed in Wyoming and is free of conflicts with other providers chosen by the participant.

(A) Determination shall include verification in medical records and a written psychological evaluation, which includes assessment scores. The evaluation or records shall be submitted to the Division and shall identify a severe, chronic disability, which:

(I) Manifested before the person turned age twenty-two;

(II) Reflects the need for a combination and sequence of special services, which are lifelong or of extended duration;

(III) Is attributable to a cognitive or physical impairment, other than mental illness;

(IV) Is likely to continue indefinitely; and

(V) Results in substantial functional limitations in three (3) or more of the following major life activity areas: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.

(B) Individuals with a diagnosis of Autism Spectrum Disorder (ASD) shall submit a current autism evaluation accepted by the Division, which demonstrates the diagnosis of ASD. The autism evaluation shall be completed by a Medicaid enrolled psychiatrist, neurologist, or clinical psychologist who is licensed in Wyoming and is free of conflicts with other providers chosen by the participant.

(iii) An Acquired Brain Injury (ABI), as defined by Chapter 1 of the Department of Health's Medicaid Rules. An individual with an ABI shall:

(A) Be between the ages of twenty-one (21) and sixty-four (64); and

(B) Have received a qualifying score on at least one of the evaluations accepted by the Division, which shall be completed by a Medicaid enrolled psychiatrist, neurologist, or clinical psychologist who is licensed in Wyoming and is free of conflicts with other providers chosen by the participant. Accepted evaluations, which shall be submitted to the Division to confirm the diagnosis, include:

(I) A score of 42 or more on the Mayo Portland Adaptability Inventory (MPAI);

(II) A score of 40 or less on the most current version of the California Verbal Learning Test Trials 1-5 T; or

(III) A score of 4 or more on the Supervision Rating Scale.

(b) A participant shall be reassessed for clinical eligibility at least annually or more frequently should a change in circumstances occur, which requires a participant to receive a higher level of services or support to ensure the participant's health, safety, and welfare.

(i) A request for a subsequent psychological evaluation, which shall be approved by the Division prior to scheduling, must be necessary due to the participant's change in condition or as determined by the Division.

(ii) A subsequent neuropsychological evaluation, which shall be approved by the Division prior to scheduling, shall be performed every five (5) years.

(iii) Psychological and neuropsychological reassessments shall be completed by a Medicaid enrolled psychiatrist, neurologist, or clinical psychologist who is licensed in Wyoming and is free of conflicts with other providers chosen by the participant.

**Section 8. Inventory for Client and Agency Planning Assessment**

(a) An individual is not eligible for waiver services pursuant to Section 4 of this Chapter unless the individual receives a qualifying Inventory for Client and Agency Planning (ICAP) assessment score for the individual's age.

(i) If an individual is age zero (0) through one (1), the adaptive behavior quotient shall be .50 or below.

(ii) If an individual is age two (2) through five (5):

(A) The ICAP service score shall be between 30 and 44, depending on age; or

(B) The adaptive behavior quotient shall be .50 or below.

(iii) If an individual is age six (6) through twenty (20):

(A) The ICAP service score shall be between 48 and 70, depending on age; or

(B) The adaptive behavior quotient shall be .70 or below.

(iv) If an individual is age twenty-one (21) or older:

(I) The ICAP service score shall be 70 or less; or

(II) The individual shall have a functional limitation in at least three (3) of the following ICAP areas: self-care, language, learning/cognition, mobility, self-direction, or independent living.

(b) The ICAP assessment shall be administered by the Division's designee, and shall be completed every five (5) years, or more frequently at the option of the Division, to provide continued verification that the participant meets waiver clinical eligibility.

**Section ~~6~~9. Statewide Data Registry.** All individuals who have been determined eligible for waiver services shall be included in the statewide data registry used by the Division for planning, monitoring, and analysis for the waiver system. Information in the registry is considered confidential and will not be released without proper authorization, or otherwise as required by law. Providers shall ~~provide~~ submit data on programs, participant outcomes, costs, and other information as required by the Division.

**Section ~~7~~10. Waiver Services, Service Requirements, and Restrictions.**

(a) ~~All w~~Waiver services specified in the individualized plan of care shall be based on the participant's assessed needs; meet the service definition(s); be considered medically or functionally necessary; align with the participant's preferences for services, supports, and

providers; and be prioritized based on the availability of funding in the participant's individual budget amount.

(b) Services shall have prior authorization before being provided to a participant.

(c) Waiver services shall support and assist the participant in acquiring, retaining, and improving the skills necessary ~~so~~ for the individual ~~can~~ to function with as much independence as possible, exercise choice and self-management, and participate in the rights and responsibilities of community membership.

(d) The ~~approved~~ individualized plan of care shall reflect the services and actual units that providers agree to provide over the plan year. The ~~approved~~ individualized plan of care shall also include details regarding the specific support, ~~the~~ settings, times of day, and ~~the specific~~ activities requiring more support than others.

(e) Providers shall not serve children under age ~~18~~ eighteen (18) and adults at the same time unless ~~prior~~ authorized in writing by the Division.

(f) Waiver services shall not be used to duplicate the same service or a similar service that is available to the participant through one of the following programs:

(i) Section 110 of the Rehabilitation Act of 1973;

(ii) Section 504 of the Rehabilitation Act of 1973;

(iii) Individuals with Disabilities Education Act (IDEA) (20 U.S.C. 1401 et seq.); or

(iv) Medicaid State Plan.~~; or~~

~~(v) Local communities or school districts.~~

(g) Participants may request an exemption from subsection (f) by submitting a third party liability form as part of the participant's ~~annual~~ individualized plan of care. This form shall document that the service is not available through another program or agency to meet the individual participant's assessed needs. Exemptions may be granted at the direction of the Division.

(h) Routine transportation for activities provided during the service is included in the reimbursement rate for the service regardless of the number of trips. The provider shall not charge a participant separately for transportation during these waiver activities unless the special activity is outside of the participant's community or normal routine.

(i) Participants receiving ~~residential habilitation~~ levels three (3) through six (6) community living services may receive up to an average of thirty-five (35) hours of day services per week, which include~~:~~ ~~A~~adult ~~D~~day, ~~C~~community ~~Integration~~ support, and ~~C~~companion~~, and Prevocational~~ services.

(j) Waiver services are outlined in the Comprehensive and Supports Waiver Service Index, which is incorporated by reference.

**Section ~~8~~11. Waiver Cost Limits and Individual Budget Amounts.**

(a) The allocation of Medicaid waiver funds that may be available to a participant to purchase services shall be based on his or her assessed needs.

(b) Eligible individuals shall be assigned a Level of Service score.

(c) ~~The Supports Waiver.~~ Participants enrolled in the Supports Waiver shall be assigned a designated budget amount outlined in the most current Supports Waiver application, which is incorporated by reference. Transition to the Comprehensive Waiver shall only occur as funding and a slot on the Comprehensive Waiver becomes available.

(i) ~~The purpose of the Supports Waiver is to assist individuals and their families in obtaining person-centered services and utilizing both natural supports and paid providers to support individuals in the home they own, lease, or share with family. This waiver allows for more flexibility for waiver participants to develop and change their service plans, provides resources and training to assist participants in learning the services system, offers new service options, gives participants an opportunity to self-direct services and hire and fire staff, and provides ongoing resources and training.~~

~~(ii) Participants enrolled in the Supports Waiver shall be assigned an individual budget amount based on:~~

~~(A) The participant's age group, whether or not the participant has reached the age of 21;~~

~~(B) An average cost for the assessed service needs for individuals in the participant's age group;~~

~~(C) The participant's access to services available through programs funded under Section 110 or 504 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.);~~

~~(D) An amount for annual case management services;~~

~~(iii) The Level of Service score shall be used in order to determine eligibility and priority order for Comprehensive Waiver funding.~~

~~(iv) Transition to the Comprehensive Waiver shall only occur as funding and a slot on the Comprehensive Waiver becomes available.~~

(d) ~~The Comprehensive Waiver.~~

~~(i)~~ Participants shall meet criteria outlined in Section ~~5~~4(d) of this Chapter to be ~~considered~~ eligible for Comprehensive Waiver Services.

(i) ~~(ii)~~ Participants enrolled on the Comprehensive Waiver shall be assigned an individual budget amount based on the following factors:

(A) Functional and medical assessments~~, including the ICAP assessment, and past approved individualized plans of care~~;

(B) The participant's age group~~, whether or not the participant has reached the age of 21~~;

(C) The participant's living situation;

(D) The participant's need for a higher level of services;

(E) An amount for annual case management services; and

(F) Any temporary or permanent increase or decrease as determined by the ECC.

(ii) ~~(iii)~~ The factors in subsection (d)(i~~i~~) determine the participant's Level of Service score in order to plan for appropriate services and supports.

~~(iv) Supports to the participant through waiver services shall align with the Level of Service scoring rubric associated with the person's Level of Service score. The scoring rubric is outlined in the Comprehensive and Supports Waiver Service Index, which is incorporated by reference.~~

(iii) ~~(v)~~ A participant's individual budget amount on the Comprehensive Waiver shall not exceed the institutional cost limit specified in the most current Comprehensive Waiver application approved by CMS, which is incorporated by reference. ~~current annual average cost of a resident at the Wyoming Life Resource Center.~~ A participant who needs services in excess of this amount shall have the individualized plan of care and budget approved by the ECC~~, who shall work with the participant's providers and plan of care team to evaluate the provision of services, monitor service delivery and participant outcomes, improve services and supports, and make plans to improve outcomes for the participant~~.

(e) Waiver services shall align with the Level of Service scoring rubric associated with the person's Level of Service score. The scoring rubric is outlined in the Comprehensive and Supports Waiver Service Index, which is incorporated by reference.

~~**Section 9. THIS SECTION RESERVED FOR FUTURE RULEMAKING**~~

**Section ~~10~~12. Self-Directed Service Delivery.**

(a) The services that may be self-directed are outlined in the Comprehensive and Supports Waiver Service Index, which is incorporated by reference.

(b) At least once a year, each participant's case manager shall provide the participant or legally authorized representative information regarding the option to self-direct waiver services. Information shall include requirements of the employer of record, not limited to:

(i) Hiring, firing, and training staff;

(ii) Setting staff work schedules; and

(iii) Monitoring and working within the participant's individual budget amount.

(c) Self-Directed services are available to a participant who:

(i) Lives in his or her own private residence or the home of a family member; or

(ii) Resides in other living arrangements where services, regardless of funding source, are furnished to three (3) or fewer persons unrelated to the proprietor.

(d) To self-direct waiver services, the participant or legally authorized representative or other designee shall act as the Employer of Record and use a Financial Management Service on contract with the Division.

(e) A participant shall only self-direct services if the Financial Management Service contractor has open slots for new people to enroll, based upon the contracted capacity.

(f) The Financial Management Service shall assist the participant in being the Employer of Record.

(g) The Division shall provide the recommended wage ranges for all self-directed services.

(h) The Employer of Record shall be responsible to recruit, hire, schedule, evaluate, and supervise self-directed employees. The Employer of Record shall have the budgetary authority to negotiate and set wages and payment terms for all services received.

(i) The Employer of Record shall hire employees to provide waiver services, and work with the Financial Management Service to determine that the potential employee meets the general and specific provider standards for the service being provided. A provider who has had their certification revoked under Chapter 45 of the Department of Health's Medicaid Rules shall not provide self-directed services.

(j) Consistent with the service definitions as outlined in the Comprehensive and Supports Waiver Service Index, which is incorporated by reference, the Employer of Record shall work with the employee hired through self-direction to determine the specific tasks to be completed during the provision of services, the employee's schedule, and how to document services and report documentation and timesheets to the Employer and Financial Management

Service. The Employer of Record shall ensure documentation is available to the case manager by the tenth ($10^{th}$) business day of the month following the month in which services were provided.

(k) When the Employer of Record and the employee have reached agreement on the services, schedule, and rate, the Financial Management Service shall track the rate and services authorized and ensure the employee wages are paid in accordance with state and federal laws.

(l) Employees hired through self-direction shall document services provided in accordance with Chapter 45 and the agreed upon manner between the Financial Management Service and the Employer of Record. The Employer of Record shall maintain documentation in accordance with the ~~Wyoming~~ Department of Health's Medicaid Rules.

(m) The Employer of Record, with assistance from the case manager as needed, shall review employee documentation of the services provided and the employee timesheets to ensure accuracy with the type, scope, amount, frequency, and duration of services agreed upon in the individualized plan of care.

(n) A participant or legally authorized representative may choose to voluntarily terminate self-direction at any time during the plan year and shall work with the case manager to transition to other available services or providers. The case manager shall disenroll the participant from the Financial Management Service within thirty (30) calendar days of notification that the participant chooses to terminate self-direction services.

(o) A participant ~~shall~~ may be involuntarily terminated from the use of self-direction if:

(i) The participant or Employer of Record is found to misuse waiver funds;

(ii) The participant's health and welfare needs are not adequately being met;

(iii) The participant exceeds the budget amount for self-directed services identified in the individualized plan of care;

(iv) The Division, the Division of Healthcare Financing, or the Medicaid Fraud Control Unit identifies situations involving the commission of fraudulent or criminal activity associated with the self-direction of services; or

(v) The participant chooses not to receive self-directed services for ninety (90) calendar days after active enrollment begins.

(p) A participant who is involuntarily terminated from this service under subsection (o) shall receive written notice from the Division and may request an administrative hearing as provided in Chapter 4 of the Department of Health's Medicaid Rules.

**Section ~~11~~13. Wait List Process.**

(a) The Division shall maintain a Supports Waiver wait list ~~for waiver services~~ to add additional participants as funding is appropriated and as approved by CMS.

(b) The Division shall prioritize eligible individuals on the Supports Waiver wait list~~s~~ on a first come, first serve basis. Funding opportunities shall be given to the person who ~~spent~~ has waited the longest ~~time waiting~~ for services, based on ~~starting from~~ the date that the individual was determined eligible.

(c) Before being added to ~~a~~ the Supports W~~w~~aiver wait list, the individual shall be determined eligible as specified in Section ~~5~~4 of this Chapter.

(d) For people with the same date of eligibility ~~on the wait list~~, the Division shall use the date that the ~~"Selection of~~ Case Manager~~"~~ Selection form was received by the Division to determine which individual shall receive the next funding opportunity.

(e) The Level of Service score and individual budget amount shall be determined for each individual on the wait list. An eligible individual who needs services in excess of the Supports Waiver ~~and has a Level of Service score of four (4) or higher~~ may request placement on the Comprehensive Waiver, and may ~~also~~ be placed on the Comprehensive Waiver wait list, if a funding ~~or slots are~~ opportunity is not available. Preference on the Comprehensive Waiver wait list is given to individuals with a Level of Service score of four (4) or higher.

(f) The Comprehensive Waiver shall reserve capacity each year for eligible individuals who have resided in a Wyoming institution, such as an ICF/IID, nursing home, Psychiatric Residential Treatment Facility, residential treatment facility, BOCES, ~~prison, jail,~~ or an inpatient psychiatric hospital, and who have been:

(i) In residence at the institution ~~for at least two (2) years~~;

(ii) On a Division wait list ~~for at least two (2) years~~; or

(iii) ~~Previously o~~On a Division waiver ~~a minimum of two (2) years~~ prior to being institutionalized.

~~(iv) Other individuals transitioning out of institutional services may request access to reserve capacity slots based on availability.~~

(g) The Comprehensive and Supports Waivers shall reserve capacity each year for qualifying dependents of active military service members who have been assigned to serve in Wyoming, or who are retiring or separating from active duty military service and intend to reside in Wyoming within eighteen (18) months.

(h) If additional capacity is available after the Comprehensive Waiver makes the required reservations under subsections (f) and (g) of this Section, the Comprehensive Waiver may reserve capacity for other individuals transitioning out of institutional services upon the request of the individual.

**Section ~~12~~14. Emergency Waiver Services.**

(a) An emergency case involves an eligible person who ~~calls for~~ requires immediate action or has an urgent need for waiver services, including placement in the least restrictive and

most appropriate environment necessary to maintain the person's vital functions because of one of the following criteria:

(i) An immediate threat, or a high probability of immediate danger to the life, health, property, or environment of the eligible person or another individual because of the eligible person's medical, mental health, or behavioral condition.

(ii) A loss of the person's primary caregiver due to death, incapacitation, critical medical condition, or inability to provide continuous care. A caregiver is defined as any person, agency, or other entity responsible for the care, both physical and supervisory, of a person because of:

(A) A family relationship;

(B) Voluntary assumption of responsibility for care;

(C) Court ordered responsibility or placement;

(D) Rendering services in a residential program;

(E) Rendering services in an institution or in a community-based program; or

(F) Acceptance of a legal obligation or responsibility of care to the person.

(iii) Homelessness, which means a situation where, for a period of thirty (30) days, a person lacks access to an adequate residence with appropriate resources to meet his or her support and supervision needs, and without such support, there is evidence of serious harm to the person's life or health.

(iv) A case involving a person removed from the home by an appropriate agency due to abuse, neglect, abandonment, exploitation, or self-neglect ~~substantiated by the Department of Family Services (DFS), Protection & Advocacy System, Inc., or law enforcement~~.

(v) A residential service request for a waiver participant or a person on the wait list not receiving 24-hour residential services, whose health or safety is at significant risk due to extraordinary needs that cannot be met in the current living arrangement because of one of following criteria:

(A) A substantial threat to a person's life or health that is either corroborated by the Department of Family Services, Protection & Advocacy System, Inc., or law enforcement;

(B) A situation where the person's health condition or significant and frequently occurring behavioral challenges pose~~s~~ a substantial threat to the person's own life or health, or to others in the home;

(C) A situation where the person's critical medical condition requires ongoing twenty-four (24) hour support and supervision to maintain the person's health and safety that cannot be met in the current living situation; or

(D) The loss of the eligible person's primary caregiver due to death, incapacitation, critical medical condition, or inability to provide continuous care.

(b) Any person who requests that the Division consider an emergency case shall be directed to work with the person's chosen case manager, the Division, and other community resources to review options for emergency services. The case manager shall submit the request for emergency services on behalf of the person.

(c) Emergency cases shall be referred to the ECC pursuant to Section ~~13~~ 15 of this ~~c~~Chapter.

(d) An individual who has not been deemed eligible for waiver services may complete the eligibility process and request emergency services. No emergency services may be provided to ineligible persons.

(e) Emergency placement in waiver services shall not be made as an alternative to incarceration or jail.

**Section ~~13~~15. Extraordinary Care Committee**.

(a) The ECC shall be composed of a Division waiver manager, a Medicaid manager, the Participant Support Specialist presenting the case, and a representative from the Department's fiscal unit. When appropriate, the ECC may also include the Division's licensed ~~P~~psychiatrist, the Medicaid Medical Director, the Division's ~~R~~registered ~~N~~nurse, or a behavioral specialist. Members may also consult other specialists in the field as appropriate.

(b) The ECC ~~may~~ shall only approve additional funds for participant cases if funding is available in the Division's waiver budget appropriation.

(c) The ECC shall review:

(i) Emergency cases as defined by Section ~~12~~ 14 of this Chapter; ~~and~~

(ii) Extraordinary cases that include a significant change in service need due to the onset of a behavioral or medical condition or injury including:

(A) A temporary change in circumstances, which requires a higher level of service or support to ensure the health, safety, and welfare of the participant;

(B) Temporary funding increases under Section ~~8 (c) and 8~~11(d) of this Chapter;

(C) Concerns about a Level of Service score; or

(D) Requests requiring ECC approval under these Rules.; and

(iii) Other supplemental requests as defined in the Comprehensive and Supports Service Index, which is incorporated by reference.

(d) Emergency cases can arise for a person who is eligible for covered services but is on the wait list, or for participants currently receiving Comprehensive or Supports waiver services who may be determined to be in an emergency situation pursuant to Section 12 14(a) of this Chapter.

(e) The ECC shall have the authority to approve, partially approve, or deny a submitted funding request for any person deemed eligible for a waiver operated by the Division.

(f) Before submission, the participant's plan of care team shall meet and come to a consensus that an ECC request is necessary and other support or resource options have been explored. An ECC The case manager shall ensure the request contains evidence of, but not limited to:request for emergency services shall contain verification of how the participant's situation meets emergency criteria. Evidence shall at least include, as applicable:

(i) Written statements or reports from the other state or regional agencies that support the emergency case including specific incidents, notes related to the type of condition or injury, witnesses, follow-up, treatment summaries, and any documented accounts of events by witnesses;

(ii) Documentation of other approaches or supports that have been attempted;

(iii) Written statements from a physician or licensed psychologist credentialed professional related to the area of concern, explaining the significant change in the participant's functioning limitations that result in an assessed need for additional supports or services and how the person's life or health is in jeopardy without such supports and services;

(iv) Evidence that the person does not qualify for funding or services through any other agency that would alleviate the emergency situation; and

(v) For persons requesting services or supports due to homelessness, evidence that:

(A) Either:

(I) Other community resources, such as a victim's shelter, or other temporary residence are not available or appropriate; or

(II) The temporary shelter is Other community resources are insufficient to meet the person's immediate health and safety needs, and there is evidence of immediate and serious harm to the person's life or health if temporarily in a temporary shelter; and

(B) Due to other conditions of the emergency or the person's condition, waiver services would be the necessary and appropriate intervention.

(g) A request may be made by the participant's plan of care team if they can demonstrate that a participant's Level of Service score does not reflect the participant's assessed need.

(h) A request shall be submitted on the form provided by the Division, and accompanied by additional information that the participant and the participant's plan of care team does not see adequately captured in the ICAP or in the information stored electronically by the Division.

(i) ECC requests that do not meet the criteria outlined in subsection (f) of this Section shall not be considered by the ECC.

(j) ~~(i)~~ The ECC may request additional assessments, referrals, or outside consultation. The additional assessments and information may result in a level of service score increase, decrease, or no change. If the participant or plan of care team declines the additional requests, the ECC request shall be denied. ~~including a new ICAP, a Supports Intensity Scale, or another appropriate and standardized assessment targeted for a specific diagnosis or condition~~.

~~(i) The additional assessment in these cases may provide more detailed information about the person's support needs and assist the ECC in evaluating the need for a different level of service or extraordinary service or support.~~

~~(ii) Information from the ICAP, along with information from other assessments and information submitted by the participant's team shall be used to make the final decision on the request for level of service score. The additional assessments and information reviewed by the ECC may result in a level of service score increase, decrease, or no change.~~

(k) ~~(j)~~ Decisions of the ECC shall be by majority vote and ~~rendered~~ issued in writing within twenty (20) business days of the ECC review.

(l) ~~(k)~~ In cases of a tie vote among members, the Section Administrator or his/her designee shall issue the final vote.

(m) ~~(l)~~ The ~~Division~~ Section Administrator or his/her designee may approve ~~a~~ time limited ~~exception~~ funding while the ECC is rendering a final decision.

(n) ~~(m)~~ Any eligible individual denied services under this section may request administrative review of that decision pursuant to Chapter 4 of the Department of Health's Medicaid Rules.

**Section ~~14~~16. Prohibited Use of Waiver Funds**.

(a) The following services are not eligible for waiver services reimbursement:

(i) The care of individuals residing in a hospital, nursing facility, ICF/IID, or other institutional placement;

(ii) ~~Waiver services provided to a person under guardianship by a spouse of the participant, a guardian of a participant age~~ eighteen (18) ~~and over, or an owner or officer of a provider organization serving their ward, shall not directly or indirectly receive reimbursement for providing waiver services;~~ Wavier services provided by:

(A) A spouse of the participant, if the spouse is also the participant's legally authorized representative;

(B) A legally authorized representative of a participant who is eighteen (18) years of age or older; or

(C) An owner or officer of a provider organization if the organization is serving a participant for whom they are the legally authorized representative;

(iii) Room and board, except when provided as part of respite in a facility, other than a private residence, approved by Medicaid;

(iv) Services currently covered under the Medicaid State Plan;

(v) Services to an individual if it is reasonably expected that the cost of these services would exceed the institutional cost limit specified in the most current Comprehensive Waiver application approved by CMS, which is incorporated by reference ~~cost of services provided in an ICF/IID, calculated by using the current annual ICF/IID rate~~; or

(vi) Service settings reimbursed by another state agency, such as the Department of Family Services or Department of Education.

(b) No direct service that is the responsibility of the school system shall be authorized as a waiver service. The Division shall not authorize direct waiver services for the hours the child is attending school or in a vocational program.

(i) Regular school hours and days apply for a child who receives home schooling or an adjusted school day.

(ii) Waiver services may be used if an individualized educational plan identifies specific times when the school system shall not cover services for the individual.

(c) Any individual eligible for funding for specialized services under the Developmental Disabilities Services Act shall apply for and accept any federal Medicaid benefits for which they may be eligible and benefits from other funding sources within the Department; the Department of Education, specifically including the Department of Workforce Services and Division of Vocational Rehabilitation; and other agencies to the maximum extent possible.

**Section ~~15~~17. Denial of Funding for Waiver Services.**

(a) The Division may deny or revoke authorization for waiver services for any of the following reasons:

(i) The individual fails to meet waiver eligibility criteria as established in Section 5;

(ii) The eligible individual has not met emergency criteria and no other waiver funding opportunities are available;

(iii) The individual or legally authorized representative has not consented to waiver services;

(iv) The individual or legally authorized representative has chosen to receive ICF/IID or nursing facility services;

(v) The individual, his or her legally authorized representative, or other person on his or her behalf has not supplied needed information;

(vi) The participant's needs are not being met through waiver services;

(vii) The individualized plan of care has not been implemented;

(viii) The legislature has not appropriated sufficient fiscal resources to fund all services for all persons determined eligible for waiver services;

(ix) Funding for requested waiver services is available as a similar service from other sources, such as a school district or the Division of Vocational Rehabilitation;

(x) The eligible individual or legally authorized representative has failed to apply for, and accept any federal Medicaid benefits for which she or he may be eligible, or benefits from other funding sources within the Department of Health, the Department of Education, Department of Workforce Services, or other agencies to the maximum extent possible.

(xi) The eligible individual or legally authorized representative has not signed documentation required by the Department;

(xii) The eligible individual or legally authorized representative has failed to cooperate with, or refused the services funded by the Division; or

(xiii) The individual could receive educational services during a regular or adjusted school day, through the end of the school year in which the individual turns twenty-one (21) years old. ~~The individual, under the age of twenty-two (22), could receive educational services during a normal, regular, or adjusted school day.~~

**Section ~~16~~18. Interpretation of Chapter.**

(a) The order in which the provisions of this Chapter appear is not to be construed to mean that any one provision is more or less important than any other provision.

(b) The text of this Chapter shall control the titles of its various provisions

**Section ~~17~~19. Superseding Effect.** This Chapter supersedes all prior rules or policy statements issued by the Division, including ~~P~~provider ~~M~~manuals and ~~P~~provider ~~B~~bulletins, which are inconsistent with this Chapter.

**Section ~~18~~20. Severability**. If any portion of this Chapter is found to be invalid or unenforceable, the remainder shall continue in full force and effect.

**Section ~~19~~21. Incorporation by Reference.**

(a) For any code, standard, rule, or regulation incorporated by reference in these rules:

(i) The Department has determined that incorporation of the full text in these rules would be cumbersome or inefficient given the length or nature of the rules;

(ii) The incorporation by reference does not include any later amendments or editions of the incorporated matter beyond the applicable date identified in subsection (b) of this ~~s~~Section; and

(iii) The incorporated code, standard, rule, or regulation is maintained at the Department and is available for public inspection and copying at cost at the same location.

(b) Each code, rule, or regulation incorporated by reference in these rules is further identified as follows:

(i) Referenced in Section 2 of this Chapter is Title XIX of the Social Security Act, 42 C.F.R. Part 441, Subpart G, incorporated as of the effective date of this Chapter and can be found at http://www.ecfr.gov.

(ii) Referenced in Section 2 and 10 of this Chapter is Wyoming Medicaid's State Plan, incorporated as of the effective date of this Chapter and can be found at http://www.health.wyo.gov/healthcarefin/medicaid/spa.

(iii) Referenced in Section 2, 11, and 16 of this Chapter is Wyoming's Comprehensive and Supports Waiver Applications, incorporated as of the effective date of this Chapter and can be found at https://health.wyo.gov/behavioralhealth/dd/~~waivers/~~bhd-public-notices/.

(iv) Referenced in Section 2, ~~7~~10, ~~and 8~~11, 12, and 15 of this Chapter is Wyoming's Comprehensive and Supports Waiver Service Index, incorporated as of the effective date of this Chapter and can be found at https://www.health.wyo.gov/behavioralhealth/dd/~~comprehensive-supports-waivers/~~servicesandrates/.

(v) Referenced in Section ~~5~~ 4of this Chapter is the Diagnostic and Statistical Manual of Mental Disorders (DSM 5), incorporated as of the effective date of this Chapter and

can be found at American Psychiatric Association Publishing, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209.

(vi) Referenced in Sections ~~7 and 8~~ 10 and 11 of this Chapter is Section 110 of the Rehabilitation Act of 1973, incorporated as of the effective date of this Chapter and can be found at https://www.ssa.gov/.

(vii) Referenced in Sections ~~7 and 8~~ 10 and 11 of this Chapter is Section 504 of the Rehabilitation Act of 1973, incorporated as of the effective date of this Chapter and can be found at https://www.ssa.gov/.

(viii) Referenced in Sections ~~7 and 8~~ 10 and 11 of this Chapter is the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. ~~§~~ 1401 *et seq.*), incorporated as of the effective date of this Chapter and can be found at https://www.ssa.gov/.