Notice of Intent to Adopt Rules

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

Revised September 2016

1. General Information

a. Agency/Board Name Behavioral Health Division		
b. Agency/Board Address 6101 Yellowstone Rd, Suite 220	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 November 16, 2016	i. Comment Period End Date January 3, 2017	
j. Public Comment URL or Email Address: bhdmail@wyo.gov		
k. Program Medicaid		

2. Legislative Enactment

For purposes of this Section 2, "new" only applies to regular 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 rules new as per the above description and the definition of "new" in Chapter 1 of the Rules on Rules?

☐ No. ☒ Yes. Please provide the Enrolled Act Numbers and Years Enacted: 2013 Wyo. Sess. Laws, 322-25

3. Rule Type and Information

a. Provide the Chapter Number, Title, and Proposed Action for Each Chapter.

Please use the Additional Rule Information form for more than 10 chapters, and attach it to this certification.

Chapter Number:	Chapter Name:	
41	Adult Developmental Disabilities Home & Community Based Waiver	☐ New ☐ Amended ☒ Repealed
42	Children's Developmental Disabilities Home & Community Based Waiver	☐ New ☐ Amended ☒ Repealed
43	Acquired Brain Injury Home & Community Based Waiver	☐ New ☐ Amended ☒ Repealed
44	Env. Mod. & Specialized Equip. for Home & Comm. Based Waiver Srv. (Env. Mod., Specialized Equip., and Self-Directed Goods and Srv. for Medicaid Home and	☐ New ☒ Amended ☐ Repealed
45	Rules and Regulations for Waiver Provider Certification and Sanctions	☐ New ☒ Amended ☐ Repealed
46	Rules and Regulations for Medicaid Supports and Comprehensive Waivers	☒ New ☐ Amended ☐ Repealed
		☐ New ☐ Amended ☐ Repealed
		☐ New ☐ Amended ☐ Repealed
		☐ New ☐ Amended ☐ Repealed
		☐ New ☐ Amended ☐ Repealed

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: 42 CFR §§ 441.301 through 441.310

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. Indicate one (1):

■ The Agency has complied with the requirements of 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: _____

☐ Not Applicable.

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	Shirley Pratt
Title of Authorized Individual	Medicaid Waiver Policy Analyst
Date of Authorization	November 15, 2016

Additional Rule Information

Revised September 2016

1. General Information		
a. Agency/Board Name Behavioral Health Division		
b. Agency/Board Address 6101 Yellowstone Rd, Suite 220	c. City Cheyenne	d. Zip Code 82002
e. Na Name of Agency Liaison	f. Agency Liaison Telephone Number 307-777-2525	
g. Agency Liaison Email Address shirley.pratt@wyo.gov	h. Adoption Date	
i. Program		

2. Rule Type and Information, Cont.

a. Provide the Chapter Number, Title, and Proposed Action for Each Chapter.

Chapter Number:	Chapter Name:	☐ New	☐ Amended	☐ Repealed
Chapter Number:	Chapter Name:	☐ New	☐ Amended	☐ Repealed
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Statement of Changes and Reasons
Chapters 41, 42, 44, 45, and 46

General Statement of Reasons and Authority Regarding All Chapters

In 2013, the Wyoming Legislature required the Wyoming Department of Health to "proceed with a reform and redesign of the Wyoming Medicaid program" including the "[c]reation of two (2) separate waiver programs, including one (1) for supportive services and one (1) for comprehensive services" for developmental disability and acquired brain injury services. 2013 Wyo. Sess. Laws 322-23. On January 16, 2014, the United States Department of Health and Human Services released new regulations impacting these programs. The new federal regulations increase opportunities for persons with disabilities "to enjoy meaningful community living," "add new person centered planning requirements, allow states to combine multiple target populations in one waiver, and streamlines waiver administration." Press Release, Centers for Medicare and Medicaid Services, HHS strengthens community living options for older Americans and people with disabilities (Jan. 10, 2014) (available at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2014-Press-releases-items/2014-01-10-2.html). These rules are the final step in implementing the changes required by the Wyoming Legislature in 2013, and are part of the Department's ongoing efforts to implement the new home and community based service requirements.

The Wyoming Department of Health is also filing rules pursuant to the statutory authority in Wyoming Statutes §§ 9-2-102, 42-4-104, 42-4-120; and the Wyoming Administrative Procedures Act found at §§ 16-3-101 through 16-3-115.

Chapter 41

Adult Developmental Disabilities Home and Community Based Waiver

Chapter 41 of the current Wyoming Medicaid Rules create separate chapters for developmental disabilities services for adults and children. Following the adoption of 2013 Senate Enrolled Act 82, the Wyoming Department of Health sought and obtained permission from the Centers for Medicare and Medicaid Services to supports and comprehensive waivers and begin serving adults and children through these programs. It is no longer appropriate to have separate chapters for these rules. The services available under the Adult Developmental Disabilities Waiver have been replaced by the services available under Chapter 46 described below.

Chapter 42

Children's Developmental Disabilities Home and Community Based Waiver

Similar to Chapter 41, above, Chapter 42 of the Wyoming Medicaid Rules previously applied to services offered only for children with developmental disabilities. Because the Wyoming Legislature and the Centers for Medicare and Medicaid Services have both sanctioned the move to comprehensive and supports waivers for all persons with developmental disabilities, the prior use if separate chapters for these populations is no longer appropriate. The services available under the Children's Developmental Disabilities Waiver have been replaced by the services available under Chapter 46 described below.

Chapter 43

Acquired Brain Injury Home and Community Based Waiver

As noted above, the Centers for Medicare and Medicaid Services amended applicable federal regulations to allow states to bundle services to separate target populations "when this will permit more efficient delivery of services and not compromise either a beneficiary's access to or free choice of providers." 42 C.F.R. § 441.301(b)(4). In Wyoming, services for persons with developmental disabilities and services for persons with acquired brain injuries were provided by separate, although nearly identical programs. In some cases, the same service was provided by the same provider, to both populations, under rules that were separate yet identical. Following the allowance to combine populations to increase efficiencies, the Department of Health is implementing plans to serve all persons with acquired brain injuries as well as developmental disabilities through the supports and comprehensive waivers. Accordingly, the services available under the Acquired Brain Injury Waiver have been replaced by the services available under Chapter 46 described below.

Chapter 44

Environmental Modifications, Specialized Equipment, and Self-Directed Goods and Services for Medicaid Home and Community Based Waiver Services

Chapter 44, Wyoming Medicaid Rules for Environmental Modifications, Specialized Equipment, and Self-Directed Goods and Services for Medicaid Home and Community Based Waiver Services was amended primarily to include Self-Directed Goods and Services for Medicaid Home and Community Based Waiver Services.

Strike and Underline revisions were applied to document all amendments to Chapter 44. These changes include minor revisions to improve ease of understanding and general readability throughout the Chapter. The large substantive changes, and reasons for the changes, are described below:

- Chapter 44, Section 4. Definitions were removed from Chapter 44 and can be referenced under the master listed documented in Chapter 1. The Chapter 1 consolidated list reduces the effort required to maintain duplicate definitions in multiple locations.

- Chapter 44, Section 6(j). The Department added additional language to include specific requirements for relatives providing services.
- Chapter 44, Section 6(k). The Department added provider certification standards for Environmental Modification providers.
- Chapter 44, Section 7(c). The specialized equipment rules were amended to reflect broader categories of allowances as opposed to a specific list of eligible equipment.
- Chapter 44, Section 9. Self-Directed Goods and Services is a new section added to Chapter 44. Section 9 captures requirements for services, equipment, and supplies and also outlines what is included for Goods and Services under the rule.
- Chapter 44, Section 10. Self-Directed Goods and Services, Limits on the Amount, Frequency, or Duration is a new section. Section 10 was created to document rules specific to annual financial limits, prior authorization, approval criteria, residence modifications, and financial management service documentation verification.
- The term "case manager" has replaced "individually selected service coordinator" throughout Chapter 44 to better describe the role.

Chapter 45

Rules and Regulations for Waiver Provider Certification and Sanctions

Chapter 45 governs certification of providers under the Supports and Comprehensive Waivers.

Many of these revisions are due to the development of the new Supports Waiver and Comprehensive Waiver contained in Chapter 46. In March 2013, the Wyoming Legislature passed Senate Enrolled Act 82, a law requiring Wyoming Department of Health, Behavioral Health Division (BHD) to develop two new waivers, the Supports Waiver and the Comprehensive Waiver. The new law required BHD to "optimize the services provided to current clients, and to extend appropriate services to persons currently on a waiting list for waiver services within the current budget." In 2014 the Wyoming Legislature also created Wyoming Statute § 42-4-103(c), which established parameters for case management services under this program. The provisions of this rule implement these requirements.

Additional changes contained in this rule are part of the State's response to changes in federal Medicaid law. On January 16, 2014, the Centers for Medicare and Medicaid Services promulgated a final rule which requires states to make several changes to new and established services. The Department received guidance from the Centers for Medicare and Medicaid Services that some of these changes, such as the use of conflict-free case management, must be implemented immediately. 42 C.F.R. § 441.301(c)(1)(vi). Additionally, many of these changes must be in place before the Centers for Medicare and Medicaid Services will approve any new waivers in the State. 42 C.F.R. § 441.301(c)(6). Accordingly, this chapter includes modifications to existing programs that are necessary for Wyoming to continue to participate in and receive funding through Home and Community Based Medicaid Waiver programs affected by this chapter.

These changes are pervasive and the creation of a strike and underscore copy of the rule is impractical. Therefore, a strike and underscore revision of this Chapter is not included with this packet. The large substantive changes, deletions and additions are described more fully below.

****** References to the current rule refer to the, December 29, 2006, rule which is in effect as of the date of this statement of reasons. References to the new rule refer to changes made in this promulgation.***

The following provisions were repealed in their entirety from the current rule:

- Chapter 45, Section 3(b): This methodology section was redundant and therefore no longer necessary.
- Chapter 45, Section 4: The definitions section was repealed. Definitions for this chapter are currently located in Chapter 1, Section 3.
- Chapter 45, Section 5: The philosophy section is repealed. All provisions for protecting participants receiving Home and Community Based Waiver services are in Sections 4 and 5 of the new rule.
- Chapter 45, Section 6: This section on covered services was deemed superfluous and was deleted.
- Chapter 45, Sections 38 through 47: These sections on provider operations are covered in other Wyoming Medicaid rules, and will remain the law in Wyoming. Therefore, it is unnecessary to restate them here.

The following provisions reflect moves and changes between the current and new rule:

- The current rule's Chapter 45, Section 7, "Case Management Services," moves to Section 9 of the new rule. Section 7(a) through (i) of the current rule are deleted because they reiterate existing provisions of law. New substantive provisions are added as Section 9(a) through (f) and Section 10(a) through (d). The new language includes:
  - An explanation in the new Section 9(b) regarding how the case manager will meet participant needs through person-centered planning, which is required by a change in federal law. *See* 42 C.F.R. 441.301(b)(1)-(2).
  - Directions for how the Case Manager must maintain an individual case file and service documentation are adopted in the new Section 9(d).
  - The new Section 10(b) describes the elements of each individual plan of care. These provisions were not previously included in Chapter 45 and were moved to this chapter to centralize case management duties in one rule.
  - The new Section 10(d) includes a requirement that plans of care must be written in plain, easily understandable, language. This is a new federal requirement. 42 C.F.R. 441.301(b)(1)-(2).
- The service definitions and qualifications found in the current rule, Chapter 45, Sections 8 through 22, are in Section 5 of the new rule, "Provider Qualifications for Each Waiver Service." Furthermore:

- The current rule states each provider category's qualifications in each section. This resulted in multiple restatements of common qualifications. Under the new rule, common qualification requirements are listed once, in Section 5(a).
- Items that repeat provisions of the chapter or other Medicaid rules are deleted. For example, the current rule's Section 10(c), requires Environmental Modification providers to "Provide environmental modification services pursuant to Chapter 44." Because Chapter 44 will retain the force and effect of law, this provision is not necessary.
- Except as identified here regarding case management services, all other existing service qualifications are not changed.
- Minimum qualifications and definitions are added to the new rule for the following services: Adult Day Services, Behavioral Support Services, Community Integration Services, Crisis Intervention Support, Independent Support Broker, Employment Discovery and Customization; Independent Support Broker; Individual Habilitation Training, Supported Employment and Prevocational.
- The current rule does not establish education and training requirements for case managers. Significant additional language is added to the new Section 5(b)(iii) for this purpose. These changes better reflect the level of responsibility required to deliver case management services. To qualify to provide Case Management Services, case managers must have a master's degree, a bachelor's degree and one year of work experience, or an associate's degree and four years of work experience. Degrees and work experience must be in one of the ten identified human service fields. Additional allowances are made for case managers certified prior to the implementation of this rule. Additionally, persons or entities seeking to provide Case Management Services must:
  - Have policies and procedures for backups;
  - Maintain proof of competencies for each employee providing Case Management Services; and
  - Meet conflict free requirements established to ensure that the case manager does not have a financial interest in other services provided to the participant or a financial relationship with other providers on the participant's individual plan of care.

- Chapter 45, Section 23. Standards for CARF Accredited Organizations of the current rule moved to Section 25 in the new rule.
  - Under Section 25(a) of the new rule, accreditation still applies to habilitation service providers. Accreditation now also includes providers involved in Residential Services, Supported Living, Community Integration, Adult Day Services, Prevocational, and Supported Employment Services. The reason for the change is to better protect participants since accreditation is available in all of these areas.
  - Section 23(a) previously required providers to obtain accreditation within 24 months of providing qualifying services to three (3) or more participants. The new Section 25(a) adds that this requirement only applies to providers whose waiver income exceeds $125,000 per calendar year. Accreditation must now be obtained within eighteen (18) months. BHD hopes this change makes accreditation more affordable for providers. The shorter timeframe protects participants.

- Section 25(b) of the new rule expands national accreditation to include the Commission on Quality and Leadership, CARF, or another nationally recognized accreditation entity approved by the Division. This change allows for provider choice in accrediting body.
- Section 25(c) of the new rule maintains the same process for decertifying providers who fail to maintain the required accreditation. Unnecessary and redundant language regarding this process was removed.
- Section 25(d) of the new rule now requires accredited providers to establish a human rights committee and establishes duties for the committee. This requirement is consistent with CARF and other accrediting entities' requirements to protect participants.

- Chapter 45, Sections 23 and 24 of the current rule both contained standards related to health, safety, emergency plans, inspections, access to food, and facility maintenance. While these standards were similar or even identical, they appeared split based upon whether the provider was CARF accredited. Inconsistency between Sections 23 and 24 created problems in the application of these standards. Accordingly, standards for provider facilities are now consolidated in Section 13 of the new rule and apply uniformly across the state to all provider facilities. Furthermore:
  - The current rule Section 24(c) regarding provider self-inspections moved to Section 13(e) of the new rule and requires all providers to annually verify that they are in compliance with the other provisions of Section 13.
  - Sections 23(e)(iii) and 24(b)(vii) of the current rule do not allow provider services in new locations until the Division reviews the external inspection report and verifies all recommendations. The new rule, Section 13(d)(v) requires the provider to create and submit a corrective action plan rather than awaiting Division approval. Services may not be provided in a facility that does not pass inspection. Similar provisions are added at Section 13(d)(vi) for renovations, which were previously not covered. BHD hopes these changes speed up the process for opening up new locations.
- Chapter 45, Section 25, Background Check Requirements from the current rule are located in Section 14 of the new rule.
  - Section 25(c)(i) of the current rules requires a background check for all providers and provider employees. The new rule, Section 14(a), adds the coverage for certain managers, supervisors, other service providers, and persons who may have unsupervised access to participants or a participant's residence on behalf of the provider organization. This is consistent with, and clarifies, the original intent of the rule.
  - The new rule, Section 14(f), maintains all excluded offense categories listed in the current rule and adds the following as offenses that limit a person's eligibility to provide services: all felonies; misdemeanor crimes against the morals, decency, or family; misdemeanor crimes against a person; misdemeanor fraud, forgery, or identify theft; and driving under the influence for persons providing transportation services.
- Chapter 45, Section 26. Provider and Provider Staff Training Requirements from the current rule are now addressed in Section 15 of the new rule. Unnecessary or redundant

language was eliminated where possible. The following significant changes were made to improve provider and staff accountability to each individual participant's needs:

- The new Section 15(b) requires provider staff be able to demonstrate competence in their ability to support participants.
- The new Section 15(d) retains previous general training categories and adds modules for: participant choice, dignity, and respectful interactions with participants.
- The Division is deleting current provisions found in Section 26(b) regarding participant specific training. Under the new rule, Section 15(g) and (h) requires providers to provide and document participant specific training that is unique to the needs of the participant. Case managers must verify that the training is participant specific and provided as documented.

- Chapter 45, Section 27, Documentation Standards, from the current rule moved to Section 8 in the new rule. Several minor changes were also made to this section, including:
  - The new rule, Section 8(a), clarifies that these documentation standards apply to all medical and financial records.
  - The new rules specify that documentation must be completed prior to or contemporaneously with all claims submissions, Section 8(b).
  - The new Section 8(c) and (d) allows providers to utilize electronic documentation systems and establishes requirements. The previous rule was silent on this topic.
  - Written documentation standards were not changed, but minor modifications were added to provide clarity and improve the accuracy of service documentation. Compare the current Section 27(b) with the new Section 8(e).
  - Written service documentation must now include a printed name of the person performing the service, Section 8(e)(vii).
  - The new Section 8(f) includes provisions for documenting self-directed services.
  - Section 27(d) of the current rule allows providers to bill for multiple services at a time when the participant's plan of care required it or when daily and monthly rates overlapped. Section 8(h) and (i) of the new rule deletes the rate overlap provision and specifies that a single provider employee may only provide one service at a time.
  - The new Section 8(l) retains the provision from the current Section 27(i), which requires providers to submit service documentation to case managers by the 10th business day of the month following the date that the services were rendered. The new Section 8(l) now requires providers to report zero units for months when services are not offered, and establishes specific sanction authority for failure to submit.
  - The Current Sections 27(j) and (k) were removed because it is unnecessary to restate or incorporate other Medicaid rules in this chapter. Remedies and sanctions available in Chapter 3, Chapter 16, and Chapter 39 remain good law, and may be enforced on their own terms.
- Chapter 45, Sections 28. Restraint standards is repealed and replaced with the new Section 18, Restrictive Intervention Standards. The new Section 18 establishes new standards for restraints and includes restraint procedures within a broader category of restrictive interventions. Providers that have used these practices under the current rule will need to review this section carefully and implement program wide changes in order to maintain compliance. The Division hopes that these changes will reduce or eliminate

the use of all forms of restriction and restraint in community service programs funded through Wyoming's Medicaid Home and Community Based Waivers, while also improving participant safety in services and allowing greater access to the community. The significant changes in these regulations include:

- The use of restrictive interventions must be unanimously approved by the plan of care team, new Section 18(b).
- Provider organizations that use restrictive interventions with more than five participants must employ one or more persons certified in a nationally recognized behavior support curriculum, new Section 18(e).
- Providers must review the plan of care to ensure that the plan of care is not provoking behaviors or leading to restraints, new Section 18(f).
- Participant specific restrictive intervention protocols must be developed before restrictive interventions may be utilized, new Section 18(g).
- Additional training is required for all provider staff who actively participate in restrictive interventions, new Section 18(k) & (l).
- Restraints, cooling off periods, and community access restrictions are all defined as restrictive interventions, new Section 18(o). Because they are restrictive interventions, cooling off periods and community access restrictions may not be part of a positive behavior support plan.
- New documentation and new requirements for follow-up are adopted in the new Section 18(p).
- Case managers are required to follow up within 2 business days of all restrictive interventions, new Section 18(p)(x).
- The Division is establishing new prohibitions and sanctions for providers that seek to seclude waiver participants, new Section 18(r).
- Additional forms of and purposes for restrictive interventions are prohibited, new Section 18(r). New prohibitions include: restraint that is contraindicated, any form of restraint that restricts a person's freedom to breathe, and supine forms of restraint.

- Chapter 45, Section 29. Positive Behavior Support Plan Standards from the current rule is now addressed in the new rule's Section 17, Positive Behavior Supports. Changes were made to positive behavior supports in order to require providers serving participants with positive behavior supports to focus on a positive approach to decreasing negative behaviors.
  - The requirements in the new Section 17(a) and (b) are new to this rule.
  - The requirements for positive behavior support plans listed in the current Section 29(a) have been expanded in the new section 17(d). Many of the new requirements for developing and implementing the positive behavior support plan are similar to the current requirements. However, several requirements have been rephrased to provide additional clarity, and emphasize the positive therapeutic nature of the plans. Providers drafting or implementing positive behavior support plans should review this section to maintain compliance.
  - Requirements for the functional analysis moved from the current Section 29(iv) to the new Section 17(c). Additional elements were added to the functional analysis, such as learning what the participant is trying to communicate through behaviors, antecedents and contributing factors, and possible symptoms of a physical or mental condition.

The Department is also including a definition of challenging behaviors, expanding the data collection requirement, and requiring specific provider staff to be involved in the functional behavior analysis.
    - The provider staff training requirement for positive behavior support plans, which is the current section 29(b), moved to the new Section 17(d). The new rule includes a new requirement for staff to receive training in specific positive de-escalation techniques and interventions before working with the participant.
    - The current Section 29(d) is repealed. Rights restrictions and restrictions from community activities are no longer allowed as a form of positive behavioral support. Rights restrictions are now separately addressed in Section 4 of the new rule. The only form of community access restriction that will be allowed under the new rules are time outs and community access restrictions. These are addressed as restrictive interventions in the new Section 18 as described above.
- Chapter 45, Section 30. Notification of Incident Process from the current rule is now addressed in Section 20 of the new rule. Changes include:
    - Adding citations for terms defined in statute, new Section 20(a);
    - Providing for additional non-critical event reporting to the Division in new Section 20(b), which promotes greater provider accountability before serious events occur; and
    - The Department is expanding the current requirement in Section 29(c), which requires providers to maintain internal incident report data. The new Section 20(3) will also require providers to review incident report data for trends including, staff involved, actions taken to prevent similar incidents from occurring, education and training of personnel, and reporting requirements.
    - The new Section 20(d) describes reporting requirements for medication errors.
    - Providers must still comply with requests for additional information. Compare the current Section 29(d) with the new Section 20(f).
- Chapter 45, Section 31. Complaint Process from the current rule is now addressed in Section 21 of the new rule. Additional changes are as follows:
    - The complaint process in the current rule, Section 31(a) and (b), distinguishes between CARF accredited providers and Non-CARF accredited providers. This distinction is eliminated in the new rule to promote consistency among providers. See Section 21 generally.
    - The current requirement in the current Section 31(c) for providers to file complaints in writing is repealed.
    - The Department is repealing the current Section 31(c)(i), which required the Division to encourage complainants to work with providers before the Division could investigate a complaint. Otherwise, the Department's process for handling complaints is unchanged. Compare the current Section 31(c) with the new Section 21(c).
- Chapter 45, Section 32. Transition Process from the current rule moved to Section 22 in the new rule. The new rule also matches current policy, practices, and expectations, and:
    - Clarifies that participants may choose to change providers at any time for any reason, new Section 22(a).
    - Specifically requires case managers to modify the participant's plan of care as part of the transition process, new Section 22(d)(v).

- Allows participants to choose from all available residential service providers any time the participant is required to move residential settings, new Section 22(f). This is consistent with new federal guidance on freedom of choice.

- Chapter 45, Section 33. Funds of Participants in the current rule is now addressed in the new rule's Section 24, Participation Funds and Personal Property. The following provisions were added in the new rule:
  - The current Section 33(b)(iii) requires providers to segregate participant funds for general accounting purposes. The new Section 24(b)(iii) also requires segregation as may be necessary for reporting to the participant, guardian, and regulatory agencies.
  - The new Section 24(b)(vii) requires providers to establish policies to reimburse participants if funds or property is stolen or unexpectedly disappears at the provider facility or during the provider's services.
  - The new Section 24(c) limits providers' ability to a use participant's own funds as rewards, punishment, as payment for damages, to purchase inventory, or as a loan. These practices are inappropriate and in some instances exploitative.
- Chapter 45, Section 34. Mortality Review Committee of the current rule is now addressed in Section 26 of the new rule. Subsections 34(c)(i) and (ii) of the current rule are repealed because they were deemed unnecessary.
- Chapter 45, Section 35. Initial Provider Certification of the current rule is now addressed in Section 27 of the new rule.
  - The Department repealed the list of applicant criteria currently in Section 35(a). Under the new Section 27(a) applicants submit evidence to show that they meet all qualifications for each service that the applicant is seeking to provide.
  - The Department also repealed the current Sections 35(b) through 35(d). These procedures for holding provider applications, assigning provider numbers, and providing telephone consultation are internal procedures that do not need to be provided in rule.
  - The new Section 27(b) adds language that states that the Division will only certify one provider per physical location. This change is being made to eliminate confusion and clearly delineate who is providing which services.
  - The length of an initial certification currently found in Section 35(e) is repealed. The initial certification period is now addressed in new content in the new rule, Sections 29(b) and 28(c). Initial certifications are still one year.
  - The current Section 35(f) moves up to become the new Section 27(c). The provision retains the former prohibition against certifying providers as new provider entities if the person or entity has an open corrective action plan with the Division. A new provision adds that providers may not be certified if they are the subject of an open case with the Medicaid Fraud Control Unit of the Wyoming Attorney General's Office.
  - The current Section 35(g), prohibition against certifying providers convicted of Medicaid fraud, was modified for clarity and moved to the new Section 27(e).
  - The current Section 35(h), regarding the denial of provider certification for failure to disclose information about past convictions, was expanded to permit the Department to deny certification for any falsification of information or concealment of material fact, new Section 27(g).

- The new Section 27(h) is new content and allows the Department to disqualify providers from individual services if they no longer meet certification criteria.

- Chapter 45, Section 36. Recertification of Providers of the current rule is repealed. The Department is adopting new regulations regarding recertification of providers and corrective action plans. These provisions are split between the Section 28, Recertification of Providers, and Section 29, Corrective Action Plan Requirements, in the new rule. Because this is new content, the Department encourages all providers to review it carefully to maintain future compliance.
  - Significant changes for the new Section 28 include:
    - The Department is making changes to make recertification easier and more standard across provider types. Accordingly, all recertification documentation must be submitted on the same timelines regardless of provider type. However, providers that provide services in a facility that they own, lease, or control, must still receive on-site recertification reviews at least once every three years, new Section 28(e).
    - The new Sections 28(h) and (i) identify which providers will not receive on-site inspections.
  - The Department is removing all reference to quality improvement plans and retains the term "corrective action plan" in the new Section 29. This was done to promote consistency across the chapter. The following provisions are important additions to the procedures in the current rule:
    - The Division will seek the cooperation of all providers in meeting the standards in the Wyoming Medicaid rules under New Section 29(a).
    - The new Section 29(b) allows the Division and providers to resolve any suspected non-compliance through a corrective action plan.
    - New Sections 29(c) and 29(d) provide new requirements for acceptable corrective action plans.
    - Under the new rule, Section 29(h), Providers have the primary responsibility for implementing and overseeing corrective action plans. However, the Division may also complete follow-up investigations and review corrective action plan completion under the new Section 29(i).
- Chapter 45, Sections 37, Sanctions, subsections (a) through (c) of the current rule are repealed because they restate the statute. The new rule, Section 30(a) reminds providers that sanctions are covered by Chapter 16 of the Medicaid Rules. Minor modifications were made to the timelines for participants to transition to covered services when providers are decertified, Section 30(c) of the new rule. These changes do not change procedures or policies, but clarify where confusion has occurred.
- Chapter 45, Section 48. Interpretation of Chapter moved to Section 32 of the new rule.
- Chapter 45, Section 49, Superseding Effect, of the current rule moved to Section 33 of the new rule and is updated to match more recent Medicaid rule promulgations.
- Chapter 45, Section 50, Severability, of the current rule moved to Section 34 of the new rule.

****** The following are sections or portions of sections that are new and not part of the current Chapter 45.***

- Section 4, Rights of Participants Receiving Services, establishes narrow limitations on the ways that Wyoming Medicaid Home and Community Based Waiver service providers may restrict a participant's state and federally recognized rights and liberties. Many of the provisions of this section will be familiar to providers, but the language was expanded to increase protections for participants.
- Section 6, Provider Agency Standards, establishes requirements for providers to ensure individual participant rights are not violated, requires quality improvement activities within provider organizations, and requires providers to adopt policies and procedures to demonstrate compliance with the provisions of this Chapter. This addition was made to articulate basic provider responsibilities and standards when serving waiver participants, which are articulated in the new federal rule and in federal guidance.
- Section 7, Provider Recordkeeping and Data Collection, outlines provider requirements to maintain data, statistics, schedules, reports, and other information.
- Section 11, Rate Reimbursement Requirements, is required by Wyoming Statutes § 42-4-120(g). This section establishes additional procedures that the Division will follow when reviewing its cost based reimbursement system.
- Section 12, Service and setting requirements for social security recipients, requires all residential service providers to supply limited information to the Division about their service settings. This information is collected so that the State can provide federal reports under Section 1616(e) of the Social Security Act.
- The new Section 13 provides additional regulations aimed at promoting a more home-like environment for all persons served on the Wyoming Medicaid Home and Community Based Waivers affected by this rule.
- Section 19, Psychoactive Medication Usage Standards, replaces and greatly expands upon community recognized practices for the use of psychoactive medications for the populations served by programs impacted by this rule. These changes support and augment policy recommendations and changes made by the Division after consultation with community providers in recent years.
- Section 31, Relative Providers is new language which defines the ways that relatives of program participants may provide services to those participants as allowed by Wyoming Statute § 42-4-102(a)(ii).

Chapter 46

Rules and Regulations for Medicaid Supports and Comprehensive Waivers

Chapter 46 was developed to establish the Supports and Comprehensive Waiver Rule using standards and guidelines from Centers for Medicare and Medicaid Services (CMS). Chapter 46 establishes a person-centered approach to determine participant support needs in the Individual Plan of Care and assigns an individual budget amount. The essential components of Chapter 46 include; development of community connections, increased independence, natural supports, self-direction, and employment opportunities. The services offered on the Supports Waiver are not as extensive as the services offered on the Comprehensive Waiver. As identified above, the Department has received approval from the Centers for Medicare

and Medicaid Services to combine all intellectual disabilities waiver and acquired brain injury waiver populations under this single waiver program.

In March 2013, the Wyoming Legislature passed Senate Enrolled Act 82, a law requiring the Wyoming Department of Health, Behavioral Health Division (BHD) to develop two new waivers, the Supports Waiver and the Comprehensive Waiver. The new law required BHD to "optimize the services provided to current clients, and to extend appropriate services to persons currently on a waiting list for waiver services within the current budget." This rule establishes these programs and implements these requirements.

All Adult or Child Developmental Disabilities Waiver participants currently receiving services will be moved to the new Comprehensive Waiver, unless the participant chooses the Supports Waiver. The Supports Waiver and the Comprehensive Waiver became effective April 1, 2014. After all current wavier participants are transitioned to the new waivers, Chapters 41 and 42 (the old waiver rules) will be repealed.

All ABI Waiver participants are in the process of transferring to the Supports Waiver or waiting to transfer to the Comprehensive Waiver. ABI specific eligibility criteria are added to this Chapter.

Chapter 46 also includes the language for Conflict Free Case Management and the situations in which conflicts must be avoided. These changes are a result of the new federal regulations in 42 CFR 441.301, which requires a plan of care to be developed using a case manager that is free from conflicts of interest.

Service definitions have been updated to align with the most recent versions of the Service Index. More extensive changes were made to the following services: Adult Day services, Community Integration Services, and Residential Habilitation Services. Three additional services have been added: remote monitoring, remote monitoring equipment installation, and remote monitoring equipment.

Rules Reduction

Consistent with the Governor's directive to reduce rules, the Department of Health removed unnecessary redundancy between these chapters, other existing Medicaid rules, and Wyoming statutes. The Department of Health also eliminated provisions where lawmaking is not necessary in favor of providing better regulatory guidance. Minor revisions were also applied to these chapters to improve ease of understanding, and general readability throughout.

We are only introducing one chapter of new rules for the two new waiver programs. We are decreasing the rules specific to the Adult DD, Child DD, and ABI waivers by 3 chapters, 52 pages, and 13047 words. This is a 64% reduction in total content for the Adult DD, Child DD and ABI waivers.

Promulgating these rules will also permit the Department of Health to repeal three additional chapters of rules listed on the Wyoming Secretary of State's website under the heading of Developmental Disabilities. This includes 2 chapters under Individually Selected Service Coordination. This repeal is possible because necessary language regarding case management services and emergency funding are now incorporated into the Wyoming Medicaid rules. The Department will also repealing Developmental Disabilities – Contested Cases, because this chapter is out of date and contested cases for case managers will now be exclusively handled under the Wyoming Medicaid rules. Rules repeal packets for these chapters are being submitted contemporaneously with the packet for these rules.

CHAPTER 41

ADULT DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY BASED WAIVER

[This chapter is repealed.]

CHAPTER 42

CHILDREN'S DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY BASED WAIVER

[This chapter is repealed.]

WYOMING MEDICAID RULES

CHAPTER 41

ADULT DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY BASED WAIVER

[This chapter is repealed.]

~~Section 1. Authority.~~

~~This Chapter is promulgated by the Department of Health pursuant to the Medical Assistance and Services Act at W.S. § 42-4-101 et seq. and the Wyoming Administrative Procedures Act at W. S. § 16-3-101 et seq.~~

~~Section 2. Purpose and Applicability.~~

~~(a) This Chapter shall apply to and govern Medicaid services provided under the Wyoming Medicaid Adult Developmental Disabilities Home and Community Based Waiver on or after June 1, 2006.~~

~~(b) The provisions contained in this Chapter shall be subordinate to the provisions in the Wyoming Medicaid Adult Developmental Disabilities Home and Community Based Waiver submitted to the Centers for Medicare and Medicaid Services pursuant to Section 1915(c) of the Social Security Act codified as 42 U.S.C. § 1396n.~~

~~(c) The Division may issue Provider Manuals, Provider Bulletins, or both, to providers and/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 or Provider Bulletins shall be subordinate to the provisions of this Chapter.~~

~~Section 3. General Provisions.~~

~~(a) Terminology. Except as otherwise specified, the terminology used in this Chapter is the standard terminology and has the standard meaning used in accounting, health care, Medicaid, and Medicare.~~

~~(b) Methodology. This Chapter establishes a person-centered methodology that is designed to match the needs of a participant with the services appropriate to meet those needs. Accordingly, participants with higher needs shall be assigned higher budget amounts that will allow them to select and access the services appropriate for their needs. By contrast, participants with lower needs shall be assigned lower budget amounts that will allow them to select and access the services they need.~~

~~(c) This Chapter is intended to be read in conjunction with the Wyoming Medicaid Adult Developmental Disabilities Home and Community Based Waiver submitted to the Centers for Medicare and Medicaid Services pursuant to Section 1915(c) of the Social Security Act, Chapter 44, Rules for Environmental Modifications and~~

~~Specialized Equipment of the Medicaid Rules, Chapter 45, Provider Standards and Certification of the Medicaid Rules, and Chapter 1, Rules for Individually-selected Service Coordinators of the Rules of the Developmental Disabilities Division.~~

~~(d) Unless otherwise specified, the incorporation by reference of any external standard is intended to be the incorporation of that standard as it is in effect on the effective date of this Chapter, including any applicable amendments, corrections, or revisions, but excluding any subsequent amendments or changes.~~

~~Section 4. Definitions.~~

~~The following definitions shall apply in the interpretation and enforcement of these rules. Where the context in which words are used in these rules indicates that such is the intent, words in the singular number shall include the plural and vice versa. Throughout these rules gender pronouns are used interchangeably. The drafters have attempted to utilize each gender pronoun in equal numbers, in random distribution. Words in each gender include individuals of the other gender.~~

~~(a) "Advocate." A person, chosen by the participant or legal guardian, who supports and represents the rights and interests of the participant in order to ensure the participant's full legal rights and access to services. The advocate can be a friend, a relative, or any other interested person. An advocate has no legal authority to make decisions on behalf of a participant.~~

~~(b) "Adult." A person twenty-one years of age or older for purposes of the Adult Developmental Disabilities Home and Community Based Waiver.~~

~~(c) "Adult Developmental Disabilities Home and Community Based Waiver." The Adult Developmental Disabilities Home and Community Based Waiver submitted to and approved by the Centers for Medicare and Medicaid Services pursuant to Section 1915(c) of the Social Security Act.~~

~~(d) "Applicant." An individual who is requesting services.~~

~~(e) "Application." A written statement, in the form specified by the Division, which is submitted to the Division, in which an individual indicates that he or she is interested in receiving covered services. An application may be submitted by one person on behalf of another but shall have the legal guardian's signature if applicable.~~

~~(f) "Assessment." A determination, pursuant to Section 6 of this Chapter, of an individual's functional capacity and needs.~~

~~(g) "Behavior support plan." A written plan that is developed based on a functional assessment of behaviors that negatively impact a person's ability to acquire, retain, and/or improve the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings, and that contains multiple intervention strategies designed to modify the environment and teach new skills.~~

~~(h) "Caregiver." A person who provides services to a participant.~~

(i) "Case management." Services that assist participants in gaining access to needed waiver and other Wyoming Medicaid state plan services, as well as needed medical, social, educational, and other services, regardless of the funding source for the services to which access is gained. Case management services are provided by individually-selected service coordinators, whose responsibilities include ongoing monitoring of the provision of services included in the individual plan of care, and initiating and overseeing the process of assessment and reassessment of the participant's level of care and review of the individual plan of care.

(j) "Centers for Medicare and Medicaid Services (CMS)." The Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services, its agent, designee, or successor.

(k) "Chapter 1." Chapter 1, Rules for Medicaid Administrative Hearings, of the Wyoming Medicaid Rules.

(l) "Chapter 3." Chapter 3, Provider Participation, of the Wyoming Medicaid Rules.

(m) "Chapter 16." Chapter 16, Medicaid Program Integrity, of the Wyoming Medicaid Rules.

(n) "Chapter 26." Chapter 26, Medicaid Covered Services, of the Wyoming Medicaid Rules.

(o) "Chapter 35." Chapter 35, Medicaid Benefit Recovery, of the Wyoming Medicaid Rules.

(p) "Chapter 39." Chapter 39, Recovery of Excess Payments, of the Wyoming Medicaid Rules.

(q) "Chapter 42." Chapter 42, DD Child Waiver Services, of the Wyoming Medicaid Rules.

(r) "Chapter 43." Chapter 43, Acquired Brain Injury Waiver Services, of the Wyoming Medicaid Rules.

(s) "Chapter 44." Chapter 44, Environmental Modifications and Specialized Equipment, of the Wyoming Medicaid Rules.

(t) "Chapter 45." Chapter 45, Waiver Provider Certification and Sanctions, of the Wyoming Medicaid Rules.

(u) "Claim." A request by a provider for Medicaid payment for covered services provided to a participant.

(v) "Clinically eligible." Determination that a person has met the requirements set forth in Section 6 (b) of this Chapter.

(w) "Conservator." A person appointed by the court to manage the estate for an individual incapable of managing his or her financial affairs.

(x) "Covered services." Those services that are Medicaid reimbursable pursuant to Section 7 of this Chapter.

(y) "Department." The Wyoming Department of Health, its agent, designee, or successor.

(z) "Department of Family Services (DFS)." The Wyoming Department of Family Services, its agent, designee, or successor.

(aa) "Developmental disability." As defined in federal law (42 U.S.C. § 15002 (8)), a severe, chronic disability of an individual that:

(i) Is attributable to a mental or physical impairment or combination of mental and physical impairments.

(ii) Is manifested before the individual attains age 22.

(iii) Is likely to continue indefinitely, and

(iv) Results in substantial functional limitations in 3 or more of the following areas of major life activity:

(A) Self-care

(B) Receptive and expressive language

(C) Learning

(D) Mobility

(E) Self-direction

(F) Capacity for independent living

(G) Economic self-sufficiency, and

(v) Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

(bb) "Dietician." A person who is registered as a dietician by the Commission on Dietetic Registration.

(cc) "Dietician services." Services furnished by a registered dietician, including:

(i) Menu planning.

(ii) Consultation with and training of caregivers, and

(iii) Education of participants.

(dd) "Director." The Director of the Department or the Director's agent, designee, or successor.

(ee) "Division." The Developmental Disabilities Division of the Department, its agent, designee or successor.

(ff) "Drug used as a restraint." Any drug that:

(i) Is administered to manage a participant's behavior in a way that reduces the safety risk to the participant or others, and

(ii) Has the temporary effect of restricting the participant's freedom of movement, and

(iii) Is not a standard treatment for the participant's medical or psychiatric condition.

(gg) "Emergency." A circumstance or set of circumstances or the resulting state that calls for immediate action or an urgent need for assistance or relief as defined in Section 14 of this Chapter.

(hh) "Emergency case." A participant currently receiving services who has an emergency.

(ii) "Emergency referral." A person who: (1) is potentially eligible for covered services; and (2) has an emergency.

(jj) "Enrolled." Enrolled as defined in Chapter 3.

(kk) "Environmental modification." The physical modification of a residence of a participant pursuant to Chapter 44.

(ll) "Excess payments." Excess payments as defined in Chapter 16 and Chapter 39.

(mm) "Extended Wyoming Medicaid state plan services." Services which are available to the general Medicaid population through the Wyoming Medicaid state plan, but which may be made available to a participant whose needs exceed state plan service limitations. Extended services include:

(i) Occupational therapy services.

(ii) Physical therapy services.

(iii) Speech, hearing, and language services.

(iv) Any other services covered by Medicaid.

(nn) "Extraordinary Care Committee (ECC)." A committee that has the authority to approve or deny individual plans of care, emergency funding, and funding due to a material change in circumstance or other condition justifying an increase in funding as defined in Section 12 of this Chapter. Membership of the ECC shall include a representative of the Division, a representative of the State Medicaid Program, and a representative of the Department's Fiscal Office.

(oo) "Extraordinary care rate." Payment in addition to the individualized budget amount, pursuant to Section 12 of this Chapter, because of an emergency, a material change in circumstances, or other condition justifying an increase in funding.

(pp) "Financial records." All records, in whatever form, used or maintained by a provider in the conduct of its business affairs and which are necessary to substantiate or understand the information contained in the provider's cost reports or a claim.

(qq) "Functionally necessary." A waiver service that is:

(i) Required due to the diagnosis or condition of the participant, and

(ii) Recognized as a prevailing standard or current practice among the provider's peer group, or

(iii) Intended to make a reasonable accommodation for functional limitations of a participant, to increase a participant's independence, or both.

(iv) Provided in the most efficient manner and/or setting consistent with appropriate care required by the participant's condition.

(v) For the purposes stated, utilization is neither experimental nor investigational and is generally accepted by the medical community.

(rr) "Funding." That combination of federal and state funds available to pay for covered services. Funding does not include any other funds available to the Department that are not designated for covered services.

(ss) "Generally Accepted Auditing Standards (GAAS)." Current auditing standards, practices, and procedures established by the American Institute of Certified Public Accountants.

(tt) "Guardian." A person lawfully appointed as guardian to act on the behalf of the participant or applicant.

(uu) "Habilitation." Services designed to assist participants in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. Habilitation includes:

(i) Day habilitation – Assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills which take place in a non-residential setting, separate from home or facility in which the participant resides.

(ii) In-home support – The provision of intermittent one-to-one habilitation services provided in the participant's home or the community to participants who reside with family, guardians, or independently. Individuals receive skills training to increase independence related to their own health care, self-care, safety, and access and use of community services.

(iii) Prevocational services – Services that prepare an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving, and safety. Prevocational services furnished under the waiver shall not be available under a program funded under the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Improvement Act of 2004.

(iv) Residential habilitation – The provision of habilitation services provided in the participant's home or community that provide assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Residential habilitation services shall include access to residential habilitation services on a 24-hour basis.

(v) Supported employment services – Services provided to assist participant in sustaining paid employment, including supervision and training. Supported employment services furnished under the waiver shall not be available under a program funded by either the Rehabilitation Act of 1973 or Disabilities Education Improvement Act of 2004.

(vv) "HHS." The United States Department of Health and Human Services, its agent, designee, or successor.

(ww) "ICF/MR." An intermediate care facility for people with mental retardation as defined in 42 U.S.C. § 1396d(d), which is incorporated by this reference.

(xx) "Individualized Budget Amount (IBA)." The Division's allocation of Medicaid waiver funds that may be available to a participant to meet his or her needs pursuant to Section 8 of this Chapter.

(yy) "Individual Plan of Care (IPC)." A written plan of care for a participant that describes the type and frequency of services to be provided to the participant regardless of the funding source and that identifies the provider or provider types that furnish the described services. The IPC shall reflect the services and actual units that providers are agreeing to provide over the plan year.

(zz) "Individual Plan of Care (IPC) team." A group of persons who are knowledgeable about the person and are qualified, collectively, to assist in developing an

individual plan of care for that person. Membership of the team shall include the participant, the guardian if applicable, the individually-selected service coordinator, providers on the person's individual plan of care, an advocate if applicable, and any other person chosen by the participant.

(aaa) "Individually-selected Service Coordinator (ISC)." An individual or entity that is qualified pursuant to Chapter 1, Rules for Individually-selected Service Coordinators of the Rules of the Developmental Disabilities Division, to act as an individually-selected service coordinator, also known as case manager.

(bbb) "Informed choice." A decision made by a participant or guardian if applicable that is made voluntarily, without coercion or undue influence, and that is based on sufficient experience and knowledge, including exposure, awareness, interactions, and/or instructional opportunities, to ensure that the choice is made with adequate awareness of all the available alternatives to and consequences of options available.

(ccc) "Inventory for Client and Agency Planning (ICAP)." An instrument used by the Division to help determine eligibility and to determine the needs of the participant, available from Riverside Publishing, its successor, or designee.

(ddd) "Institution." An Intermediate Care Facility for people with Mental Retardation (ICF/MR), nursing facility, hospital, prison, or jail.

(eee) "LT-MR-104." A document, or its successor, completed by the individually-selected service coordinator that verifies that the participant or applicant meets the ICF/MR level of care.

(fff) "Mechanical restraint." 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.

(ggg) "Medicaid." Medical assistance and services provided pursuant to Title XIX of the Social Security Act and/or the Wyoming Medical Assistance and Services Act. "Medicaid" includes any successor or replacement program enacted by Congress and/or the Wyoming Legislature.

(hhh) "Medicaid allowable payment." Medicaid reimbursement for covered services as determined pursuant to Section 18 of this Chapter.

(iii) "Medicaid Fraud Control Unit (MFCU)." The Medicaid Fraud Control Unit of the Wyoming Attorney General's Office, its agent, designee, or successor.

(jjj) "Medical records." All documents, in whatever form, in the possession of or subject to the control of a provider, which describe the participant's diagnosis, condition, or treatment, including, but not limited to, the individual plan of care.

(kkk) "Medically necessary." A health service that is required to diagnose, treat, cure, or prevent an illness, injury or disease which has been diagnosed or is reasonably

~~suspected to relieve pain or to improve and preserve health and be essential to life. The services must be:~~

~~(i) Consistent with the diagnosis and treatment of the participant's condition.~~

~~(ii) Recognized as the prevailing standard or current practice among the provider's peer group.~~

~~(iii) Required to meet the medical needs of the participant and undertaken for reasons other than the convenience of the participant and the provider, and~~

~~(iv) Provided in the most efficient manner and/or setting consistent with appropriate care required by the participant's condition.~~

~~(lll) "Medicare." The health insurance program for the aged and disabled established pursuant to Title XVIII of the Social Security Act.~~

~~(mmm) "Medication administration." Medication physically given by someone other than a participant because the participant cannot take his or her own medications or administer treatments.~~

~~(nnn) "Medication management training." Medication management training completed by a nurse, including instructing and assisting the participant in setting up medications.~~

~~(ooo) "Medication monitoring." Observation and documentation of participant's self-administration of medication by provider or provider staff for participants who do not require medication administration or medication management by a nurse.~~

~~(ppp) "Mental retardation." A diagnosis as determined by a psychologist per the American Association on Mental Deficiency, *Classification in Mental Retardation* (Herbert J. Grossman ed., 8th ed. 1983).~~

~~(qqq) "Modification to individual plan of care." A change to an individual plan of care pursuant to Section 9 of this Chapter. A modification may include the addition, substitution, or deletion of providers, covered services, or both. Modifications may increase or decrease the Medicaid waiver allowable payment.~~

~~(rrr) "Objectives." Set of meaningful and measurable goals for the participant and the methods used to train the person on the goals.~~

~~(sss) "Occupational therapist." A person licensed to practice occupational therapy pursuant to W. S. § 33-40-102(a)(iii).~~

~~(ttt) "Occupational therapy services." Occupational therapy services that are:~~

(i) Provided by or under the scope of practice of an occupational therapist, and

(ii) Necessary to keep a participant in his or her home or out of an institution.

(iii) Occupational therapy services may include individual therapy and group therapy.

(uuu) "Overpayments." Overpayments as defined in Chapter 16 and Chapter 39.

(vvv) "Participant." An individual who has been determined eligible for covered services on the Waiver.

(www) "Personal care services." Services to assist a participant with the activities of daily living, including eating, bathing, dressing, and personal hygiene, and household activities.

(xxx) "Personal restraint." The application of physical force or physical presence without the use of any device, for the purposes of restraining the free movement of the body of the participant. The term personal restraint does not include briefly holding, without undue force, a participant 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.

(yyy) "Person-centered planning." A process, directed by a participant, that identifies the participant's strengths, capacities, preferences, needs, the services needed to meet the needs, and providers available to provide services. Person-centered planning allows a participant to exercise choice and control over the process of developing and implementing the individual plan of care.

(zzz) "Physical therapist." A person licensed to practice physical therapy pursuant to W. S. § 33-25-101(a)(ii).

(aaaa) "Physical therapy services." Maintenance or restorative physical therapy services that are:

(i) Prescribed by a physician.

(ii) Provided by or under the scope of practice of a licensed physical therapist, and

(iii) Necessary to keep a participant in his or her home or out of an institution.

(iv) Physical therapy services may include individual therapy and group therapy.

(bbbb) "Physician." A person licensed to practice medicine or osteopathy by the Wyoming Board of Medical Examiners or a similar agency in a different state.

(cccc) "Power of Attorney." An instrument in writing whereby one person, as principal, appoints another as his agent and confers authority to perform certain specified acts or kinds of acts on behalf of principal (Black's Law Dictionary, Sixth Edition, 1990).

(dddd) "Prior authorization." Prior authorization as defined in Chapter 3.

(eeee) "Provider." A person or entity that is certified by the Division to furnish covered services and is currently enrolled as a Medicaid waiver provider.

(ffff) "Psychologist." A person licensed to practice psychology pursuant to W.S. § 33-27-113(a)(v).

(gggg) "Related condition." A condition that results in a severe, chronic disability affecting an individual which manifests before he or she reaches age twenty-two and that is attributable to cerebral palsy, seizure disorder, or any condition other than mental illness that is closely related to mental retardation and that requires similar services, as determined by a licensed psychologist or physician.

(hhhh) "Representative payee." A person or organization appointed by the Social Security Administration to manage Social Security, Veterans' Administration, Railroad Retirement, Welfare Assistance, or other state or federal benefits or entitlement program payments on behalf of an individual who cannot manage or direct the management of his/her own money.

(iiii) "Respiratory therapist." A person licensed as a respiratory care practitioner by the Wyoming Board for Respiratory Care, or a person certified or registered with the American Respiratory Therapy Association.

(jjjj) "Respiratory therapy services." Respiratory therapy services which are:

(i) Prescribed by a physician.

(ii) Furnished directly by a respiratory therapist to a participant, and

(iii) For habilitation purposes.

(kkkk) "Respite" or "Respite services." Services provided:

(i) On a short-term basis pursuant to the individual plan of care.

(ii) To a participant who is unable, unassisted, to care for himself or herself, and

(iii) Because the participant's primary caregiver is absent or in need of relief from furnishing such services.

(llll) "Restraint." A ''personal restraint,'' ''mechanical restraint,'' or ''drug used as a restraint'' as defined in this section.

(mmmm) "Schedule." A personalized list of tasks or activities that describe a typical week for a participant. The schedule shall reflect the desires of the participant and shall include the service being provided, details on training on specific goals for habilitation services, level of supervision needed if specified in the individual plan of care, health and safety needs, activities, date, time in and time out for provision of services, provider signatures, and approximate number of hours in service.

(nnnn) "Seclusion." The involuntary confinement of a participant alone in a room or an area from which the participant is physically prevented from leaving. Providers seeking reimbursement for waiver services shall not use seclusion.

(oooo) "Services." Medical, habilitation, or other services, equipment, or supplies, appropriate to meet the needs of a participant.

(pppp) "Skilled nursing services." Services listed in the individual plans of care that are within the scope of the Wyoming Nurse Practice Act.

(qqqq) "Specialized equipment." New or used devices, controls, or appliances that enable a participant to increase his or her ability to perform the activities of daily living or to perceive, control, or communicate with the environment in which the participant lives, pursuant to Chapter 44.

(rrrr) "Speech, hearing and language services." The following services, if furnished by a speech pathologist or audiologist or under the scope of practice of a speech pathologist or audiologist:

(i) Speech pathology and audiology services, including articulation, pragmatic language training, and devices used by the participant.

(ii) Assessment of participant's use of visual cues.

(iii) Assessment of the need for and use of amplification.

(iv) Assessment of a person's need for alternative speech output devices.

(v) Speech, hearing and language services may be provided as individual therapy and group therapy.

(ssss) "Speech pathologist." A person licensed to practice speech pathology pursuant to W. S. 33-33-102(a)(iii).

(tttt) "Third-party liability." Third-party liability pursuant to Chapter 35.

(uuuu) "Time out." The restriction of a participant for a reasonable period of time to a designated area from which the participant is not physically prevented from leaving, for the purpose of providing the participant an opportunity to regain self-control.

(vvvv) "Transition process." The process of changing from one provider of services to another, from one home and community based service to another, or from one residential location to another.

(wwww) "Waiting list." A list of persons who are eligible for covered services and who have submitted a completed application, but the services are unavailable because of limits imposed by funding or the waiver. The waiting list is maintained by the Division as specified in Section 13 of this Chapter.

(xxxx) "Waiver." The Adult Developmental Disabilities Home and Community Based Waiver submitted to and approved by the Centers for Medicare and Medicaid Services pursuant to Section 1915(c) of the Social Security Act.

Section 5. 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, and which are included as Appendix A to this Chapter.

(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 6. Assessment and Eligibility.

(a) Eligibility under this Chapter is limited to persons who complete the application process and who meet the following requirements for clinical eligibility and financial eligibility. In addition, in order to be eligible for the waiver all persons shall be:

(i) A United States Citizen as determined by the Department of Family Services.

(ii) A resident of Wyoming as determined by the Department of Family Services.

(iii) 21 years of age or older.

(b) Clinical eligibility criteria. An applicant is considered clinically eligible if he or she has:

(i) A diagnosis of mental retardation as determined by a psychologist, or

(ii) A diagnosis of a related condition as determined by a physician and

functional limitations verified by a psychologist, and

(iii) An Inventory for Client and Agency Planning (ICAP) services score equal to or less than 70, or

(iv) When the Inventory for Client and Agency Planning score is more than 70, the applicant has an Inventory for Client and Agency Planning deficit in 3 or more of the following 6 domains:

(A) Self care

(B) Language

(C) Learning/cognition

(D) Mobility

(E) Self-direction, and

(F) Independent living, and

(v) A completed LT-MR-104 that verifies that the participant or applicant meets the ICF/MR level of care.

(vi) Financial eligibility. Eligibility for covered services is limited to persons who meet the income and resource criteria set forth in the waiver and in the rules and policies of the Wyoming Medicaid program, as determined by the Department of Family Services.

(c) Application process.

(i) A completed application on a form required by the Division shall be submitted to the Division.

(A) For individuals who are not yet 21 years of age, an application shall be submitted no more than 6 months prior to turning 21 years of age.

(B) An application is valid for one year. After that time, if necessary documentation has not been received so that the Division can determine clinical eligibility, the applicant shall be required to re-apply.

(C) Once an applicant has been determined to be clinically eligible and has been placed on a wait list, he/she does not need to re-apply.

(ii) Selection of individually-selected service coordinator.

(A) After an applicant requests services pursuant to this Chapter, the Division shall provide the applicant with a list of individually-selected service coordinators in the area(s) he or she wishes to receive services.

(B) The applicant, family, or guardian shall select and meet with an individually-selected service coordinator from that list. Once both the applicant and the individually-selected service coordinator have agreed to work together, the individually-selected service coordinator shall notify the Division of that selection on a form designated by the Division.

(d) Determination of clinical eligibility. A person shall not receive covered services unless that person is clinically eligible. The determination of a person's clinical eligibility shall be made as follows:

(i) Psychological evaluation.

(A) The applicant and the individually-selected service coordinator shall arrange for a psychological evaluation to determine whether the applicant has a diagnosis of mental retardation or a related condition.

(B) If the applicant has a diagnosis of mental retardation or a related condition, he or she shall be further assessed pursuant to (ii)(B) of this Section to determine clinical eligibility.

(C) The Division may obtain a second opinion on a psychological evaluation from a contracted expert in order to confirm or deny that an applicant has a related condition.

(ii) Inventory for Client and Agency Planning.

(A) An individual who has a diagnosis of mental retardation or related condition as determined by the psychological evaluation shall be assessed to determine his or her functional capacity.

(B) Assessments shall be performed by a third party, under contract to the Division, who is qualified to perform such assessments using the Inventory for Client and Agency Planning (ICAP).

(iii) LT-MR-104.

(A) The individually-selected service coordinator shall complete the LT-MR-104 that verifies that the participant or applicant meets the ICF/MR level of care.

(e) Notification of determination of clinical eligibility.

(i) The Division shall determine clinical eligibility within 60 calendar days of receipt of the psychological assessment. If additional data or review is needed to determine eligibility, the Division shall notify the applicant in writing that the process will take an additional 30 calendar days.

(ii) If the applicant does not have a diagnosis of mental retardation or related condition, the applicant does not meet the clinical eligibility requirements.

(iii) If the applicant does not meet the ICF/MR level of care as determined by the LT-MR-104, the applicant does not meet the clinical eligibility requirements.

(iv) If the applicant does not meet the ICAP service score requirement or the ICAP scores with a deficit in 3 out of the 6 domains, the applicant does not meet the clinical eligibility requirements.

(A) If an applicant is determined not to meet clinical eligibility criteria, the applicant or the applicant's legal guardian shall be notified in writing within 15 business days.

(B) An applicant determined to not meet clinical eligibility requirements, may appeal the decision pursuant to Chapter 1.

(v) If an applicant is determined to be clinically eligible, the applicant or applicant's legal representative will be notified in writing that:

(A) There is a funding opportunity available, or

(B) There is not a funding opportunity available but the applicant is placed on the Division's waiting list, as specified in Section 13 of this Chapter.

(vi) Once an individual is notified that there is a funding opportunity available, financial eligibility shall be determined by the Department of Family Services.

(f) Loss of eligibility.

(i) A participant shall be determined to no longer be eligible when the participant:

(A) Does not meet clinical eligibility when re-tested, or

(B) Does not meet financial eligibility requirements as determined by the Department of Family Services, or

(C) Changes residence to another state.

(ii) Services to a participant determined to not meet clinical eligibility requirements shall be terminated no more than 45 days after the determination is made.

(A) If an applicant is determined not to meet clinical eligibility criteria, the applicant or the applicant's legal guardian shall be notified in writing within 15 business days.

(B) A participant determined to not meet eligibility requirements may appeal the decision pursuant to Chapter 1.

(iii) A participant may be denied waiver placement and may be required to reapply when the participant:

(A) Voluntarily does not receive any waiver services for 3 consecutive months.

(B) Is in a nursing home, hospital, or residential treatment facility for 6 consecutive months.

(C) Is in an out-of-state placement for 6 consecutive months.

(iv) Upon written notification of the denial of waiver placement:

(A) The participant may submit, in writing, reasons why he/she should still be considered eligible for the services.

(B) This request shall be reviewed by the Waiver Manager and the Division Administrator.

(v) If the participant is determined not to be eligible for services due to one of the criteria in (iii) of this section, the participant or the participant's legal guardian shall be notified in writing within 15 business days.

(A) The participant may appeal the decision pursuant to Chapter 1.

Section 7. Covered Services, Service Requirements, and Restrictions.

(a) The services listed in this section are covered services if they are functionally necessary and part of a current individual plan of care approved by the Division.

(i) Case management services.

(A) Case management is a stand alone service. A participant (or guardian, if applicable) may choose any individually-selected service coordination provider, and shall not be expected or required to receive any other service from that provider.

(B) Individually-selected service coordinators shall be required to provide a minimum of 60 minutes per calendar month of person-to-person contact with the participant or guardian.

(I) This may include face-to-face meetings and telephone conversations between the individually-selected service coordinator, the participant, and/or the guardian.

(II) Individually-selected service coordinators shall be required to complete one monthly visit to participant in his or her home.

(C) Individually-selected service coordinators shall schedule and facilitate six month review team meetings and annual individual plan of care meetings, including:

(I) Notifying all individual plan of care team members of the scheduling of the meetings at least 30 days in advance unless a shorter notification time is approved by the Division.

(II) Notifying the Division in writing of the scheduling of the meetings at least 30 days in advance unless a shorter notification time is approved by the Division.

(III) Following Division requirements for facilitating team meetings; and for documenting minutes of the team meetings in the form and manner prescribed by the Division in provider manuals and bulletins issued by the Division.

(D) Individually-selected service coordinators shall facilitate other team meetings when requested by the participant, guardian, member of the team, or the Division.

(ii) Dietician.

(A) Dietician services shall be supported by a formal assessment completed by a registered dietician.

(B) Providers of dietician services may seek Medicaid reimbursement for providing such services to a group of up to three participants at a time.

(iii) Environmental modification.

(A) Environmental modifications shall be approved pursuant to Chapter 44.

(iv) Habilitation services.

(A) Participants may receive more than one habilitation service in a given day.

(B) Participants shall be in attendance in service areas in order for providers to bill for services.

(C) Purposes of the habilitation service codes shall be met, including assisting participants in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings.

(I) Habilitation providers shall work with the participant on objectives as stipulated in the individual plan of care and document the results in the form and manner established by the individual plan of care team.

(D) Habilitation rates shall include personal care and respite services, except for in the cases listed under (E) of this section.

(E) Residential habilitation services and respite services may appear on the same individual plan of care when:

(I) The participant is transitioning into a residential setting such as a group home, or

(II) Unpaid caregivers need respite when the participant spends time at home visiting on weekends or vacations.

(III) When residential habilitation providers who are not required to obtain and maintain CARF accreditation pursuant to Chapter 45 require respite for vacations, sick days, or other emergencies. In these cases, a maximum of 1,344 units of respite shall be allowed during a plan year.

(F) In-home support services and residential habilitation services may appear on the same individual plan of care when the participant is transitioning into or out of a residential setting such as a group home.

(G) When supported employment services are provided in a work site in which persons without disabilities are employed, payment shall be made only for the adaptations, supervision, and training required by individuals receiving waiver services as a result of their disabilities, and shall not include payment for the supervisory activities rendered as a normal part of the business setting.

(H) Reimbursement for habilitation services shall not be made directly or indirectly to a parent, stepparent, spouse, or guardian of a participant.

(I) Habilitation rates for each participant shall include the cost for routine transportation by the provider regardless of the number of trips.

(J) Residential habilitation services shall not be provided in residential settings other than the home of the participant or in the community.

(K) In-home support services shall not be provided in residential settings other than the home of the participant or in the community.

(v) Occupational therapy.

(A) Reimbursement for occupational therapy services shall require both a prescription and a treatment letter or recommendation from a physician.

~~(B) Providers of occupational therapy services may seek Medicaid reimbursement for providing such services to a group of up to three participants at a time.~~

~~(vi) Personal care services.~~

~~(A) The participant shall be present when personal care services are provided.~~

~~(B) Personal care services may include the preparation of meals, exclusive of the cost of the meals.~~

~~(C) When specified in the individual plan of care, personal care services may also include such housekeeping chores as bed making, dusting, and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the participant, rather than that individual's family.~~

~~(D) Personal care providers may include members of the family of the participant, except that Medicaid shall not reimburse a parent for providing such services to an adult child, or a spouse for providing such services to the other spouse.~~

~~(E) Providers certified to provide personal care services who are family members of the participant shall meet the same standards as providers certified to provide personal care services who are unrelated to the participant.~~

~~(F) Providers of personal care services shall not seek Medicaid reimbursement for providing such services to more than one participant at a time.~~

~~(vii) Physical therapy.~~

~~(A) Reimbursement for physical therapy services shall require both a prescription and a treatment letter or recommendation from a physician.~~

~~(B) Providers of physical therapy services may seek Medicaid reimbursement for providing such services to a group of up to three participants at a time.~~

~~(viii) Respiratory therapy.~~

~~(A) Reimbursement for respiratory therapy services shall require both a prescription and a treatment letter or recommendation from a physician.~~

~~(ix) Respite services.~~

~~(A) Respite services shall be covered if provided in one of the following locations:~~

~~(I) The residence of the participant.~~

~~(II) A group home.~~

(III) Certified provider location, or

(IV) The community, including parks, stores, and recreation centers.

(B) A respite service provider or provider staff providing respite services:

(I) Shall serve no more than two participants at a given time unless approved by the Division.

(II) May also provide supervision to other children under the age of 12 or other individuals requiring support and supervision, and

(III) Shall limit the total combined number of persons in (I) and (II) to no more than three persons unless approved by the Division.

(C) Respite services shall not take the place of residential or day habilitation services.

(D) Respite services shall accommodate each family's living routine.

(E) Respite services shall accommodate the needs of the participant.

(F) The respite site and services shall be matched to the identified needs of each participant and family.

(G) A respite provider shall not provide respite services to adults and children at the same time except to participants who are 18 to 20 years of age who may receive respite services with adults. In exceptional cases, such as when participants are members of the same family, respite may be provided to adults and children at the same time with Division approval.

(x) Skilled nursing.

(A) Shall be prescribed by a physician.

(B) May include preventative and rehabilitative procedures.

(C) Shall be listed on a form required by the Division and identified in the individual plan of care.

(D) Shall involve direct patient care.

(xi) Specialized equipment.

(A) Shall be provided pursuant to Chapter 44.

(xii) Speech, hearing, and language services.

(A) Reimbursement for speech, hearing, and language services shall require both a prescription and a treatment letter or recommendation from a physician.

(B) Providers of speech, hearing, and language services may seek Medicaid reimbursement for providing such services to a group of up to three participants at one time.

(b) Services otherwise covered by Medicaid shall not be covered services under this Chapter.

(c) Extended state plan services shall be funded to the maximum allowable amount under the state plan before these services are paid for under the waiver.

(d) Parents, stepparents, and/or spouses shall not be reimbursed by waiver funding for any waiver services.

Section 8. The Individualized Budget Amount.

(a) Eligibility shall be determined pursuant to Section 6 of this Chapter before an individualized budget amount is determined.

(b) Determination of the targeted individualized budget amount.

(i) The Division's methodology to determine the amount of Medicaid waiver funds that shall be available to a participant to meet his or her needs shall include the following factors:

(A) The services the participant has received in the past or that are determined by projected services.

(B) Participant characteristics, including the participant's needs, as measured on the Inventory for Client and Agency Planning, and

(C) Economic factors, such as the cost of receiving services in different geographical areas or where the participant resides.

(ii) Using specific participant factors, the methodology shall correlate a participant's characteristics with the participant's individualized budget amount, so that the participants with higher needs are assigned a higher individualized budget amount, and vice versa.

(c) Re-determination of the individualized budget amount.

~~(i) The Division or the individual plan of care team may request a new Inventory for Client and Agency Planning or psychological assessment to determine if the characteristics or needs of the participant have changed and if a new individualized budget amount may be assigned.~~

~~(A) The Division may request a new Inventory for Client and Agency Planning or psychological assessment at any time.~~

~~(B) If the individual plan of care team requests a new Inventory for Client and Agency Planning or psychological assessment, the Division shall review the request and decide whether a new Inventory for Client and Agency Planning or psychological assessment will be approved.~~

~~(C) If the new Inventory for Client and Agency Planning or psychological assessment results in a change in the individualized budget amount determination, a change in the individualized budget amount shall be approved or denied in accordance with the procedure described in paragraph (b) of this section.~~

~~(ii) If the individualized budget amount does not meet the characteristics and needs of an individual, the Extraordinary Care Committee may approve a new individualized budget amount as a long-term increase, pursuant to Section 12. This will be re-evaluated at least every five years.~~

~~(iii) At least once every two years, the Division shall update the targeted individualized budget amount model using the most current Inventory for Client and Agency Planning data, current services, and current funding information.~~

~~(d) If funds for covered services become, or are projected to become limited or unavailable, the Division may modify participants' individualized budget amounts as necessary to bring projected expenditures in line with projected funding, recognizing that services shall be altered accordingly.~~

~~(e) If funding for covered services is, or is projected to be reduced below the level required to pay for all approved individualized budget amounts, or is eliminated, the Division shall have the discretion to modify participants' individualized budget amounts in order to bring projected expenditures for covered services within the projected available funding.~~

~~(f) If the waiver is modified or eliminated, the Division shall have the discretion to modify the individualized budget amounts in order to bring projected expenditures for covered services within projected available funding.~~

~~(g) Reinstatement of services. If additional funding becomes available, services that were reduced or eliminated shall be reinstated based on individual needs to the extent of the available funds. There shall be no requirement for the Division to disperse all available funds without a demonstrated need as described in these rules.~~

~~Section 9.~~ Development and Approval of the Individual Plan of Care~~.~~

(a) Development of the individual plan of care.

(i) After the targeted individualized budget amount is identified by the Division, the individual plan of care team, coordinated by the individually-selected service coordinator, shall assist the participant in determining the use of the targeted individualized budget amount in developing the individual plan of care.

(ii) The individual plan of care shall be completed in the form and manner prescribed by the Division in accordance with Section 23 of Chapter 1, Rules for Individually-selected Service Coordinators of the Rules of the Developmental Disabilities Division.

(iii) The individually selected service coordinator shall develop the individual plan of care that includes:

(A) A completed pre-approval page signed by the participant or guardian and the individually-selected service coordinator.

(B) Freedom of Choice Document or its successor.

(C) LT-MR-104 form or its successor.

(D) Medical report signed by a physician if the participant is eligible due to a diagnosis of a related condition. The medical report shall discuss the diagnosis and what the recommended treatments or services may be.

(E) Psychological report that is no more than 5 years old and signed by a psychologist.

(I) The psychological report shall specify a clinical diagnosis of mental retardation or a related condition.

(II) The psychological report shall provide recommendations that the individual plan of care team shall review and address through the individual plan of care.

(F) ICAP report that is no more than 5 years old.

(G) Objective pages as required by the Division for each habilitation service. The individually-selected service coordinator is responsible for ensuring that objective pages are completed. The objectives shall:

(I) Define the training activities of an individual and the methods used to train the activity.

(II) Be measurable and meaningful to the participant.

(III) Be reflected on the personal schedule.

(H) Identification of rights and rights restrictions in accordance with Appendix A of this Chapter, including the use of restraints as defined in Section 4 of this Chapter, including:

(I) Why the restriction is imposed.

(II) How the restriction is imposed.

(III) The plan to restore the right being restricted.

(IV) Signature of the participant and/or guardian.

(V) Rights restrictions shall be reviewed at least every six months by the individual plan of care team.

(VI) Rights restrictions that occur that are not part of the individual plan of care shall be reported to the Division on a form designated by the Division.

(I) Skilled nursing information on the form required by the Division that includes all areas of skilled nursing required by the participant.

(J) Medication administration indicating the level of medication administration or monitoring required for the participant. Levels of support include:

(I) Medication administration.

(II) Medication management training.

(III) Medication monitoring.

(IV) Ability to self-medicate with no assistance.

(K) A behavior support plan, if applicable, that reflects and addresses maladaptive behaviors identified by the individual plan of care team, the psychological evaluations, and the Inventory for Client and Agency Planning, including maladaptive behaviors listed as moderate or above pursuant to Section 30 of Chapter 45.

(L) Schedules for habilitation, personal care, and respite services. The purpose of the schedule shall be to provide information about the services and supports needed throughout a participant's day and justify the rates for services. Schedules shall be personalized and shall:

(I) Reflect the purpose of the services.

(II) Reflect recommendations from therapists, physicians, psychologists, and other professionals.

(III) Reflect the participant's desires and goals.

(IV) Include all information required by Chapter 45.

(b) Approval of the individual plan of care.

(i) The individually-selected service coordinator shall submit the individual plan of care to the Division with the Division's current technical checklist.

(ii) The Division shall have 20 calendar days to review and approve an individual plan of care contingent upon the individually-selected service coordinator submitting all the requested information to the Division.

(iii) The Division shall approve or make recommendations to modify the plan. This may result in an adjustment to the individualized budget amount.

(iv) Upon approval and prior to implementation of the plan, the individually-selected service coordinator shall distribute copies of the individual plan of care to the participant, the guardian, advocates, or representatives designated by the participant or guardian, and to habilitation, respite, personal care, and therapy providers on the individual plan of care in accordance with applicable privacy and confidentiality law and regulation.

(v) All other providers shall be given information from the individual plan of care pertinent to the provision of services.

(vi) All services shall be provided pursuant to the individual plan of care.

(vii) Medicaid reimbursement shall be limited to the covered services and the providers specified in the individual plan of care on the pre-approval form signed by the Division.

(viii) The Division shall not reimburse for services in excess of those specified in an approved individual plan of care or to providers not so specified.

(ix) The Division shall not approve an individual plan of care nor reimburse for services provided to a participant before clinical eligibility has been established pursuant to Section 6.

(x) Any provider who submits a claim for payment for services that have been approved but not yet provided to the participant shall be subject to the requirements of Chapter 16 and Chapter 39 including any available sanctions.

(xi) The Division shall review and approve Individual plans of care at least annually or more frequently at the option of the Division.

(c) Modification of individual plan of care requiring approval of the Division.

(i) Modifications to the pre-approval page of the individual plan of care shall be submitted for approval to the Division when there is a change in service rates, a change in service units, or a change in providers.

(ii) If the change does not require an increase in the individualized budget amount the Division shall approve, deny, or make recommendations to modify the plan.

(iii) If the change requires an increase in the individualized budget amount, the modification to the plan shall be due to an emergency, a material change in circumstance, a potential emergency, or other condition justifying an increase in funding and the modification shall be reviewed by the Extraordinary Care Committee in accordance with Section 12 of this Chapter.

(iv) The Division shall have 7 calendar days to review and approve modifications to the pre-approval page of the individual plan of care contingent upon the individually-selected service coordinator submitting all the requested information to the Division.

(v) The effective date of the modification shall be the date indicated on the pre-approval page by the signature of a Division representative.

(vi) When the level or intensity of services is permanently decreased, modifications to the individual plan of care shall be submitted for approval to the Division. The rates on the modification shall reflect the decrease in need of services. The decrease in services may include but is not limited to decreases in staffing levels or decreases in total hours of service provided in a day.

(d) Modifications to the individual plan of care that do not require Division approval.

(i) The individual plan of care shall be updated by the individually-selected service coordinator whenever there are significant changes to the participant's needs, including:

(A) Changes in health and safety needs.

(B) Changes in employment status.

(C) Changes in medication.

(D) Changes in adaptive equipment.

(E) Changes in diagnoses.

(F) Changes in mealtime needs.

(G) These changes do not need to be submitted to the Division unless the changes result in a change listed in (c) of this Section.

(e) Participant no longer receiving waiver services.

(i) The individually-selected service coordinator shall submit a modification ending the plan within 45 calendar days of the last date of service.

Section 10. Reassessments. A participant shall be reassessed for clinical eligibility at least every five years, and more frequently at the option of the Division. The reassessment shall include a review of the Inventory for Client and Agency Planning and the psychological evaluation.

Section 11. Transitions.

(a) Participants and/or guardians shall have the right to informed choice in providers and services.

(b) Participants and/or guardians may choose to change individually-selected service coordinators pursuant to Chapter 1, Rules for Individually-selected Service Coordinators of the Rules of the Developmental Disabilities Division.

(c) Participants may choose to change any providers, other than individually-selected service coordinators, anytime during the plan year pursuant to Chapter 45, Section 11.

(d) Applicants for the waiver may change individually-selected service coordinators at any time during the application process.

(e) When a participant or guardian chooses to change providers, they shall inform the individually-selected service coordinator of the decision. The individually-selected service coordinator shall then complete the required steps pursuant to Chapter 45, Section 11.

(f) If a provider providing residential services to a participant requires a participant to move to another residential location, the provider and participant's individually selected service coordinator shall complete the required steps pursuant to Chapter 45, Section 11.

(g) Providers who are terminating services with a participant shall notify the participant/guardian in writing at least 30 days prior to ending services unless a shorter transition period is approved in advance by the Division. Failure to provide services during this 30 day period shall be considered abandonment of services and may result in decertification of the provider.

Section 12. Extraordinary Care Committee.

(a) The Extraordinary Care Committee has the following authority:

(i) Determining if a funding request for an emergency case or an emergency referral shall be funded.

(ii) Determining if a funding request due to a material change in circumstance, a potential emergency, or other condition justifying an increase in funding shall be funded.

(iii) Approving or denying rates for services that are not commensurate with the average rates as defined in the Adult DD Waiver document approved by Centers for Medicare and Medicaid Services.

(iv) Approving rate changes due to increased or decreased funding from legislative appropriations or under utilization of approved individualized budgeted amounts.

(b) The Extraordinary Care Committee shall review the requests to determine if the request meets criteria, has necessary documentation, and if funding is available.

(c) The Extraordinary Care Committee shall make the following determinations:

(i) Request further information.

(ii) Approve the request for one year or less.

(iii) Approve the request as a long term individually budgeted amount pursuant to Section 8 (c)(ii).

(iv) Deny the request.

(d) The individually-selected service coordinators shall present funding requests due to a material change in circumstance, a potential emergency, or other conditions justifying an increase in funding to the Extraordinary Care Committee by conference call, compressed video, or physical presence. The individually-selected service coordinators shall have previously sent written documentation to their waiver specialist of the emergency criteria, material change in circumstance, or other conditions required for the case.

(e) Membership of the Extraordinary Care Committee shall include a representative of the Division, a representative of the State Medicaid Program and a representative of the Department's Fiscal Office.

(f) Decisions of the Extraordinary Care Committee shall be by majority and shall be rendered in writing.

(i) The Division shall notify the individually-selected service coordinator of the decision in writing within 10 business days of the decision.

Section 13. Waiting List Process.

(a) Waiting List. When there is insufficient funding to add additional participants, the Division shall maintain one waiting list for the Adult DD Home and Community Based Waiver as specified below.

(b) Factors. The Division shall assign two rankings to each person on the waiting list based on the following two factors:

(i) The severity of the person's condition based on the Inventory for Client and Agency Planning according to the service score.

(ii) The person's placement date on the waiting list.

(c) When covered services become available, the Division shall alternate between the two factors listed in (b) of this section, beginning with the waiting list based on severity, in selecting the next person to whom covered services shall be provided. Before being added to the waiting list, the person shall be otherwise eligible as determined in Section 6 of this Chapter.

(d) In cases when the severity levels are the same or when the placement date on the waiting list is the same, the Division shall use the date that the Selection of Individually-selected Service Coordinator form was received by the Division to determine which name goes first on the waiting list.

(e) The Division shall determine the availability of funding for the approved individualized budget amounts for applicants on the waiting lists waiting for funding opportunities.

(f) The Extraordinary Care Committee shall review information on an applicant who meets the eligibility requirements in Section 6 of this Chapter and who is potentially an emergency referral to determine if he/she shall be funded as an emergency as specified in Section 14 of this Chapter.

Section 14. Emergency Services.

(a) The emergency criteria used by the Division includes:

(i) A substantial threat to a person's life or health caused by:

(A) The loss of the person's primary caregiver.

(B) Homelessness.

(C) Abuse or neglect that is either substantiated by the Wyoming Department of Family Services or corroborated by the Division or Protection and Advocacy of Wyoming.

(ii) Situations where the person's condition poses a substantial threat to his or her life or health and is documented, in writing, by a physician.

(iii) Situations where a person:

(A) Has caused serious physical harm to himself or someone else, or a person whose condition presents a substantial risk of physical threat to himself or others, and

(B) The harm or threat of harm is verified, in writing, by a psychologist or a psychiatrist, and

(C) The use of covered services would be an appropriate response to the person's condition, and

(D) Other resources to provide appropriate services are not available.

(b) Identification of emergency referrals and emergency cases.

(i) Any person may request that the Division consider whether an individual has an emergency.

(ii) The Division may identify persons on the waiting lists who have an emergency. Once a potential emergency case or emergency referral has been identified:

(A) The individually-selected service coordinator shall submit in the form specified by the Division specific information on the potential emergency. The information shall include:

(I) Description of the factors or condition that have created an emergency and their expected duration.

(II) Description of the covered services that are functionally necessary.

(III) Copies of incident reports, physician reports, assessments, or other documentation that relate to the factors or conditions that have created an emergency, and

(IV) A detailed plan of how the funds shall be spent, the expected outcome, and how the results shall be monitored with respect to the funds.

(iii) For emergency referrals, determination of eligibility as defined in Section 6 of this Chapter, shall be completed within 14 calendar days after receipt of the Inventory for Client and Agency Planning and the psychological assessment.

(c) The Extraordinary Care Committee shall review specific information on the potential emergency referral or emergency case to determine if the case meets the emergency criteria as defined in (a) of this section. Such persons shall receive covered services, subject to available funding.

(d) An emergency plan may be submitted to the Division by the participant's individually-selected service coordinator to cover services until the complete individual plan of care is submitted and approved by the Division.

(i) The emergency plan shall include significant health and safety information and shall be approved by the Division in order for services to be reimbursed.

(ii) The Division shall have 3 business days to review and approve the plan.

(e) In no event shall the Division be required to provide or fund covered services in the absence of available funding or in the absence of clinical or financial eligibility.

Section 15. Provider Participation.

(a) Payments only to providers. No person or entity that furnishes covered services to a participant shall receive Medicaid funds unless the person or entity has signed a provider agreement, is enrolled, and is certified by the Division as a provider at the time of service delivery.

(b) Compliance with Chapter 3, Provider Participation, of the Wyoming Medicaid Rules. A provider that wishes to receive Medicaid reimbursement for services furnished to a participant shall meet the provider participation requirements of Chapter 3, Provider Participation, of the Wyoming Medicaid Rules, Sections 4 through 6, which are incorporated by this reference.

(c) Compliance with Chapter 45, Provider Certification and Sanctions, of the Wyoming Medicaid Rules. A provider that wishes to provide Waiver services shall also meet the applicable criteria for Division certification set forth in Chapter 45, which is incorporated by this reference.

Section 16. Provider Records.

(a) A provider shall comply with Chapter 3, Provider Participation, of the Wyoming Medicaid Rules, Section 7, which is incorporated by this reference.

(b) Individually-selected service coordinators shall maintain copies of documentation from other providers for a twelve month period.

(c) For documentation of case management services, individually-selected service coordinators shall comply with Chapter 3, Section 7, which is incorporated by this reference.

Section 17. Verification of Participant Data. A provider shall comply with Chapter 3, Section 8, which is incorporated by this reference.

Section 18. Medicaid Waiver Allowable Payment. Medicaid payments shall be pursuant to and limited to each approved individual plan of care.

Section 19. Excluded Services.

(a) Services not covered under the waiver include:

(i) Services furnished to a participant while in an institution.

(ii) Room and board of participant; which are the responsibility of the participant or representative payee.

(iii) Room and board expenses of a live-in personal caregiver or provider.

Section 20. Third-party Liability.

(a) Submission of claims. Claims for which third-party liability exists shall be submitted in accordance with Chapter 35.

(b) Medicaid payment. The Medicaid payment for a claim for which third-party liability exists shall be the difference between the Medicaid allowable payment and the third-party payment. In no case shall the Medicaid payment exceed the payment otherwise allowable pursuant to this Chapter.

Section 21. Submission and Payment of Claims. The submission and payment of claims shall be pursuant to the provisions of Chapter 3.

Section 22. Recovery of Excess Payments or Overpayments.

(a) The Department may recover excess payments pursuant to Chapter 39.

(b) The Department may recover overpayments pursuant to Chapter 16.

Section 23. Audits.

(a) The Division or the Centers for Medicare and Medicaid Services may audit a provider's financial records, medical records, or employment records, at any time to determine whether the provider has received excess payments or overpayments.

(b) The Division or the Centers for Medicare and Medicaid Services may perform audits through employees, agents, or through a third-party. Audits shall be performed in accordance with generally accepted auditing standards.

(c) Disallowance. The Division shall recover excess payments or overpayments pursuant to Section 22 of this Chapter.

(d) Reporting audit results. If at anytime during a financial audit or a medical audit, the Division discovers evidence suggesting fraud or abuse by a provider, that evidence, in addition to the Division's final audit report regarding that provider, shall be referred to the Medicaid Fraud Control Unit.

(e) The Division shall share the results of the audit with the provider before excess payments or overpayments are recovered. However, nothing in this section shall abrogate the rights of the State to recover excess payments or overpayments in accordance with Chapter 16 or Chapter 39.

Section 24. Reconsideration. A provider may request that the Department reconsider a decision to recover excess payments or overpayments. The request for reconsideration, the reconsideration, and any administrative hearing shall be pursuant to the reconsideration provisions of Chapter 3, Chapter 16 or Chapter 39 as applicable.

Section 25. Disposition of Recovered Funds. The Department shall dispose of recovered funds pursuant to the provisions of Chapter 16.

Section 26. 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 27. 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, except Chapter 1, Rules for Individually-selected Service Coordinators of the Rules of the Developmental Disabilities Division, which remains in effect.

Section 28. Severability. If any portion of this Chapter is found to be invalid or unenforceable, the remainder shall continue in full force and effect.

CHAPTER 42

CHILDREN'S DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY BASED WAIVER

[This chapter is repealed.]

~~Section 1. Authority.~~

~~This Chapter is promulgated by the Department of Health pursuant to the Medical Assistance and Services Act at W.S. 42-4-101 et seq. and the Wyoming Administrative Procedures Act at W. S. 16-3-101 et seq.~~

~~Section 2. Purpose and Applicability.~~

(a) ~~This Chapter shall apply to and govern Medicaid services provided under the Wyoming Medicaid Children's Developmental Disabilities Home and Community Based Waiver on or after June 1, 2006.~~

(b) ~~The provisions contained in this Chapter shall be subordinate to the provisions in the Wyoming Medicaid Children's Developmental Disabilities Home and Community Based Waiver submitted to the Centers for Medicare and Medicaid Services pursuant to Section 1915(c) of the Social Security Act codified as 42 U.S.C. § 1396n.~~

(c) ~~The Division may issue Provider Manuals, Provider Bulletins, or both, to providers and/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 or Provider Bulletins shall be subordinate to the provisions of this Chapter.~~

~~Section 3. General Provisions.~~

(a) ~~Terminology. Except as otherwise specified, the terminology used in this Chapter is the standard terminology and has the standard meaning used in accounting, health care, Medicaid, and Medicare.~~

(b) ~~Methodology. This Chapter establishes a person-centered methodology that is designed to match the needs of a participant with the services appropriate to meet those needs. Accordingly, participants with higher needs shall be assigned higher budget amounts that will allow them to select and access the services appropriate for their needs. By contrast, participants with lower needs shall be assigned lower budget amounts that will allow them to select and access the services they need.~~

(c) ~~This Chapter is intended to be read in conjunction with the Wyoming Medicaid Children's Developmental Disabilities Home and Community Based Waiver submitted to the Centers for Medicare and Medicaid Services pursuant to Section~~

~~1915(c) of the Social Security Act, Chapter 44, Rules for Environmental Modifications and Specialized Equipment of the Medicaid Rules, Chapter 45, Provider Standards and Certification of the Medicaid Rules, and Chapter 1, Rules for Individually-selected Service Coordinators of the Rules of the Developmental Disabilities Division.~~

(d) ~~Unless otherwise specified, the incorporation by reference of any external standard is intended to be the incorporation of that standard as it is in effect on the effective date of this Chapter, including any applicable amendments, corrections, or revisions, but excluding any subsequent amendments or changes.~~

~~Section 4. Definitions.~~

~~The following definitions shall apply in the interpretation and enforcement of these rules. Where the context in which words are used in these rules indicates that such is the intent, words in the singular number shall include the plural and vice versa. Throughout these rules gender pronouns are used interchangeably. The drafters have attempted to utilize each gender pronoun in equal numbers, in random distribution. Words in each gender include individuals of the other gender.~~

(a) ~~"Adaptive behavior quotient." A formula used in determining eligibility calculated by dividing the ICAP age equivalent score in months by the child's chronological age in months. For individuals ages 18 through 20 the divisor is always 216 months.~~

(b) ~~"Advocate." A person, chosen by the participant or legal guardian, who supports and represents the rights and interests of the participant in order to ensure the participant's full legal rights and access to services. The advocate can be a friend, a relative, or any other interested person. An advocate has no legal authority to make decisions on behalf of a participant.~~

(c) ~~"Adult." A person twenty-one years of age or older for purposes of the Adult Developmental Disabilities Home and Community Based Waiver. Participants between the ages of 18 and 21 receive services on the Children's Developmental Disabilities Home and Community Based Waiver but are considered an adult in the State of Wyoming.~~

(d) ~~"Applicant." An individual who is requesting services.~~

(e) ~~"Application." A written statement, in the form specified by the Division, which is submitted to the Division, in which an individual indicates that he or she is interested in receiving covered services. An application may be submitted by one person on behalf of another but shall have the legal guardian's signature if applicable.~~

(f) ~~"Assessment." A determination, pursuant to Section 6 of this Chapter, of an individual's functional capacity and needs.~~

(g) ~~"Behavior support plan." A written plan that is developed based on a functional assessment of behaviors that negatively impact a person's ability to acquire, retain, and/or improve the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings, and that contains multiple intervention strategies designed to modify the environment and teach new skills.~~

(h) ~~"Caregiver." A person who provides services to a participant.~~

(i) ~~"Case management." Services that assist participants in gaining access to needed waiver and other Wyoming Medicaid state plan services, as well as needed medical, social, educational, and other services, regardless of the funding source for the services to which access is gained. Case management services are provided by individually-selected service coordinators, whose responsibilities include ongoing monitoring of the provision of services included in the individual plan of care, and initiating and overseeing the process of assessment and reassessment of the participant's level of care and review of the individual plan of care.~~

(j) ~~"Centers for Medicare and Medicaid Services (CMS)." The Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services, its agent, designee, or successor.~~

(k) ~~"Chapter 1." Chapter 1, Rules for Medicaid Administrative Hearings, of the Wyoming Medicaid Rules.~~

(l) ~~"Chapter 3." Chapter 3, Provider Participation, of the Wyoming Medicaid Rules.~~

(m) ~~"Chapter 16." Chapter 16, Medicaid Program Integrity, of the Wyoming Medicaid Rules.~~

(n) ~~"Chapter 26." Chapter 26, Medicaid Covered Services, of the Wyoming Medicaid Rules.~~

(o) ~~"Chapter 35." Chapter 35, Medicaid Benefit Recovery, of the Wyoming Medicaid Rules.~~

(p) ~~"Chapter 39." Chapter 39, Recovery of Excess Payments, of the Wyoming Medicaid Rules.~~

(q) ~~"Chapter 41." Chapter 41, Adult Waiver Services, of the Wyoming Medicaid Rules.~~

(r) ~~"Chapter 43." Chapter 43, Acquired Brain Injury Waiver Services, of the Wyoming Medicaid Rules.~~

(s) ~~"Chapter 44." Chapter 44, Environmental Modifications and Specialized Equipment, of the Wyoming Medicaid Rules.~~

(t) ~~"Chapter 45." Chapter 45, Waiver Provider Certification and Sanctions, of the Wyoming Medicaid Rules.~~

(u) ~~"Child." A person under 21 years of age for participants receiving services on the Children's Developmental Disabilities Home and Community Based Waiver. Participants between the ages of 18 and 21 receive services on the Children's Developmental Disabilities Home and Community Based Waiver but are considered an adult in the State of Wyoming and shall sign their own documents unless they have a legal guardian.~~

(v) ~~"Children's Developmental Disabilities Home and Community Based Waiver." The Children's Developmental Disabilities Home and Community Based Waiver submitted to and approved by the Centers for Medicare and Medicaid Services pursuant to Section 1915(c) of the Social Security Act.~~

(w) ~~"Claim." A request by a provider for Medicaid payment for covered services provided to a participant.~~

(x) ~~"Clinically eligible." Determination that a person has met the requirements set forth in Section 6 (b) of this Chapter.~~

(y) ~~"Conservator." A person appointed by the court to manage the estate for an individual incapable of managing his or her financial affairs.~~

(z) ~~"Covered services." Those services that are Medicaid reimbursable pursuant to Section 7 of this Chapter.~~

(aa) ~~"Department." The Wyoming Department of Health, its agent, designee, or successor.~~

(bb) ~~"Department of Family Services (DFS)." The Wyoming Department of Family Services, its agent, designee, or successor.~~

(cc) ~~"Developmental disability." As defined in federal law (42 U.S.C. § 15002 (8)), a severe, chronic disability of an individual that:~~

(i) ~~Is attributable to a mental or physical impairment or combination of mental and physical impairments.~~

(ii) ~~Is manifested before the individual attains age 22.~~

(iii) ~~Is likely to continue indefinitely, and~~

(iv) ~~Results in substantial functional limitations in 3 or more of the following areas of major life activity:~~

(A) ~~Self-care~~

(B) ~~Receptive and expressive language~~

(C) ~~Learning~~

(D) ~~Mobility~~

(E) ~~Self-direction~~

(F) ~~Capacity for independent living~~

(G) ~~Economic self-sufficiency, and~~

(v) ~~Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.~~

(dd) ~~"Dietician." A person who is registered as a dietician by the Commission on Dietetic Registration.~~

(ee) ~~"Dietician services." Services furnished by a registered dietician, including:~~

(i) ~~Menu planning.~~

(ii) ~~Consultation with and training of caregivers, and~~

(iii) ~~Education of participants.~~

(ff) ~~"Director." The Director of the Department or the Director's agent, designee, or successor.~~

(gg) ~~"Division." The Developmental Disabilities Division of the Department, its agent, designee, or successor.~~

(hh) ~~"Drug used as a restraint." Any drug that:~~

(i) ~~Is administered to manage a participant's behavior in a way that reduces the safety risk to the participant or others, and~~

(ii) ~~Has the temporary effect of restricting the participant's freedom of~~

~~movement, and~~

(iii) ~~Is not a standard treatment for the participant's medical or psychiatric condition.~~

(ii) ~~"Emergency." A circumstance or set of circumstances or the resulting state that calls for immediate action or an urgent need for assistance or relief as defined in Section 14 of this Chapter.~~

(jj) ~~"Emergency case." A participant currently receiving services who has an emergency.~~

(kk) ~~"Emergency referral." A person who: (1) is potentially eligible for covered services; and (2) has an emergency.~~

(ll) ~~"Enrolled." Enrolled as defined in Chapter 3, which definition is incorporated by this reference.~~

(mm) ~~"Environmental modification." The physical modification of a residence of a participant pursuant to Chapter 44, which definition is incorporated by this reference.~~

(nn) ~~"EPSDT." Early and periodic screening, diagnosis, and treatment services for participants under the age of 21 pursuant to Chapter 6, Health Check, of the Wyoming Medicaid Rules.~~

(oo) ~~"Excess payments." Excess payments as defined in Chapter 16 and Chapter 39, which definition is incorporated by this reference.~~

(pp) ~~"Extended Wyoming Medicaid state plan services." Services which are available to the general Medicaid population through the Wyoming Medicaid state plan, but which may be made available to a participant whose needs exceed state plan service limitations.~~

(qq) ~~"Extraordinary Care Committee (ECC)." A committee that has the authority to approve or deny individual plans of care, emergency funding, and funding due to a material change in circumstance or other condition justifying an increase in funding as defined in Section 12 of this Chapter. Membership of the ECC shall include a representative of the Division, a representative of the State Medicaid Program and a representative of the Department's Fiscal Office.~~

(rr) ~~"Extraordinary care rate." Payment in addition to the individualized budget amount, pursuant to Section 12 of this Chapter, because of an emergency, a material change in circumstances, or other condition justifying an increase in funding.~~

(ss) ~~"Financial records." All records, in whatever form, used or maintained by a provider in the conduct of its business affairs and which are necessary to substantiate or understand the information contained in the provider's cost reports or a claim.~~

(tt) ~~"Functionally necessary." A waiver service that is:~~

(i) ~~Required due to the diagnosis or condition of the participant, and~~

(ii) ~~Recognized as a prevailing standard or current practice among the provider's peer group, or~~

(iii) ~~Intended to make a reasonable accommodation for functional limitations of a participant, to increase a participant's independence, or both.~~

(iv) ~~Provided in the most efficient manner and/or setting consistent with appropriate care required by the participant's condition.~~

(v) ~~For the purposes stated, utilization is not experimental or investigational and is generally accepted by the medical community.~~

(uu) ~~"Funding." That combination of federal and state funds available to pay for covered services. Funding does not include any other funds available to the Department that are not designated for covered services.~~

(vv) ~~"Generally Accepted Auditing Standards (GAAS)." Current auditing standards, practices, and procedures established by the American Institute of Certified Public Accountants.~~

(ww) ~~"Guardian." A person lawfully appointed as a guardian to act on the behalf of the participant or applicant.~~

(xx) ~~"Habilitation." Services designed to assist participants in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. Habilitation includes:~~

(i) ~~Residential habilitation – The provision of habilitation services to individuals age 18-20 that are provided in the participant's home or community and that provide assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Residential habilitation services shall include access to residential habilitation services on a 24-hour basis.~~

(ii) ~~Residential habilitation training – Residential habilitation training~~

~~provides participant specific, individually designed and coordinated training in an individualized setting in the person's home, provider home, and community. Individuals receive skills training to increase independence related to their own health care, selfcare, safety, and access and use of community services. This service is intended for children birth through 20 years of age who reside in the home of their parents or extended family members, and for those individuals age 18-20 who reside in their own home or apartment. This service cannot be used in conjunction with residential habilitation or special family habilitation home services.~~

(iii) ~~Special family habilitation home services – Special family habilitation home consists of participant specific, individually designed and coordinated training within a family (other than biological or adoptive parents) host home environment. This service is intended for children birth through 20 years of age. The provider is the primary caregiver and assumes 24 hour care of the individual. This service cannot be used in conjunction with residential habilitation training services.~~

(yy) ~~"Homemaker." Services consisting of general household activities, including meal preparation and routine household care provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.~~

(zz) ~~"HHS." The United States Department of Health and Human Services, its agent, designee, or successor.~~

(aaa) ~~"ICF/MR." An intermediate care facility for people with mental retardation as defined in 42 U.S.C. § 1396d(d), which is incorporated by this reference.~~

(bbb) ~~"Individualized Budget Amount (IBA)." The Division's allocation of Medicaid waiver funds that may be available to a participant to meet his or her needs pursuant to Section 8 of this Chapter.~~

(ccc) ~~"Individual Plan of Care (IPC)." A written plan of care for a participant that describes the type and frequency of services to be provided to the participant regardless of the funding source and that identifies the provider or provider types that furnish the described services. The IPC shall reflect the services and actual units that providers are agreeing to provide over the plan year.~~

(ddd) ~~"Individual Plan of Care (IPC) team." A group of persons who are knowledgeable about the person and are qualified, collectively, to assist in developing an individual plan of care for that person. Membership of the team shall include the participant, the guardian if applicable, the individually-selected service coordinator, providers on the person's individual plan of care, an advocate if applicable, and any other person chosen by the participant or guardian, if applicable.~~

(eee) ~~"Individually-selected Service Coordinator (ISC)." An individual or entity that is qualified pursuant to Chapter 1, Rules for Individually-selected Service~~

~~Coordinators of the Rules of the Developmental Disabilities Division, to act as an individually-selected service coordinator, also known as case manager.~~

(fff) ~~"Informed choice." A decision made by a participant, or guardian if applicable, that is made voluntarily, without coercion or undue influence and that is based on sufficient experience and knowledge, including exposure, awareness, interactions, and/or instructional opportunities, to ensure that the choice is made with adequate awareness of all the available alternatives to and consequences of options available.~~

(ggg) ~~"Inventory for Client and Agency Planning (ICAP)." An instrument used by the Division to help determine eligibility and to determine the needs of the participant, available from Riverside Publishing, its successor, or designee.~~

(hhh) ~~"Institution." An Intermediate Care Facility for people with Mental Retardation (ICF/MR), nursing facility, hospital, prison, or jail.~~

(iii) ~~"LT-MR-104." A document, or its successor, completed by the individually-selected service coordinator that verifies that the participant or applicant meets the ICF/MR level of care.~~

(jjj) ~~"Mechanical restraint." 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.~~

(kkk) ~~"Medicaid." Medical assistance and services provided pursuant to Title XIX of the Social Security Act and/or the Wyoming Medical Assistance and Services Act. "Medicaid" includes any successor or replacement program enacted by Congress and/or the Wyoming Legislature.~~

(lll) ~~"Medicaid allowable payment." Medicaid reimbursement for covered services as determined pursuant to Section 18 of this Chapter.~~

(mmm) ~~"Medicaid Fraud Control Unit (MFCU)." The Medicaid Fraud Control Unit of the Wyoming Attorney General's Office, its agent, designee, or successor.~~

(nnn) ~~"Medical records." All documents, in whatever form, in the possession of or subject to the control of a provider, which describe the participant's diagnosis, condition or treatment, including, but not limited to, the individual plan of care.~~

(ooo) ~~"Medically necessary." A health service that is required to diagnose, treat, cure, or prevent an illness, injury, or disease which has been diagnosed or is reasonably suspected, to relieve pain or to improve and preserve health and be essential to life. The services must be:~~

(i) ~~Consistent with the diagnosis and treatment of the participant's condition.~~

(ii) ~~Recognized as the prevailing standard or current practice among the provider's peer group.~~

(iii) ~~Required to meet the medical needs of the participant and undertaken for reasons other than the convenience of the participant and the provider, and~~

(iv) ~~Provided in the most efficient manner and/or setting consistent with appropriate care required by the participant's condition.~~

(ppp) ~~"Medicare." The health insurance program for the aged and disabled established pursuant to Title XVIII of the Social Security Act.~~

(qqq) ~~"Medication administration." Medication physically given by someone other than a participant because the participant cannot take his or her own medications or administer treatments. Parents of a child on the Children's Developmental Disabilities Home and Community Based Waiver may give written authorization to a provider to administer medications to the child.~~

(rrr) ~~"Medication management training." Medication management training completed by a nurse, including instructing and assisting the participant in setting up medications.~~

(sss) ~~"Medication monitoring." Observation and documentation of participant's self-administration of medication by provider or provider staff for participants who do not require medication administration or medication management by a nurse.~~

(ttt) ~~"Mental retardation." A diagnosis as determined by a psychologist per the American Association on Mental Deficiency, *Classification in Mental Retardation* (Herbert J. Grossman ed., 8th ed. 1983).~~

(uuu) ~~"Modification to individual plan of care." A change to an individual plan of care pursuant to Section 9 of this Chapter. A modification may include the addition, substitution, or deletion of providers, covered services, or both. Modifications may increase or decrease the Medicaid waiver allowable payment.~~

(vvv) ~~"Objectives." Set of meaningful and measurable goals for the participant and the methods used to train the person on the goals.~~

(www) ~~"Overpayments." Overpayments as defined in Chapter 16 and Chapter 39.~~

(xxx) ~~"Participant." An individual who has been determined eligible for covered services on the Waiver.~~

(yyy) ~~"Personal care services." Services to assist a participant with the activities of daily living, including eating, bathing, dressing, and personal hygiene, and household activities.~~

(zzz) ~~"Personal restraint." The application of physical force or physical presence, without the use of any device, for the purposes of restraining the free movement of the body of the participant. The term personal restraint does not include briefly holding, without undue force, a participant 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.~~

(aaaa) ~~"Person-centered planning." A process, directed by a participant, that identifies the participant's strengths, capacities, preferences, needs, the services needed to meet the needs, and providers available to provide services. Person-centered planning allows a participant to exercise choice and control over the process of developing and implementing the individual plan of care.~~

(bbbb) ~~"Physician." A person licensed to practice medicine or osteopathy by the Wyoming Board of Medical Examiners or a similar agency in a different state.~~

(cccc) ~~"Power of Attorney." An instrument in writing whereby one person, as principal, appoints another as his agent and confers authority to perform certain specified acts or kinds of acts on behalf of principal (Black's Law Dictionary, Sixth Edition, 1990).~~

(dddd) ~~"Prior authorization." Prior authorization as defined in Chapter 3.~~

(eeee) ~~"Provider." A person or entity that is certified by the Division to furnish covered services and is currently enrolled as a Medicaid Waiver provider.~~

(ffff) ~~"Psychologist." A person licensed to practice psychology pursuant to W.S. § 33-27-113(a)(v).~~

(gggg) ~~"Related condition." A condition that results in a severe, chronic disability affecting an individual which manifests before he or she reaches age twenty-two and that is attributable to cerebral palsy, seizure disorder, or any condition other than mental illness that is closely related to mental retardation and that requires similar services, as determined by a licensed psychologist or physician.~~

(hhhh) ~~"Representative payee." A person or organization appointed by the Social Security Administration to manage Social Security, Veterans' Administration,~~

Railroad Retirement, Welfare Assistance, or other state or federal benefits or entitlement program payments on behalf of an individual who cannot manage or direct the management of his/her own money.

(iiii) "Respiratory therapist." A person licensed as a respiratory care practitioner by the Wyoming Board for Respiratory Care, or a person certified or registered with the American Respiratory Therapy Association.

(jjjj) "Respiratory therapy services." Respiratory therapy services which are:

(i) Prescribed by a physician.

(ii) Furnished directly by a respiratory therapist to a participant, and

(iii) For habilitation purposes.

(kkkk) "Respite" or "Respite services." Services provided:

(i) On a short-term basis pursuant to the individual plan of care.

(ii) To a participant who is unable, unassisted, to care for himself or herself, and

(iii) Because the participant's primary caregiver is absent or in need of relief from furnishing such services.

(llll) "Restraint." A personal restraint, mechanical restraint, or drug used as a restraint as defined in this section.

(mmmm) "Schedule." A personalized list of tasks or activities that describe a typical week for a participant. The schedule shall reflect the desires of the participant and shall include the service being provided, details on training on specific goals for habilitation services, level of supervision needed if specified in the individual plan of care, health and safety needs, activities, date, time in and time out for provision of services, provider signatures, and approximate number of hours in service.

(nnnn) "Seclusion." The involuntary confinement of a participant alone in a room or an area from which the participant is physically prevented from leaving. Providers seeking reimbursement for waiver services shall not use seclusion.

(oooo) "Services." Medical, habilitation, or other services, equipment, or supplies, appropriate to meet the needs of a participant.

(pppp) "Skilled nursing services." Services listed in the individual plans of care that are within the scope of the Wyoming Nurse Practice Act.

(qqqq) ~~"Specialized equipment." New or used devices, controls, or appliances that enable a participant to increase his or her ability to perform the activities of daily living or to perceive, control, or communicate with the environment in which the participant lives, pursuant to Chapter 44.~~

(rrrr) ~~"Third-party liability." Third-party liability pursuant to Chapter 35.~~

(ssss) ~~"Time out." The restriction of a participant for a reasonable period of time to a designated area from which the participant is not physically prevented from leaving, for the purpose of providing the participant an opportunity to regain self-control.~~

(tttt) ~~"Transition process." The process of changing from one provider of services to another, from one home and community based service to another, or from one residential location to another.~~

(uuuu) ~~"Waiting list." A list of persons who are eligible for covered services and who have submitted a completed application, but the services are unavailable because of limits imposed by funding or the waiver. The waiting list is maintained by the Division as specified in Section 13 of this Chapter.~~

(vvvv) ~~"Waiver." The Children's Developmental Disabilities Home and Community Based Waiver submitted to and approved by the Centers for Medicare and Medicaid Services pursuant to Section 1915(c) of the Social Security Act.~~

~~Section 5. 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, and which are included as Appendix A to this Chapter.~~

(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 6. Assessment and Eligibility.~~

(b) ~~Eligibility under this Chapter is limited to persons who complete the application process and who meet the following requirements for clinical eligibility and financial eligibility. In addition, in order to be eligible for the waiver, all persons shall be:~~

(i) ~~A United States Citizen as determined by the Department of Family Services.~~

(ii) ~~A resident of Wyoming as determined by the Department of Family Services.~~

(iii) ~~Under 21 years of age.~~

(c) ~~Clinical eligibility criteria. An applicant is considered clinically eligible if he or she has:~~

(i) ~~A diagnosis of mental retardation as determined by a psychologist, or~~

(ii) ~~A diagnosis of a related condition as determined by a physician and functional limitations verified by a psychologist, and~~

(iii) ~~An Inventory for Client and Agency Planning (ICAP) age adjusted services score equal to or less than 70, or~~

(iv) ~~An adaptive behavior quotient of 0.50 or below for children birth through age 5, or~~

(v) ~~An adaptive behavior quotient of 0.70 or below for individuals age 6 through age 20, and~~

(vi) ~~A completed LT-MR-104 that verifies that the participant or applicant meets the ICF/MR level of care.~~

(d) ~~Financial eligibility. Eligibility for covered services is limited to persons who meet the income and resource criteria set forth in the waiver and in the rules and policies of the Wyoming Medicaid program, as determined by the Department of Family Services.~~

(e) ~~Application process.~~

(i) ~~A completed application on a form required by the Division shall be submitted to the Division.~~

(A) ~~An application is valid for one year. After that time, if necessary documentation has not been received so that the Division can determine clinical eligibility, the applicant shall be required to re-apply.~~

(B) ~~Once an applicant has been determined to be clinically eligible and has been placed on a wait list, he/she does not need to re-apply.~~

(ii) ~~Selection of individually-selected service coordinator.~~

(A) ~~After an applicant requests services pursuant to this Chapter, the Division shall provide the applicant with a list of individually-selected service coordinators in the area(s) he or she wishes to receive services.~~

(B) ~~The applicant, family, or guardian shall select and meet with an individually-selected service coordinator from that list. Once both the applicant and the individually-selected service coordinator have agreed to work together, the individually-selected service coordinator shall notify the Division of that selection on a form designated by the Division.~~

(f) ~~Determination of clinical eligibility. A person shall not receive covered services unless that person is clinically eligible. The determination of a person's clinical eligibility shall be made as follows:~~

(i) ~~Psychological evaluation.~~

(A) ~~The applicant and the individually-selected service coordinator shall arrange for a psychological evaluation to determine whether the applicant has a diagnosis of mental retardation or a related condition.~~

(B) ~~If the applicant has a diagnosis of mental retardation or a related condition, he or she shall be further assessed pursuant to (ii)(B) of this Section to determine clinical eligibility.~~

(C) ~~The Division may obtain a second opinion on a~~

~~psychological evaluation from a contracted expert in order to confirm or deny that an applicant has a related condition.~~

(ii) ~~Inventory for Client and Agency Planning.~~

(A) ~~An individual who has a diagnosis of mental retardation or~~ related condition as determined by the psychological evaluation shall be assessed to determine his or her functional capacity.

(B) ~~Assessments shall be performed by a third party, under~~ contract to the Division, who is qualified to perform such assessments using the Inventory for Client and Agency Planning (ICAP).

(iii) ~~LT-MR-104. The individually-selected service coordinator shall~~ complete the LT-MR-104 that verifies that the participant or applicant meets the ICF/MR level of care.

(g) ~~Notification of determination of clinical eligibility.~~

(i) ~~The Division shall determine clinical eligibility within 60 calendar~~ days of receipt of the psychological assessment. If additional data or review is needed to determine eligibility, the Division shall notify the applicant in writing that the process will take an additional 30 calendar days.

(ii) ~~If the applicant does not have a diagnosis of mental retardation or~~ related condition, the applicant does not meet the clinical eligibility requirements.

(iii) ~~If an applicant does not meet the ICAP service score or adaptive~~ behavior quotient, the applicant does not meet the clinical eligibility requirements.

(iv) ~~If the applicant does not meet the ICF/MR level of care as~~ determined by the LT-MR-104, the applicant does not meet the clinical eligibility requirements.

(A) ~~If an applicant is determined not to meet clinical eligibility~~ criteria, the applicant or the applicant's legal guardian shall be notified in writing within 15 business days.

(B) ~~An applicant determined to not meet clinical eligibility requirements, may appeal the decision pursuant to Chapter 1.~~

(v) ~~If an applicant is determined to be clinically eligible, the applicant or applicant's legal representative will be notified in writing that:~~

(A) ~~There is a funding opportunity available, or~~

(B) ~~There is not a funding opportunity available but the applicant is placed on the Division's waiting list, as specified in Section 13 of this Chapter.~~

(vi) ~~Once an individual is notified that there is a funding opportunity available, financial eligibility shall be determined by the Department of Family Services.~~

(h) ~~Loss of eligibility.~~

(i) ~~A participant shall be determined to no longer be eligible when the participant:~~

(A) ~~Does not meet clinical eligibility when re-tested, or~~

(B) ~~Does not meet financial eligibility requirements as determined by the Department of Family Services, or~~

(C) ~~Changes residence to another state, or~~

(D) ~~Turns 21 years of age.~~

(ii) ~~Services to a participant determined to not meet clinical eligibility requirements shall be terminated no more than 45 days after the determination is made.~~

(A) ~~If an applicant is determined not to meet clinical eligibility criteria, the applicant or the applicant's legal guardian shall be notified in writing within 15 business days.~~

(B) ~~A participant determined to not meet eligibility requirements may appeal the decision pursuant to Chapter 1.~~

(iii) ~~A participant may be denied waiver placement and may be required to reapply when the participant:~~

(A) ~~Voluntarily does not receive waiver services or case management services, which includes a monthly home visit at the residence of the child, for three consecutive months.~~

(B) ~~Is in a nursing home, hospital, or residential treatment facility for six consecutive months.~~

(C) ~~Is in an out-of-state placement for six consecutive months.~~

(iv) ~~Upon written notification of the denial of waiver placement:~~

(A) ~~The participant may submit, in writing, reasons why he/she should still be considered eligible for the services.~~

(B) ~~This request shall be reviewed by the Waiver Manager and the Division Administrator.~~

(v) ~~If the participant is determined not to be eligible for services due to one of the criteria in (iii) of this section, the participant or the participant's legal guardian shall be notified in writing within 15 business days.~~

(A) ~~The participant may appeal the decision pursuant to Chapter 1.~~

~~Section 7. Covered Services, Service Requirements and Restrictions.~~

~~(a) The services listed in this section are covered services if they are functionally necessary and part of a current individual plan of care approved by the Division.~~

~~(i) Case management services.~~

(A) ~~Case management is a stand-alone service. A participant (or guardian, if applicable) may choose any individually-selected service coordination provider, and shall not be expected or required to receive any other service from that provider.~~

(B) ~~Individually-selected service coordinators shall be required~~ to provide a minimum of 60 minutes per calendar month of person-to-person contact with the participant or guardian.

(I) ~~This may include face-to-face meetings and telephone conversations between the individually-selected service coordinator, the participant, and/or the guardian.~~

(II) ~~Individually-selected service coordinators shall be required to complete one monthly visit to participant in his or her home.~~

~~(C) Individually-selected service coordinators shall schedule and facilitate six month review team meetings and annual individual plan of care meetings, including:~~

(I) ~~Notifying all individual plan of care team members of the scheduling of the meetings at least 30 days in advance unless a shorter notification time is approved by the Division.~~

(II) ~~Notifying the Division in writing of the scheduling of the meetings at least 30 days in advance unless a shorter notification time is approved by the Division.~~

(III) ~~Following Division requirements for facilitating team meetings; and for documenting minutes of the team meetings in the form and manner prescribed by the Division in provider manuals and bulletins issued by the Division.~~

~~(D) Individually-selected service coordinators shall facilitate other team meetings when requested by the participant, guardian, member of the team, or the Division.~~

~~(ii) Dietician.~~

(A) ~~Dietician services shall be supported by a formal assessment completed by a registered dietician.~~

(B) ~~Providers of dietician services may seek Medicaid~~

~~reimbursement for providing such services to a group of up to three participants at a time.~~

~~(iii) Environmental modification.~~

~~(A) Environmental modifications shall be approved pursuant to Chapter 44.~~

~~(iv) Habilitation services.~~

~~(A) For all habilitation services:~~

~~(I) Participants shall be in attendance in service areas in order for providers to bill for services.~~

~~(II) Purposes of the habilitation service codes shall be met, including assisting participants in acquiring, retaining, and improving the self-help, socialization, adaptive, and safety skills necessary to reside successfully in home and community-based settings.~~

~~(III) Habilitation providers shall work with participant on objectives as stipulated in the individual plan of care and document the results in the form and manner established by the individual plan of care team.~~

~~(IV) Reimbursement for habilitation services shall not be made directly or indirectly to a parent, stepparent, spouse, or guardian of a participant.~~

~~(B) For residential habilitation services.~~

~~(I) Residential habilitation services may be provided for participants who are 18 through 20 years old.~~

~~(II) Habilitation rates shall include personal care and respite services, except in the cases listed under (III) of this section.~~

~~(III) Residential habilitation and respite services may appear on the same individual plan of care when:~~

~~(a) The participant is transitioning into a residential setting such as a group home, or~~

~~(b) Unpaid caregivers need respite when the participant spends time at home visiting on weekends or vacations, or~~

~~(c) When residential habilitation providers who~~

~~are not required to obtain and maintain CARF accreditation pursuant to Chapter 45 require respite for vacations, sick days, or other emergencies. In these cases, a maximum of 1,344 units of respite shall be allowed during a plan year.~~

~~(IV) Habilitation rates for each participant shall include the cost for routine transportation when it is provided by the provider regardless of the number of trips.~~

~~(V) Residential habilitation services shall not be provided in residential settings other than the home of the participant or the community.~~

~~(VI) Residential habilitation services and residential habilitation training services shall not appear on the same individual plan of care unless the participant is transitioning into a residential setting such as a group home.~~

~~(C) For special family habilitation home services.~~

~~(I) Special family habilitation home services may be provided for participants who are birth through 20 years old.~~

~~(II) Special family habilitation home services and respite services may be on the same plan and may be billed for the same day.~~

~~(D) For residential habilitation training services.~~

~~(I) Providers of residential habilitation training services shall not seek reimbursement for providing any services to more than one participant at the same time unless approved in advance by the Division.~~

~~(II) Residential habilitation training services shall not be reimbursed for persons receiving special family habilitation home services.~~

~~(III) Residential habilitation training services shall be provided in the participant's home, provider home, or in the community.~~

~~(v) Homemaker Services.~~

~~(A) Providers of homemaker services shall provide a maximum of three hours of homemaker services per week per participant, unless more hours are approved by the Division.~~

~~(B) Providers of homemaker services shall not be responsible for supervision of a participant while completing homemaker services.~~

(C) ~~The Division shall not approve homemaker services that are provided in residential habilitation settings except for homemaker services provided to special family habilitation home providers and residential habilitation providers who are not required to obtain and maintain CARF accreditation pursuant to Chapter 45.~~

(vi) ~~Personal care services.~~

(A) ~~The participant shall be present when personal care services are provided.~~

(B) ~~Personal care services may include the preparation of meals, exclusive of the cost of the meals.~~

(C) ~~When specified in the individual plan of care, personal care services may also include such housekeeping chores as bed making, dusting, and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the participant, rather than that individual's family.~~

(D) ~~Personal care providers may include members of the family of the participant, except that Medicaid shall not reimburse a parent or a spouse for providing such services to the child or the other spouse.~~

(E) ~~Providers certified to provide personal care services who are family members of the participant shall meet the same standards as providers certified to provide personal care services who are unrelated to the participant.~~

(F) ~~Providers of personal care services shall not seek Medicaid reimbursement for providing such services to more than one participant at a time.~~

(vii) ~~Respiratory therapy.~~

(A) ~~Reimbursement for respiratory therapy services shall require a treatment letter or recommendation plus a physician's order.~~

(viii) ~~Respite services.~~

~~(A) Respite services shall be covered if provided in one of the following locations:~~

~~(I) The residence of the participant.~~

~~(II) A foster home.~~

~~(III) A group home.~~

~~(IV) Certified provider location, or~~

~~(V) The community, including parks, stores, and recreation centers.~~

~~(B) A respite service provider or provider staff providing respite services:~~

~~(I) Shall serve no more than two participants at a given time, unless approved by the Division.~~

~~(II) May also provide supervision to other children under the age of 12 or other individuals requiring support and supervision, and~~

~~(III) Shall limit the total combined number of persons in (I) and (II) to no more than three persons, unless approved by the Division.~~

~~(C) Respite services shall not take the place of residential or day habilitation services.~~

~~(D) Respite services shall accommodate each family's living routine.~~

~~(E) Respite services shall accommodate the needs of the participant.~~

~~(F) The respite site and services shall be matched to the identified needs of each participant and family.~~

~~(G) A respite provider shall not provide respite services to adults and children at the same time except to participants who are 18 to 20 years of age who may receive respite services with adults. In exceptional cases, such as when participants are members of the same family, respite may be provided to adults and children at the same time with Division approval.~~

~~(H) A child shall not receive respite during the designated~~

~~school hours, unless such services are provided due to illness of the child limiting school attendance.~~

(I) ~~Respite services shall not exceed 7,280 units per year unless more are approved by the Division.~~

(ix) ~~Skilled nursing.~~

(A) ~~Shall be prescribed by a physician.~~

(B) ~~May include preventative and rehabilitative procedures.~~

(C) ~~Shall be listed on a form required by the Division and identified in the individual plan of care.~~

(D) ~~Shall involve direct patient care.~~

(x) ~~Specialized equipment.~~

(A) ~~Shall be provided pursuant to Chapter 44.~~

(b) ~~Services otherwise covered by Medicaid, EPSDT, or the Department of Education shall not be covered services under this Chapter.~~

(c) ~~Extended state plan services shall be funded to the maximum allowable amount under the state plan before these services are paid for under the waiver.~~

(d) ~~Parents, step parents, and/or spouses shall not be reimbursed by waiver funding for any waiver services.~~

~~Section 8. The Individualized Budget Amount.~~

(a) ~~Eligibility shall be determined pursuant to Section 6 of this Chapter before an individualized budget amount is determined.~~

(b) ~~Determination of the targeted individualized budget amount.~~

~~(i) The Division's methodology to determine the amount of Medicaid waiver funds that shall be available to a participant to meet his or her needs shall include the following factors:~~

(A) ~~The services the participant has received in the past or that are determined by projected services.~~

(B) ~~Participant characteristics, including the participant's needs, as measured on the Inventory for Client and Agency Planning, and~~

(C) ~~Economic factors, such as the cost of receiving services in different geographical areas or where the participant resides.~~

~~(ii) Using specific participant factors, the methodology shall correlate a participant's characteristics with the participant's individualized budget amount, so that the participants with higher needs are assigned a higher individualized budget amount, and vice versa.~~

~~(c) Redetermination of the individualized budget amount.~~

(i) ~~The Division or the individual plan of care team may request a new Inventory for Client and Agency Planning or psychological assessment to determine if the characteristics or needs of the participant have changed and if a new individualized budget amount may be assigned.~~

(A) ~~The Division may request a new Inventory for Client and Agency Planning or psychological assessment at any time.~~

(B) ~~If the individual plan of care team requests a new Inventory for Client and Agency Planning or psychological assessment, the Division shall review the request and decide whether a new Inventory for Client and Agency Planning or psychological assessment will be approved.~~

(C) ~~If the new Inventory for Client and Agency Planning or psychological assessment results in a change in the individualized budget amount determination, a change in the individualized budget amount shall be approved or denied in accordance with the procedure described in paragraph (b) of this section.~~

(ii) ~~If the individualized budget amount does not meet the characteristics and needs of an individual, the Extraordinary Care Committee may approve a new individualized budget amount as a long-term increase, pursuant to Section 12 of this Chapter. This will be re-evaluated at least every five years.~~

(iii) ~~At least once every two years, the Division shall update the targeted individualized budget amount model using the most current Inventory for Client and Agency Planning data, current services, and current funding information.~~

(d) ~~If funds for covered services become, or are projected to become limited or unavailable, the Division may modify participants' individualized budget amounts as necessary to bring projected expenditures in line with projected funding, recognizing that services shall be altered accordingly.~~

(e) ~~If funding for covered services is, or is projected to be reduced below the level required to pay for all approved individualized budget amounts, or is eliminated, the Division shall have the discretion to modify participants' individualized budget amounts in order to bring projected expenditures for covered services within the projected available funding.~~

(f) ~~If the waiver is modified or eliminated, the Division shall have the discretion to modify the individualized budget amounts in order to bring projected expenditures for covered services within projected available funding.~~

(g) ~~Reinstatement of services. If additional funding becomes available, services that were reduced or eliminated shall be reinstated based on individual needs to the extent of the available funds. There shall be no requirement for the Division to disperse all available funds without a demonstrated need as described in these rules.~~

~~Section 9.~~ Development and Approval of the Individual Plan of Care.

(b) ~~Development of the individual plan of care.~~

(i) ~~After the targeted individualized budget amount is identified by the Division, the individual plan of care team, coordinated by the individually-selected service coordinator, shall assist the participant in determining the use of the targeted individualized budget amount in developing the individual plan of care.~~

(ii) ~~The individual plan of care shall be completed in the form and manner prescribed by the Division in accordance with Section 23 of Chapter 1, Rules for Individually-selected Service Coordinators of the Rules of the Developmental Disabilities Division.~~

(iii) ~~The individually selected service coordinator shall develop the individual plan of care that includes:~~

(A) ~~A completed pre-approval page signed by the participant or guardian and the individually-selected service coordinator.~~

(B) ~~Freedom of Choice Document or its successor.~~

(C) ~~LT-MR-104 form or its successor.~~

(D) ~~Medical report signed by a physician if the participant is eligible due to a diagnosis of a related condition. The medical report shall discuss the diagnosis and what the recommended treatments or services may be.~~

(E) ~~Psychological report that is no more than 5 years old and signed by a psychologist.~~

(I) ~~The psychological report shall specify a clinical diagnosis of mental retardation or a related condition.~~

(II) ~~The psychological report shall provide recommendations that the individual plan of care team shall review and address through the individual plan of care.~~

(F) ~~ICAP report that is no more than 5 years old.~~

(G) ~~Objective pages as required by the Division for each habilitation service. The individually-selected service coordinator is responsible for ensuring that objective pages are completed. The objectives shall:~~

(I) ~~Define the training activities of an individual and the methods used to train the activity.~~

(II) ~~Be measurable and meaningful to the participant.~~

(III) ~~Be reflected on the personal schedule.~~

(H) ~~Identification of rights and rights restrictions in accordance with Appendix A of this Chapter, including the use of restraints as defined in Section 4 of this Chapter, including:~~

(I) ~~Why the restriction is imposed.~~

(II) ~~How the restriction is imposed.~~

(III) ~~The plan to restore the right being restricted.~~

(IV) ~~Signature of the participant and/or guardian.~~

(V) ~~Rights restrictions shall be reviewed at least every six months by the individual plan of care team.~~

(VI) ~~Rights restrictions that occur that are not part of the individual plan of care shall be reported to the Division on a form designated by the Division.~~

(I) ~~Skilled nursing information on the form required by the Division that includes all areas of skilled nursing required by the participant.~~

(J) ~~Medication administration indicating the level of medication administration or monitoring required for the participant. Levels of support include:~~

(I) ~~Medication administration.~~

(II) ~~Medication management training.~~

(III) ~~Medication monitoring.~~

(IV) ~~Ability to self-medicate with no assistance.~~

(K) ~~A behavior support plan, if applicable, that reflects and addresses maladaptive behaviors identified by the individual plan of care team, the psychological evaluations, and the Inventory for Client and Agency Planning, including maladaptive behaviors listed as moderate or above pursuant to Section 30 of Chapter 45.~~

(L) ~~Schedules for habilitation, personal care, and respite services. The purpose of the schedule shall be to provide information about the services and supports needed throughout a participant's day and justify the rates for services. Schedules shall be personalized and shall:~~

(I) ~~Reflect the purpose of the services.~~

(II) ~~Reflect recommendations from therapists, physicians, psychologists, and other professionals.~~

(III) ~~Reflect the participant's desires and goals.~~

(IV) ~~Include all information required by Chapter 45.~~

(c) ~~Approval of the individual plan of care.~~

(i) ~~The individually-selected service coordinator shall submit the individual plan of care to the Division with the Division's current technical checklist.~~

(ii) ~~The Division shall have 20 calendar days to review and approve an individual plan of care contingent upon the individually-selected service coordinator submitting all the requested information to the Division.~~

(iii) ~~The Division shall approve or make recommendations to modify the plan. This may result in an adjustment to the individualized budget amount.~~

(iv) ~~Upon approval and prior to implementation of the plan, the individually-selected service coordinator shall distribute copies of the individual plan of care to the participant, the guardian, advocates, or representatives designated by the participant or guardian, and to habilitation, respite, personal care, and therapy providers on the individual plan of care in accordance with applicable privacy and confidentiality law and regulation.~~

(v) ~~All other providers shall be given information from the individual plan of care pertinent to the provision of services.~~

(vi) ~~All services shall be provided pursuant to the individual plan of care.~~

(vii) ~~Medicaid reimbursement shall be limited to the covered services and the providers specified in the individual plan of care on the pre-approval form signed by the Division.~~

(viii) ~~The Division shall not reimburse for services in excess of those specified in an approved individual plan of care or to providers not so specified.~~

(ix) ~~The Division shall not approve an individual plan of care nor reimburse for services provided to a participant before clinical eligibility has been established pursuant to Section 6 of this Chapter.~~

(x) ~~Any provider who submits a claim for payment for services that have been approved but not yet provided to the participant shall be subject to the requirements of Chapter 16 and Chapter 39 including any available sanctions.~~

(xi) ~~The Division shall review and approve individual plans of care at least annually or more frequently at the option of the Division.~~

(d) ~~Modification of individual plan of care requiring approval of the Division.~~

(i) ~~Modifications to the pre-approval page of the individual plan of care shall be submitted for approval to the Division when there is a change in service rates, a change in service units, or a change in providers.~~

(ii) ~~If the change does not require an increase in the individualized budget amount, the Division shall approve, deny, or make recommendations to modify the plan.~~

(iii) ~~If the change requires an increase in the individualized budget amount, the modification to the plan shall be due to an emergency, a material change in circumstance, a potential emergency, or other condition justifying an increase in funding and the modification shall be reviewed by the Extraordinary Care Committee in accordance with Section 12 of this Chapter.~~

(iv) ~~The Division shall have 7 calendar days to review and approve modifications to the pre-approval page of the individual plan of care contingent upon the individually-selected service coordinator submitting all the requested information to the Division.~~

(v) ~~The effective date of the modification shall be the date indicated on the pre-approval page by the signature of a Division representative.~~

(vi) ~~When the level or intensity of services is permanently decreased,~~

~~modifications to the individual plan of care shall be submitted for approval to the Division. The rates on the modification shall reflect the decrease in need of services. The decrease in services may include but is not limited to decreases in staffing levels or decreases in total hours of service provided in a day.~~

~~(e) Modifications to the individual plan of care that do not require Division approval.~~

~~(i) The individual plan of care shall be updated by the individually-~~
~~selected service coordinator whenever there are significant changes to the participant's needs, including:~~

~~(A) Changes in health and safety needs.~~

~~(B) Changes in employment status.~~

~~(C) Changes in medication.~~

~~(D) Changes in adaptive equipment.~~

~~(E) Changes in diagnoses.~~

~~(F) Changes in mealtime needs.~~

~~(G) These changes do not need to be submitted to the Division~~
~~unless the changes result in a change listed in (c) of this Section.~~

~~(f) Participant no longer receiving waiver services.~~

~~(i) The individually-selected service coordinator shall submit a~~
~~modification ending the plan within 45 calendar days of the last date of service.~~

~~Section 10. Reassessments. A participant shall be reassessed for clinical eligibility at least every five years, and more frequently at the option of the Division. The reassessment shall include a review of the Inventory for Client and Agency Planning and the psychological evaluation.~~

~~Section 11. Transitions.~~

~~(a) Participants and/or guardians shall have the right to informed choice in providers and services.~~

(b) ~~Participants and/or guardians may choose to change individually-selected service coordinators pursuant to Chapter 1, Rules for Individually-selected Service Coordinators of the Rules of the Developmental Disabilities Division.~~

(c) ~~Participants may choose to change any providers, other than individuallyselected service coordinators, anytime during the plan year pursuant to Chapter 45, Section 11.~~

(d) ~~Applicants for the waiver may change individually-selected service coordinators at any time during the application process.~~

(e) ~~When a participant or guardian chooses to change providers, they shall inform the individually-selected service coordinator of the decision. The individuallyselected service coordinator shall then complete the required steps pursuant to Chapter 45, Section 11.~~

(f) ~~If a provider providing residential services to a participant requires a participant to move to another residential location, the provider and participant's individually selected service coordinator shall complete the required steps pursuant to Chapter 45, Section 11.~~

(g) ~~Providers who are terminating services with a participant shall notify the participant/guardian in writing at least 30 days prior to ending services unless a shorter transition period is approved in advance by the Division. Failure to provide services during this 30 day period shall be considered abandonment of services and may result in decertification of the provider.~~

~~Section 12. Extraordinary Care Committee.~~

~~(a) The Extraordinary Care Committee has the following authority:~~

(i) ~~Determining if a funding request for an emergency case or an emergency referral shall be funded.~~

(ii) ~~Determining if a funding request due to a material change in circumstance, a potential emergency, or other condition justifying an increase in funding shall be funded.~~

(iii) ~~Approving or rejecting rates for services that are not commensurate with the average rates as defined in the Children's DD Waiver Document approved by the Centers for Medicare and Medicaid Services.~~

(iv) ~~Approving rate changes due to increased or decreased funding from Legislative Appropriations or under utilization of approved individualized budgeted amounts.~~

(b) ~~The Extraordinary Care Committee shall review the requests to determine if the request meets criteria, has necessary documentation, and if funding is available.~~

(c) ~~The Extraordinary Care Committee shall make the following determinations:~~

(i) ~~Request further information.~~

(ii) ~~Approve the request for one year or less.~~

(iii) ~~Approve the request as a long term individually budgeted amount pursuant to Section 8 (c)(ii).~~

(iv) ~~Deny the request.~~

(d) ~~The individually-selected service coordinators shall present funding requests due to a material change in circumstance, a potential emergency, or other conditions justifying an increase in funding to the Extraordinary Care Committee by conference call, compressed video, or physical presence. The individually-selected service coordinators shall have previously sent written documentation to their waiver specialist of the emergency criteria, material change in circumstance, or other conditions required for the case.~~

(e) ~~Membership of the Extraordinary Care Committee shall include a representative of the Division, a representative of the State Medicaid Program and a representative of the Department's Fiscal Office.~~

(f) ~~Decisions of the Extraordinary Care Committee shall be by majority and shall be rendered in writing.~~

~~(i) The Division shall notify the individually-selected service coordinator of the decision in writing within 10 business days of the decision.~~

~~Section 13. Waiting List Process.~~

(a) ~~Waiting List. When there is insufficient funding to add additional participants, the Division shall maintain one waiting list for the Children's Developmental Disabilities Home and Community Based Waiver as specified below.~~

(b) ~~Factors. The Division shall assign two rankings to each person on the waiting list based on the following two factors:~~

(i) ~~The severity of the person's condition based on the Adaptive Behavior Quotient of the Inventory for Client and Agency Planning.~~

(ii) ~~The person's placement date on the waiting list.~~

(c) ~~When covered services become available, the Division shall alternate between the two factors listed in (b) of this section, beginning with the waiting list based on severity, in selecting the next person to whom covered services shall be provided. Before being added to the waiting list, the person shall be otherwise eligible as determined in Section 6 of this Chapter.~~

(d) ~~In cases when the severity levels are the same or when the placement date on the waiting list is the same, the Division shall use the date that the Selection of Individually-selected Service Coordinator form was received by the Division to determine which name goes first on the waiting list.~~

(e) ~~The Division shall determine the availability of funding for the approved individualized budget amounts for applicants on the waiting lists waiting for funding opportunities.~~

(f) ~~The Extraordinary Care Committee shall review information on an applicant who meets the eligibility requirements in Section 6 of this Chapter and who is potentially an emergency referral to determine if he/she shall be funded as an emergency as specified in Section 14 of this Chapter.~~

~~Section 14. Emergency Services.~~

~~(a) The emergency criteria used by the Division includes:~~

~~(i) A substantial threat to a person's life or health caused by:~~

~~(A) The loss of the person's primary caregiver.~~

~~(B) Homelessness.~~

~~(C) Abuse or neglect that is either substantiated by the Wyoming Department of Family Services, or corroborated by the Division or Protection and Advocacy of Wyoming.~~

~~(ii) Situations where the person's condition poses a substantial threat to a person's life or health and is documented, in writing, by a physician.~~

~~(iii) Situations where a person:~~

~~(A) Has caused serious physical harm to the person or~~

~~someone else, or a person whose condition presents a substantial risk of physical threat to the person or others, and~~

~~(B) The harm or threat of harm is verified, in writing, by a psychologist or a psychiatrist, and~~

~~(C) The use of covered services would be an appropriate response to the person's condition, and~~

~~(D) Other resources to provide appropriate services are not available.~~

~~(b) Identification of emergency referrals and emergency cases.~~

~~(i) Any person may request that the Division consider whether an individual has an emergency.~~

~~(ii) The Division may identify persons on the waiting lists who have an emergency.~~

~~(c) Once a potential emergency case or emergency referral has been identified:~~

~~(i) The individually-selected service coordinator shall submit in the form specified by the Division specific information on the potential emergency. The information shall include:~~

~~(A) Description of the factors or condition that have created an emergency and their expected duration.~~

~~(B) Description of the covered services that are functionally necessary.~~

~~(C) Copies of incident reports, physician reports, assessments, or other documentation that relate to the factors or conditions that have created an emergency.~~

~~(D) A detailed plan of how the funds shall be spent, the expected outcome, and how the results shall be monitored with respect to the funds.~~

~~(ii) For emergency referrals, determination of eligibility as defined in Section 6 of this Chapter, shall be completed within 14 calendar days after receipt of the Inventory for Client and Agency Planning and the psychological assessment.~~

(d) ~~The Extraordinary Care Committee shall review specific information on the potential emergency referral or emergency case to determine if the case meets the emergency criteria as defined in (a) of this section. Such persons shall receive covered services, subject to available funding.~~

(e) ~~An emergency plan may be submitted to the Division by the participant's individually-selected service coordinator to cover services until the complete individual plan of care is submitted and approved by the Division.~~

(i) ~~The emergency plan shall include significant health and safety information and shall be approved by the Division in order for services to be reimbursed.~~

(ii) ~~The Division shall have 3 business days to review and approve the plan.~~

(g) ~~In no event shall the Division be required to provide or fund covered services in the absence of available funding or in the absence of clinical and financial eligibility.~~

~~Section 15. Provider Participation.~~

(a) ~~Payments only to providers. No person or entity that furnishes covered services to a participant shall receive Medicaid funds unless the person or entity has signed a provider agreement, is enrolled, and is certified by the Division as a provider at the time of service delivery.~~

(b) ~~Compliance with Chapter 3, Provider Participation, of the Wyoming Medicaid Rules. A provider that wishes to receive Medicaid reimbursement for services furnished to a participant shall meet the provider participation requirements of Chapter 3, Provider Participation, of the Wyoming Medicaid Rules, Sections 4 through 6, which are incorporated by this reference.~~

(c) ~~Compliance with Chapter 45, Provider Certification and Sanctions, of the Wyoming Medicaid Rules. A provider that wishes to provide Waiver services shall also meet the applicable criteria for Division certification set forth in Chapter 45, which is incorporated by this reference.~~

~~Section 16. Provider Records.~~

(a) ~~A provider shall comply with Chapter 3, Provider Participation, of the Wyoming Medicaid Rules, Section 7, which is incorporated by this reference.~~

(b) ~~Individually-selected service coordinators shall maintain copies of documentation from other providers for a twelve month period.~~

(c) For documentation of case management services, individually-selected service coordinators shall comply with Chapter 3, Section 7, which is incorporated by this reference.

Section 17. Verification of Participant Data. A provider shall comply with Chapter 3, Section 8, which is incorporated by this reference.

Section 18. Medicaid Waiver Allowable Payment. Medicaid payments shall be pursuant to and limited to each approved individual plan of care.

Section 19. Excluded Services.

(a) Services not covered under the waiver include:

(i) Services furnished to a participant while in an institution.

(ii) Room and board of participant, which are the responsibility of the participant or representative payee.

(iii) Room and board expenses of a live-in personal caregiver or provider.

Section 20. Third-party Liability.

(a) Submission of claims. Claims for which third-party liability exists shall be submitted in accordance with Chapter 35.

(b) Medicaid payment. The Medicaid payment for a claim for which third party liability exists shall be the difference between the Medicaid allowable payment and the third party payment. In no case shall the Medicaid payment exceed the payment otherwise allowable pursuant to this Chapter.

Section 21. Submission and Payment of Claims. The submission and payment of claims shall be pursuant to the provisions of Chapter 3.

Section 22. Recovery of Excess Payments or Overpayments.

(a) The Department may recover excess payments pursuant to Chapter 39.

(b) The Department may recover overpayments pursuant to Chapter 16.

Section 23. Audits.

(a) ~~The Division or the Centers for Medicare and Medicaid Services may audit a provider's financial records, medical records, or employment records, at any time to determine whether the provider has received excess payments or overpayments.~~

(b) ~~The Division or the Centers for Medicare and Medicaid Services may perform audits through employees, agents, or through a third party. Audits shall be performed in accordance with generally accepted auditing standards.~~

(c) ~~Disallowance. The Division shall recover excess payments or overpayments pursuant to Section 22 of this Chapter.~~

(d) ~~Reporting audit results. If at anytime during a financial audit or a medical audit, the Division discovers evidence suggesting fraud or abuse by a provider, that evidence, in addition to the Division's final audit report regarding that provider, shall be referred to the Medicaid Fraud Control Unit.~~

(e) ~~The Division shall share the results of the audit with the provider before excess payments or overpayments are recovered. However, nothing in this section shall abrogate the rights of the State to recover excess payments or overpayments in accordance with Chapter 16 or Chapter 39.~~

~~Section 24 Reconsideration. A provider may request that the Department reconsider a decision to recover excess payments or overpayments. The request for reconsideration, the reconsideration, and any administrative hearing shall be pursuant to the reconsideration provisions of Chapter 3, Chapter 16, or Chapter 39 as applicable.~~

~~Section 25. Disposition of Recovered Funds. The Department shall dispose of recovered funds pursuant to the provisions of Chapter 16.~~

~~Section 26. 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 27. 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, except Chapter 1, Rules for Individually-selected Service Coordinators of the Rules of the Developmental Disabilities Division, which remains in effect.~~

~~Section 28. Severability. If any portion of this Chapter is found to be invalid or unenforceable, the remainder shall continue in full force and effect.~~

CHAPTER 43

ACQUIRED BRAIN INJURY
HOME AND COMMUNITY BASED WAIVER

[This chapter is repealed.]

WYOMING MEDICAID RULES

CHAPTER 43

ACQUIRED BRAIN INJURY
HOME AND COMMUNITY BASED WAIVER

[This chapter is repealed.]

~~Section 1. Authority.~~

~~This Chapter is promulgated by the Department of Health pursuant to the Medical Assistance and Services Act at W.S. 42-4-101 et seq. and the Wyoming Administrative Procedures Act at W. S. 16-3-101 et seq.~~

~~Section 2. Purpose and Applicability.~~

~~(a) This Chapter shall apply to and govern Medicaid services provided under the Wyoming Medicaid Acquired Brain Injury Home and Community Based Waiver on or after June 1, 2006.~~

~~(b) The provisions contained in this Chapter shall be subordinate to the provisions in the Wyoming Medicaid Acquired Brain Injury Home and Community Based Waiver submitted to Centers for Medicare and Medicaid Services pursuant to Section 1915(c) of the Social Security Act codified as 42 U.S.C. § 1396n.~~

~~(c) The Division may issue Provider Manuals, Provider Bulletins, or both, to providers and/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 or Provider Bulletins shall be subordinate to the provisions of this Chapter.~~

~~Section 3. General Provisions.~~

~~(a) Terminology. Except as otherwise specified, the terminology used in this Chapter is the standard terminology and has the standard meaning used in accounting, health care, Medicaid and Medicare.~~

~~(b) Methodology. This Chapter establishes a person-centered methodology that is designed to match the needs of a participant with the services appropriate to meet those needs. Accordingly, participants with higher needs shall be assigned higher budget amounts that will allow them to select and access the services appropriate for their needs. By contrast, participants with lower needs shall be assigned lower budget amounts that will allow them to select and access the services they need.~~

~~(c) This Chapter is intended to be read in conjunction with the Wyoming Acquired Brain Injury Home and Community Based Waiver submitted to Centers for Medicare and Medicaid Services pursuant to Section 1915(c) of the Social Security Act,~~

Chapter 44, Rules for Environmental Modifications and Specialized Equipment of the Medicaid Rules, Chapter 45, Provider Standards and Certification of the Medicaid Rules, and Chapter 1, Rules for Individually-selected Service Coordinators of the Rules of the Developmental Disabilities Division.

(d) Unless otherwise specified, the incorporation by reference of any external standard is intended to be the incorporation of that standard as it is in effect on the effective date of this Chapter, including any applicable amendments, corrections, or revisions, but excluding any subsequent amendments or changes.

Section 4. Definitions.

The following definitions shall apply in the interpretation and enforcement of these rules. Where the contexts in which words are used in these rules indicate that such is the intent, words in the singular number shall include the plural and vice versa. Throughout these rules gender pronouns are used interchangeably. The drafters have attempted to utilize each gender pronoun in equal numbers, in random distribution. Words in each gender include individuals of the other gender.

(a) "Acquired brain injury."

(i) Any combination of focal and diffuse central nervous system dysfunction, both immediate and/or delayed, at the brain stem level and above.

(ii) These dysfunctions are acquired through the interaction of any external forces and the body, oxygen deprivation, infection, toxicity, surgery and vascular disorders not associated with aging.

(iii) It is an injury to the brain that has occurred since birth.

(iv) It may have been caused by an external physical force or by a metabolic disorder(s).

(v) It includes traumatic brain injuries such as open or closed head injuries and non-traumatic brain injuries such as those caused by strokes, tumors, infectious disease, hypoxic injuries, metabolic disorders and toxic products taken into the body through inhalation or ingestion.

(vi) It does not include brain injuries that are congenital or brain injuries induced by birth trauma.

(vii) These dysfunctions are not developmental or degenerative.

(b) "Acquired Brain Injury Home and Community Based Waiver." The Acquired Brain Injury Home and Community Based Waiver submitted to and approved by the Centers for Medicare and Medicaid Services pursuant to Section 1915(c) of the Social Security Act.

(c) "Advocate." A person, chosen by the participant or legal guardian, who supports and represents the rights and interests of the participant in order to ensure the participant's full legal rights and access to services. The advocate can be a friend, a relative, or any other interested person. An advocate has no legal authority to make decisions on behalf of a participant.

(d) "Adult." A person twenty-one years of age or older for purposes of the Acquired Brain Injury Home and Community Based Waiver.

(e) "Applicant." An individual who is requesting services.

(f) "Application." A written statement, in the form specified by the Division, which is submitted to the Division, in which an individual indicates that he or she is interested in receiving covered services. An application may be submitted by one person on behalf of another but shall have the legal guardian's signature if applicable.

(g) "Assessment." A determination, pursuant to Section 6 of this Chapter, of an individual's functional capacity and needs.

(h) "Behavior support plan." A written plan that is developed based on a functional assessment of behaviors that negatively impact a person's ability to acquire, retain and/or improve the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings, and that contains multiple intervention strategies designed to modify the environment and teach new skills.

(i) "Caregiver." A person who provides services to a participant.

(j) "Case Management." Services that assist participants in gaining access to needed waiver and other Wyoming Medicaid State plan services, as well as needed medical, social, educational, and other services, regardless of the funding source for the services to which access is gained. Case management services are provided by individually-selected service coordinators, whose responsibilities include ongoing monitoring of the provision of services included in the individual plan of care, and initiating and overseeing the process of assessment and reassessment of the participant's level of care and review of the individual plan of care.

(k) "Centers for Medicare and Medicaid Services (CMS)." The Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services, its agent, designee or successor.

(l) "Chapter 1." Chapter 1, Rules for Medicaid Administrative Hearings, of the Wyoming Medicaid Rules.

(m) "Chapter 3." Chapter 3, Provider Participation, of the Wyoming Medicaid Rules.

(n) "Chapter 16." Chapter 16, Medicaid Program Integrity, of the Wyoming Medicaid Rules.

(o) "Chapter 26." Chapter 26, Medicaid Covered Services, of the Wyoming Medicaid Rules.

(p) "Chapter 35." Chapter 35, Medicaid Benefit Recovery, of the Wyoming Medicaid Rules.

(q) "Chapter 39." Chapter 39, Recovery of Excess Payments, of the Wyoming Medicaid Rules.

(r) "Chapter 41." Chapter 41, DD Adult Waiver Services, of the Wyoming Medicaid Rules.

(s) "Chapter 42." Chapter 42, DD Child Waiver Services, of the Wyoming Medicaid Rules.

(t) "Chapter 44." Chapter 44, Environmental Modifications and Specialized Equipment, of the Wyoming Medicaid Rules.

(u) "Chapter 45." Chapter 45, Waiver Provider Certification and Sanctions, of the Wyoming Medicaid Rules.

(v) "Claim." A request by a provider for Medicaid payment for covered services provided to a participant.

(w) "Clinically eligible." Determination that a person has met the requirements set forth in Section 6 (c) of this Chapter.

(x) "Cognitive retraining services." Training provided to the participant or family members that shall assist the compensation or restoring of cognitive function, including but not limited to ability/skills for learning, analysis, memory, attention, concentration, orientation, and information processing.

(y) "Conservator." A person appointed by the court to manage the estate for an individual incapable of managing his or her financial affairs.

(z) "Covered services." Those services that are Medicaid reimbursable pursuant to Section 7 of this Chapter.

(aa) "Department." The Wyoming Department of Health, its agent, designee, or successor.

(bb) "Department of Family Services (DFS)." The Wyoming Department of Family Services, its agent, designee, or successor.

(cc) "Dietician." A person who is registered as a dietician by the Commission on Dietetic Registration.

(dd) "Dietician services." Services furnished by a registered dietician, including:

(i) Menu planning.

(ii) Consultation with and training of caregivers, and

(iii) Education of participants.

(ee) "Director." The Director of the Department or the Director's agent, designee, or successor.

(ff) "Division." The Developmental Disabilities Division of the Department, its agent, designee or successor.

(gg) "Drug used as a restraint." Any drug that:

(i) Is administered to manage a participant's behavior in a way that reduces the safety risk to the participant or others, and

(ii) Has the temporary effect of restricting the participant's freedom of movement, and

(iii) Is not a standard treatment for the participant's medical or psychiatric condition.

(hh) "Emergency." A circumstance or set of circumstances or the resulting state that calls for immediate action or an urgent need for assistance or relief as defined in Section 14 of this Chapter.

(ii) "Emergency case." A participant currently receiving services who has an emergency.

(jj) "Emergency referral." A person who: (1) is potentially eligible for covered services; and (2) has an emergency.

(kk) "Enrolled." Enrolled as defined in Chapter 3.

(ll) "Environmental modification." The physical modification of a residence of a participant pursuant to Chapter 44.

(mm) "Excess payments." Excess payments as defined in Chapter 16 and Chapter 39.

(nn) "Extended Wyoming Medicaid state plan services." Services which are available to the general Medicaid population through the Wyoming Medicaid State Plan, but which may be made available to a participant whose needs exceed State Plan service limitations. Extended services include:

(i) Occupational therapy services.

(ii) Physical therapy services.

(iii) Speech, hearing, and language services.

(iv) Any other services covered by Medicaid.

(nn) "Extraordinary Care Committee (ECC)." A committee that has the authority to approve or deny individual plans of care, emergency funding, and funding due to a material change in circumstance or other condition justifying an increase in funding as defined in Section 12 of this Chapter. Membership of the ECC shall include a representative of the Division, a representative of the State Medicaid Program and a representative of the Department's Fiscal Office.

(oo) "Extraordinary care rate." Payment in addition to the individualized budget amount, pursuant to Section 12 of this Chapter, because of an emergency, a material change in circumstances, or other condition justifying an increase in funding.

(pp) "Financial records." All records, in whatever form, used or maintained by a provider in the conduct of its business affairs and which are necessary to substantiate or understand the information contained in the provider's cost reports or a claim.

(qq) "Functionally necessary." A waiver service that is:

(i) Required due to the diagnosis or condition of the participant, and

(ii) Recognized as a prevailing standard or current practice among the provider's peer group, or

(iii) Intended to make a reasonable accommodation for functional limitations of a participant, to increase a participant's independence, or both.

(iv) Provided in the most efficient manner and/or setting consistent with appropriate care required by the participant's condition.

(v) For the purposes stated, utilization is not experimental or investigational and is generally accepted by the medical community.

(ss) "Funding." That combination of federal and state funds available to pay for covered services. Funding does not include any other funds available to the Department that are not designated for covered services.

(tt) "Generally Accepted Auditing Standards (GAAS)." Current auditing standards, practices and procedures established by the American Institute of Certified Public Accountants.

(uu) "Guardian." A person lawfully appointed as a guardian to act on the behalf of the participant or applicant.

(vv) "Habilitation." Services designed to assist participants in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. Habilitation includes:

(i) Day habilitation – Assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills which take place in a non-residential setting, separate from the home or facility in which the participant resides.

(ii) In-home support – The provision of intermittent one-to-one habilitation services provided in the participant's home or the community to participants who reside with family, guardians, or independently. Individuals receive skills training to increase independence related to their own health care, self-care, safety, and access and use of community services.

(iii) Prevocational services – Services that prepare an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services furnished under the waiver shall not be available under a program funded under the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Improvement Act of 2004.

(iv) Residential habilitation – The provision of habilitation services provided in the participant's home or community that provide assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Residential habilitation services shall include access to residential habilitation services on a 24-hour basis.

(v) Supported employment services – Services provided to assist participant in sustaining paid employment, including supervision and training. Supported employment services furnished under the waiver shall not be available under a program funded by either the Rehabilitation Act of 1973 or Disabilities Education Improvement Act of 2004.

(ww) "HHS." The United States Department of Health and Human Services, its agent, designee or successor.

(xx) "ICF/MR." An intermediate care facility for people with mental retardation as defined in 42 U.S.C. § 1396d(d), which is incorporated by this reference.

(yy) "Individualized Budget Amount (IBA)." The Division's allocation of Medicaid waiver funds that may be available to a participant to meet his or her needs pursuant to Section 8 of this Chapter.

(zz) "Individual Plan of Care (IPC)." A written plan of care for a participant that describes the type and frequency of services to be provided to the participant regardless of the funding source and that identifies the provider or provider types that furnish the described services. The IPC shall reflect the services and actual units that providers are agreeing to provide over the plan year.

(aaa) "Individual Plan of Care (IPC) team." A group of persons who are knowledgeable about the person and are qualified, collectively, to assist in developing an individual plan of care for that person. Membership of the team shall include the participant, the guardian if applicable, the individually-selected service coordinator, providers on the person's individual plan of care, an advocate if applicable, and any other person chosen by the participant.

(bbb) "Individually-selected Service Coordinator (ISC)." An individual or entity that is qualified pursuant to Chapter 1, Rules for Individually-selected Service Coordinators of the Rules of the Developmental Disabilities Division to act as an individually-selected service coordinator, also known as case manager.

(ccc) "Informed choice." A decision made by a participant or guardian if applicable, that is made voluntarily, without coercion or undue influence and that is based on sufficient experience and knowledge, including exposure, awareness, interactions, and/or instructional opportunities, to ensure that the choice is made with adequate awareness of all the available alternatives to and consequences of options available.

(ddd) "Inventory for Client and Agency Planning (ICAP)." An instrument used by the Division to help determine eligibility and to determine the needs of the participant, available from Riverside Publishing, its successor or designee.

(eee) "Institution." An Intermediate Care Facility for people with Mental Retardation (ICF/MR), nursing facility, hospital, prison, or jail.

(fff) "LT-ABI-105." A document, or its successor, completed by the individually-selected service coordinator that verifies that the participant or applicant meets the ICF/MR level of care.

(ggg) "Mechanical restraint." 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.

(hhh) "Medicaid." Medical assistance and services provided pursuant to Title XIX of the Social Security Act and/or the Wyoming Medical Assistance and Services Act. "Medicaid" includes any successor or replacement program enacted by Congress and/or the Wyoming Legislature.

(iii) "Medicaid allowable payment." Medicaid reimbursement for covered services as determined pursuant to Section 18 of this Chapter.

(jjj) "Medicaid Fraud Control Unit (MFCU)." The Medicaid Fraud Control Unit of the Wyoming Attorney General's Office, its agent, designee, or successor.

(kkk) "Medical determination." Determination that a person has met the requirements set forth in Section 6 of this Chapter.

(lll) "Medical records." All documents, in whatever form, in the possession of or subject to the control of a provider, which describe the participant's diagnosis, condition or treatment, including, but not limited to, the individual plan of care.

(mmm) "Medically necessary." A health service that is required to diagnose, treat, cure or prevent an illness, injury or disease which has been diagnosed or is reasonably suspected, to relieve pain or to improve and preserve health and be essential to life. The services must be:

(i) Consistent with the diagnosis and treatment of the participant's condition.

(ii) Recognized as the prevailing standard or current practice among the provider's peer group.

(iii) Required to meet the medical needs of the participant and undertaken for reasons other than the convenience of the participant and the provider, and

(iv) Provided in the most efficient manner and/or setting consistent with appropriate care required by the participant's condition.

(nnn) "Medicare." The health insurance program for the aged and disabled established pursuant to Title XVIII of the Social Security Act.

(ooo) "Medication administration." Medication physically given by someone other than a participant because the participant cannot take his or her own medications or administer treatments.

(ppp) "Medication management training." Medication management training completed by a nurse, including instructing and assisting the participant in setting up medications.

(qqq) "Medication monitoring." Observation and documentation of participant's self-administration of medication by provider or provider staff for participants who do not require medication administration or medication management by a nurse.

(rrr) "Modification to individual plan of care." A change to an individual plan of care pursuant to Section 9 of this Chapter. A modification may include the addition, substitution or deletion of providers, covered services, or both. Modifications may increase or decrease the Medicaid waiver allowable payment.

(sss) "Neuropsychological evaluation." Evaluation using a battery of tests identified by the Division administered by a psychologist trained in administering neuropsychological assessments.

(ttt) "Objectives." Set of meaningful and measurable goals for the participant and the methods used to train the person on the goals.

(uuu) "Occupational therapist." A person licensed to practice occupational therapy pursuant to W. S. § 33-40-102(a)(iii).

~~(vvv) "Occupational therapy services." Occupational therapy services that are:~~

~~(i) Provided by or under the scope of practice of an occupational therapist, and~~

~~(ii) Necessary to keep a participant in his or her home or out of an institution.~~

~~(iii) Occupational therapy services may include individual therapy and group therapy.~~

~~(www) "Overpayments." Overpayments as defined in Chapter 16 and Chapter 39.~~

~~(xxx) "Participant." An individual who has been determined eligible for covered services on the Waiver.~~

~~(yyy) "Personal care services." Services to assist a participant with the activities of daily living, including eating, bathing, dressing and personal hygiene, and household activities.~~

~~(zzz) "Personal restraint." The application of physical force or physical presence without the use of any device, for the purposes of restraining the free movement of the body of the participant. The term personal restraint does not include briefly holding without undue force a participant 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.~~

~~(aaaa) "Person-centered planning." A process, directed by a participant, that identifies the participant's strengths, capacities, preferences, needs, the services needed to meet the needs, and providers available to provide services. Person-centered planning allows a participant to exercise choice and control over the process of developing and implementing the individual plan of care.~~

~~(bbbb) "Physical therapist." A person licensed to practice physical therapy pursuant to W. S. § 33-25-101(a)(ii).~~

~~(cccc) "Physical therapy services." Maintenance or restorative physical therapy services that are:~~

~~(i) Prescribed by a physician.~~

~~(ii) Provided by or under the scope of practice of a licensed physical therapist, and~~

~~(iii) Necessary to keep a participant in his or her home or out of an institution.~~

~~(iv) Physical therapy services may include individual therapy and group therapy.~~

(dddd) "Physician." A person licensed to practice medicine or osteopathy by the Wyoming Board of Medical Examiners or a similar agency in a different state.

(eeee) "Power of Attorney." An instrument in writing whereby one person, as principal, appoints another as his agent and confers authority to perform certain specified acts or kinds of acts on behalf of principal (Black's Law Dictionary, Sixth Edition, 1990).

(ffff) "Prior authorization." Prior authorization as defined in Chapter 3.

(gggg) "Provider." A person or entity that is certified by the Division to furnish covered services and is currently enrolled as a Medicaid Waiver provider.

(hhhh) "Psychologist." A person licensed to practice psychology pursuant to W.S. § 33-27-113(a)(v).

(iiii) "Representative payee." A person or organization appointed by the Social Security Administration to manage Social Security, Veterans' Administration, Railroad Retirement, Welfare Assistance or other state or federal benefits or entitlement program payments on behalf of an individual who cannot manage or direct the management of his/her own money.

(jjjj) "Respite" or " "Respite services." Services provided:

(i) On a short-term basis pursuant to the individual plan of care.

(ii) To a participant who is unable, unassisted, to care for himself or herself, and

(iii) Because the participant's primary caregiver is absent or in need of relief from furnishing such services.

(kkkk) "Restraint." A personal restraint, mechanical restraint, or drug used as a restraint as defined in this section.

(llll) "Schedule." A personalized list of tasks or activities that describe a typical week for a participant. The schedule shall reflect the desires of the participant and shall include the service being provided, details on training on specific goals for habilitation services, level of supervision needed if specified in the individual plan of care, health and safety needs, activities, date, time in and time out for provision of services, provider signatures and approximate number of hours in service.

(mmmm) "Seclusion." The involuntary confinement of a participant alone in a room or an area from which the participant is physically prevented from leaving. Providers seeking reimbursement for waiver services shall not use seclusion.

(nnnn) "Services." Medical, habilitation or other services, equipment, or supplies, appropriate to meet the needs of a participant.

(oooo) "Skilled nursing services." Services listed in the individual plans of care that are within the scope of the Wyoming Nurse Practice Act.

(pppp) "Specialized equipment." New or used devices, controls, or appliances that enable a participant to increase his or her ability to perform the activities of daily living or to perceive, control, or communicate with the environment in which the participant lives, pursuant to Chapter 44.

(qqqq) "Speech, hearing and language services." The following services, if furnished by a speech pathologist or audiologist or under the scope of practice of a speech pathologist or audiologist:

(i) Speech pathology and audiology services, including artic, pragmatic, language training and devices used by the participant.

(ii) Assessment of participant's use of visual cues.

(iii) Assessment of the need for and use of amplification.

(iv) Assessment of a person's need for alternative speech output devices.

(v) Speech, hearing and language services may be provided as individual therapy and group therapy.

(rrrr) "Speech pathologist." A person licensed to practice speech pathology pursuant to W. S. 33-33-102(a)(iii).

(ssss) "Third-party liability." Third-party liability pursuant to Chapter 35.

(tttt) "Time out." The restriction of a participant for a reasonable period of time to a designated area from which the participant is not physically prevented from leaving, for the purpose of providing the participant an opportunity to regain self-control.

(uuuu) "Transition process." The process of changing from one provider of services to another, from one home and community based service to another, or from one residential location to another.

(vvvv) "Waiting list." A list of persons who are eligible for covered services and who have submitted a completed application, but the services are unavailable because of limits imposed by funding or the waiver. The waiting list is maintained by the Division as specified in Section 13 of this Chapter.

(wwww) "Waiver." The Acquired Brain Injury Home and Community Based Waiver submitted to and approved by the Centers for Medicare and Medicaid Services pursuant to Section 1915(c) of the Social Security Act.

Section 5. Philosophy.

(a) All persons possess inalienable rights under the Constitutions of the United States and the State of Wyoming, including persons with acquired brain injuries.

(b) It is the philosophy of the Division to develop reasonable and enforceable rules for the provision of services to individuals with acquired brain injuries 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 6. Assessment and Eligibility.

(a) Eligibility under this Chapter is limited to persons who complete the application process and who meet the following requirements for medical determination, clinical eligibility and financial eligibility. In addition, in order to be eligible for the waiver, all persons shall be:

(i) A United States Citizen as determined by the Department of Family Services.

(ii) A resident of Wyoming as determined by the Department of Family Services.

(iii) Aged 21 through 64 years.

(b) Medical determination. In order to meet the medical determination criteria for the waiver an applicant shall meet the acquired brain injury definition pursuant to Section 4 of this Chapter as determined by the Medical team pursuant to this section.

(c) Clinical eligibility criteria. An applicant is considered clinically eligible if:

(i) The applicant has met the medical determination criteria pursuant to this section, and

(ii) The neuropsychological or other evaluations confirm that the applicant meets the following:

(A) Has a score of 42 or more on the Mayo Portland Adaptability Inventory (MPAI), or

(B) Has a score of 40 or less on the California Verbal Learning Test II Trials 1-5 T, or

(C) Has a score of 4 or more on the Supervision Rating Scale, or

(D) Has an Inventory for Client and Agency Planning (ICAP) service score of 70 or less, and

(iii) A completed LT-ABI-105 verifies that the participant or applicant meets the ICF/MR level of care.

(d) Financial eligibility. Eligibility for covered services is limited to persons who meet the income and resource criteria set forth in the waiver and in the rules and policies of the Wyoming Medicaid program, as determined by the Department of Family Services.

(e) Application process:

(i) A completed application on a form required by the Division shall be submitted to the Division.

(A) An application is valid for one year. After that time, if necessary documentation has not been received so that the Division can determine clinical eligibility, the applicant shall be required to re-apply.

(B) Once an applicant has been determined to be clinically eligible and has been placed on a wait list, he/she does not need to re-apply.

(ii) Selection of individually-selected service coordinator.

(A) After an applicant requests services pursuant to this Chapter, the Division shall provide the applicant with a list of individually-selected service coordinators in the area(s) he or she wishes to receive service.

(B) The applicant shall select and meet with an individually-selected service coordinator from that list. Once both the applicant and the individually-selected service coordinator have agreed to work together, the individually-selected service coordinator shall notify the Division of that selection on a form designated by the Division.

(f) Medical determination process.

(i) The individually-selected service coordinator shall work with the applicant to identify and compile medical documentation of the brain injury and submit information to the Division.

(ii) The medical team coordinated by the Division shall review the medical documentation of the brain injury to determine if the medical criteria are met.

(A) If the medical team does not feel they have sufficient information to determine medical eligibility, the ISC shall be notified as to what types of additional information is needed.

(iii) If medical team agrees that medical criteria are met, the individually selected service coordinator shall be notified and shall work with the applicant to determine clinical eligibility pursuant to (g) of this section.

(iv) If the applicant does not have a diagnosis of acquired brain injury the applicant does not meet the medical determination criteria and is not eligible for the waiver.

(v) If an applicant is determined not to meet the medical determination criteria, the applicant or the applicant's legal guardian shall be notified in writing within 15 business days of the determination.

(A) An applicant determined to not meet the medical criteria requirements, may appeal the decision pursuant to Chapter 1.

(g) Determination of clinical eligibility. A person shall not receive covered services unless that person is clinically eligible. The determination of a person's clinical eligibility shall be made as follows:

(i) Neuropsychological evaluation. The individually-selected service coordinator shall schedule a neuropsychological evaluation for the applicant to determine if the applicant meets the criteria pursuant to (c) of this section.

(ii) Inventory for Client and Agency Planning. Upon completion of the neuropsychological exam the individual shall be assessed pursuant to (c) of this section to determine functional ability using the Inventory for Client and Agency Planning. Assessments shall be performed by a third party, under contract to the Division, who is qualified to perform such assessments using the Inventory for Client and Agency Planning (ICAP).

(iii) LT-ABI-105. The individually-selected service coordinator shall complete the LT-ABI-105 that verifies that the participant or applicant meets the ICF/MR level of care.

(h) Notification of determination of clinical eligibility.

(i) The Division shall determine clinical eligibility within 90 calendar days of receipt of the neuropsychological evaluation. If additional data or review is needed to determine eligibility, the Division shall notify the applicant in writing that the process will take an additional 30 calendar days.

(ii) If an applicant is determined not to meet clinical eligibility criteria, pursuant to (c) of this section, the applicant or the applicant's legal guardian shall be notified in writing within 15 business days.

(A) An applicant determined to not meet clinical eligibility requirements may appeal the decision pursuant to Chapter 1.

(iii) If an applicant is determined to be clinically eligible, the applicant or applicant's legal representative will be notified in writing that:

(A) There is a funding opportunity available, or

(B) There is not a funding opportunity available but the applicant is placed on the Division's waiting list, as specified in Section 13 of this Chapter.

(iv) Once an individual is notified that there is a funding opportunity available, financial eligibility shall be determined by the Department of Family Services.

(i) Loss of eligibility.

(i) A participant shall be determined to no longer be eligible when the participant:

(A) Does not meet clinical eligibility when re-tested, or

(B) Does not meet financial eligibility requirements as determined by the Department of Family Services, or

(C) Changes residence to another state, or

(D) Turns the age of 65.

(ii) Services to a participant determined to not meet clinical eligibility requirements shall be terminated no more than 45 days after the determination is made.

(A) If an applicant is determined not to meet clinical eligibility criteria, the applicant or the applicant's legal guardian shall be notified in writing within 15 business days.

(B) A participant determined to not meet eligibility requirements may appeal the decision pursuant to Chapter 1.

(iii) A participant may be denied waiver placement and may be required to reapply when the participant:

(A) Voluntarily does not receive any waiver services for 3 consecutive months.

(B) Is in a nursing home, hospital, or residential treatment facility for 6 consecutive months.

(C) Is in an out-of-state placement for 6 consecutive months.

(iv) Upon written notification of the denial of waiver placement:

(A) The participant may submit, in writing, reasons why he/she should still be considered eligible for the services.

(B) This request shall be reviewed by the Waiver Manager and the Division Administrator.

(v) If the participant is determined not to be eligible for services due to one of the criteria in (iii) of this section, the participant or the participant's legal guardian shall be notified in writing within 15 business days.

(A) The participant may appeal the decision pursuant to Chapter 1.

Section 7. Covered Services, Service Requirements and Restrictions.

(a) The services listed in this section are covered services if they are functionally necessary and part of a current individual plan of care approved by the Division.

(i) Case management services.

(A) Case management is a stand-alone service. .A participant (or guardian, if applicable) may choose any individually-selected service coordination provider, and shall not be expected or required to receive any other service from that provider.

(B) Individually-selected service coordinators shall be required to provide a minimum of 60 minutes per calendar month of person-to-person contact with the participant or guardian.

(I) This may include face-to-face meetings and telephone conversations between the individually-selected service coordinator, the participant and/or the guardian.

(II) Individually-selected service coordinators shall be required to complete one monthly visit to participant in his or her home.

(C) Individually-selected service coordinators shall schedule and facilitate six month review team meetings and annual individual plan of care meetings, including:

(I) Notifying all individual plan of care team members of the scheduling of the meetings at least 30 days in advance unless a shorter notification time is approved by the Division.

(II) Notifying the Division in writing of the scheduling of the meetings at least 30 days in advance unless a shorter notification time is approved by the Division.

(III) Following Division requirements for facilitating team meetings; and for documenting minutes of the team meetings in the form and manner prescribed by the Division in provider manuals and bulletins issued by the Division.

(D) Individually-selected service coordinators shall facilitate other team meetings when requested by the participant, guardian, member of the team, or the Division.

(ii) Cognitive retraining services.

(A) Providers of cognitive retraining services shall not seek reimbursement for providing cognitive retraining services for more than three participants at the same time.

(B) Cognitive retraining services shall be provided in the participant's home or in the community.

(iii) Dietician.

(A) Dietician services shall be supported by a formal assessment completed by a registered dietician.

(B) Providers of dietician services may seek Medicaid reimbursement for providing such services to a group of up to three participants at a time.

(iv) Environmental modification.

(A) Environmental modifications shall be approved pursuant to Chapter 44.

(v) Habilitation services.

(A) Participants may receive more than one habilitation service in a given day.

(B) Participants shall be in attendance in service areas in order for providers to bill for services.

(C) Purposes of the habilitation service codes shall be met, including assisting participants in acquiring, retaining and improving the self-help, socialization, adaptive and safety skills necessary to reside successfully in home and community-based settings.

(I) Habilitation providers shall work with participant on objectives as stipulated in the individual plan of care and document the results in the form and manner established by the individual plan of care team.

(D) Habilitation rates shall include personal care and respite services, except for in the cases listed under (E) of this section.

(E) Residential habilitation services and respite services may appear on the same individual plan of care when:

(I) The participant is transitioning into a residential setting such as a group home, or

(II) Unpaid caregivers need respite when the participant spends time at home visiting on weekends or vacations.

(III) When residential habilitation providers who are not required to obtain and maintain CARF accreditation pursuant to Chapter 45 require respite for vacations, sick days or other emergencies. In these cases, a maximum of 1,344 units of respite shall be allowed during a plan year.

(F) In-home support services and residential habilitation services may appear on the same individual plan of care when the participant is transitioning into or out of a residential setting such as a group home.

(G) When supported employment services are provided in a work site in which persons without disabilities are employed, payment shall be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and shall not include payment for the supervisory activities rendered as a normal part of the business setting.

(H) Reimbursement for habilitation services shall not be made directly or indirectly to a parent, stepparent, spouse or guardian of a participant.

(I) Habilitation rates for each participant shall include the cost for routine transportation by the provider regardless of the number of trips.

(J) Residential habilitation services shall not be provided in residential settings other than the home of the participant or in the community.

(K) In-home support services shall not be provided in residential settings other than the home of the participant or in the community.

(vi) Occupational therapy.

(A) Reimbursement for occupational therapy services shall require both a prescription and a treatment letter or recommendation from a physician.

(B) Providers of occupational therapy services may seek Medicaid reimbursement for providing such services to a group of up to three participants at a time.

(vii) Personal care services.

(A) ~~The participant shall be present when personal care services are provided.~~

(B) ~~Personal care services may include the preparation of meals, exclusive of the cost of the meals.~~

(C) ~~When specified in the individual plan of care, personal care services may also include such housekeeping chores as bed making, dusting, and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the participant, rather than that individual's family.~~

(D) ~~Personal care providers may include members of the family of the participant, except that Medicaid shall not reimburse a spouse for providing such services to the other spouse.~~

(E) ~~Providers certified to provide personal care services who are family members of the participant shall meet the same standards as providers of certified to provide personal care services who are unrelated to the participant.~~

(F) ~~Providers of personal care services shall not seek Medicaid reimbursement for providing such services to more than one participant at a time.~~

~~(viii) Physical therapy.~~

(A) ~~Reimbursement for physical therapy services shall require both a prescription and a treatment letter or recommendation from a physician.~~

(B) ~~Providers of physical therapy services may seek Medicaid reimbursement for providing such services to a group of up to three participants at a time.~~

~~(ix) Respite services.~~

(A) ~~Respite services shall be covered if provided in one of the following locations:~~

~~(I) The residence of the participant.~~

~~(II) A group home.~~

~~(III) Certified provider location, or~~

~~(IV) The community, including parks, stores, and recreation centers.~~

(B) ~~A respite service provider or provider staff providing respite services:~~

~~(I) Shall serve no more than two participants at a given time, unless approved by the Division.~~

(II) May also provide supervision to other children under the age of 12 or other individuals requiring support or supervision, and

(III) Shall limit the total combined number of persons in (I) and (II) to no more than three persons, unless approved by the Division.

(C) Respite services shall not take the place of residential or day habilitation services.

(D) Respite services shall accommodate each family's living routine.

(E) Respite services shall accommodate the needs of the participant.

(F) The respite site and services shall be matched to the identified needs of each participant and family.

(G) A respite provider shall not provide respite services to adults and children at the same time except to participants who are 18 to 20 years of age who may receive respite services with adults. In exceptional cases, such as when the participants are members of the same family, respite may be provided to adults and children at the same time with Division approval.

(x) Skilled nursing.

(A) Shall be prescribed by a physician.

(B) May include preventative and rehabilitative procedures.

(C) Shall be listed on a form required by the Division and identified in the individual plan of care.

(D) Shall involve direct patient care.

(xi) Specialized equipment.

(A) Shall be provided pursuant to Chapter 44.

(xii) Speech hearing and language services.

(A) Reimbursement for speech hearing and language services shall require both a prescription and a treatment letter or recommendation from a physician.

(B) Providers of speech, hearing and language services may seek Medicaid reimbursement for providing such services to a group of up to three participants at one time.

~~(xiii) Services otherwise covered by Medicaid shall not be covered services under this Chapter.~~

~~(xiv) Extended state plan services shall be funded to the maximum allowable amount under the state plan before these services are paid for under the waiver.~~

~~(xv) Parents, step parents, and/or spouses shall not be reimbursed by waiver funding for any waiver services, except pursuant to (vii)(D) of this section.~~

~~Section 8. The Individualized Budget Amount.~~

~~(a) Eligibility shall be determined pursuant to Section 6 of this Chapter before an individualized budget amount is determined.~~

~~(b) Determination of the targeted individualized budget amount.~~

~~(i) The Division's methodology to determine the amount of Medicaid waiver funds that shall be available to a participant to meet his or her needs shall include the following factors:~~

~~(A) The services the participant has received in the past or that are determined by projected services.~~

~~(B) Participant characteristics, including the participant's needs, as measured on the Inventory for Client and Agency Planning, and~~

~~(C) Economic factors, such as the cost of receiving services in different geographical areas or where the participant resides.~~

~~(ii) Using specific participant factors, the methodology shall correlate a participant's characteristics with the participant's individualized budget amount, so that the participants with higher needs are assigned a higher individualized budget amount, and vice versa.~~

~~(iii) The Division shall not approve an individualized budget amount that is above the average cost of the ICF/MR.~~

~~(c) Redetermination of the individualized budget amount.~~

~~(i) The Division or the individual plan of care team may request a new Inventory for Client and Agency Planning or neuropsychological assessments to determine if the characteristics or needs of the participant have changed and if a new individualized budget amount may be assigned.~~

~~(A) The Division may request a new Inventory for Client and Agency Planning or neuropsychological assessment at any time.~~

(B) If the individual plan of care team requests a new Inventory for Client and Agency Planning or neuropsychological assessment, the Division shall review the request and decide whether a new Inventory for Client and Agency Planning or neuropsychological assessment will be approved.

(C) If the new Inventory for Client and Agency Planning or neuropsychological assessment results in a change in the individualized budget amount determination, a change in the individualized budget amount shall be approved or denied in accordance with the procedure described in paragraph (b) of this section.

(ii) If the model does not meet the characteristics and needs of an individual, the Extraordinary Care Committee may approve a new individualized budget amount as a long-term increase, pursuant to Section 12. This will be re-evaluated at least every five years.

(iii) At least once every two years the Division shall update the targeted individualized budget amount model using the most current Inventory for Client and Agency Planning data, current services, and current funding information.

(d) If funds for covered services become or are projected to become limited or unavailable, the Division may modify participants' individualized budget amounts as necessary to bring projected expenditures in line with projected funding, recognizing that services shall be altered accordingly.

(e) If funding for covered services is or is projected to be reduced below the level required to pay for all approved individualized budget amounts, or is eliminated, the Division shall have the discretion to modify participants' individualized budget amounts in order to bring projected expenditures for covered services within the projected available funding.

(f) If the waiver is modified or eliminated, the Division shall have the discretion to modify the individualized budget amounts in order to bring projected expenditures for covered services within projected available funding.

(g) Reinstatement of services. If additional funding becomes available, services that were reduced or eliminated shall be reinstated based on individual needs to the extent of the available funds. There shall be no requirement for the Division to disperse all available funds without a demonstrated need as described in these rules.

Section 9. Development and Approval of the Individual Plan of Care.

(a) Development of the individual plan of care.

(i) After the targeted individualized budget amount is identified by the Division, the individual plan of care team, coordinated by the individually-selected service coordinator, shall assist the participant in determining the use of the targeted individualized budget amount in developing the individual plan of care.

(ii) The individual plan of care shall be completed in the form and manner prescribed by the Division in accordance with Section 23 of Chapter 1, Rules for

~~Individually-selected Service Coordinators of the Rules of the Developmental Disabilities Division.~~

~~(iii) The individually selected service coordinator shall develop the individual plan of care that includes:~~

~~(A) A completed pre-approval page signed by the participant or guardian and the individually-selected service coordinator.~~

~~(B) Freedom of Choice Document or its successor.~~

~~(C) LT-ABI-105 form or its successor.~~

~~(D) Neuropsychological report that is no more than 5 years old and signed by a psychologist.~~

~~(I) The neuropsychological report shall contain all scores on the battery of tests required by the Division. This report shall also contain diagnosis codes, summary of findings, and recommendations for treatment.~~

~~(II) The neuropsychological report shall provide recommendations that the individual plan of care team shall review and address through the individual plan of care.~~

~~(E) ICAP report that is no more than 5 years old.~~

~~(F) Objective pages as required by the Division for each habilitation service. The individually-selected service coordinator is responsible for ensuring that objective pages are completed. The objectives shall:~~

~~(I) Define the training activities of an individual and the methods used to train the activity.~~

~~(II) Be measurable and meaningful to the participant.~~

~~(III) Be reflected on the personal schedule.~~

~~(G) Identification of rights and rights restrictions in accordance with Appendix A of this Chapter, including the use of restraints as defined in Section 4 of this Chapter, including:~~

~~(I) Why the restriction is imposed.~~

~~(II) How the restriction is imposed.~~

~~(III) The plan to restore the right being restricted.~~

~~(IV) Signature of the participant and/or guardian.~~

(V) Rights restrictions shall be reviewed at least every six months by the individual plan of care team.

(VI) Rights restrictions that occur that are not part of the individual plan of care shall be reported to the Division on a form designated by the Division.

(H) Skilled nursing information on the form required by the Division that includes all areas of skilled nursing required by the participant.

(I) Medication administration indicating the level of medication administration or monitoring required for the participant. Levels of support include:

(I) Medication administration.

(II) Medication management training.

(III) Medication monitoring.

(IV) Ability to self-medicate with no assistance.

(J) A behavior support plan, if applicable, that reflects and addresses maladaptive behaviors identified by the individual plan of care team, the neuropsychological evaluations and the Inventory for Client and Agency Planning, including maladaptive behaviors listed as moderate or above pursuant to Section 30 of Chapter 45.

(K) Schedules for habilitation, personal care and respite services. The purpose of the schedule shall be to provide information about the services and supports needed throughout a participant's day and justify the rates for services. Schedules shall be personalized and shall:

(I) Reflect the purpose of the services.

(II) Reflect recommendations from therapists, physicians, psychologists and other professionals.

(III) Reflect the participant's desires and goals.

(IV) Include all information required by Chapter 45.

(b) Approval of the individual plan of care.

(i) The individually-selected service coordinator shall submit the individual plan of care to the Division with the Division's current technical checklist.

(ii) The Division shall have 20 calendar days to review and approve an individual plan of care contingent upon the individually-selected service coordinator submitting all the requested information to the Division.

(iii) The Division shall approve or make recommendations to modify the plan. This may result in an adjustment to the individualized budget amount.

(iv) Upon approval and prior to implementation of the plan, the individually-selected service coordinator shall distribute copies of the individual plan of care to the participant, the guardian, advocates, or representatives designated by the participant or guardian, and to habilitation, respite, personal care, and therapy providers on the individual plan of care in accordance with applicable privacy and confidentiality law and regulation.

(v) All other providers shall be given information from the individual plan of care pertinent to the provision of services.

(vi) All services shall be provided pursuant to the individual plan of care.

(vii) Medicaid reimbursement shall be limited to the covered services and the providers specified in the individual plan of care on the pre-approval form signed by the Division.

(viii) The Division shall not reimburse for services in excess of those specified in an approved individual plan of care or to providers not so specified.

(ix) The Division shall not approve an individual plan of care nor reimburse for services provided to a participant before clinical eligibility has been established pursuant to Section 6.

(x) Any provider who submits a claim for payment for services that have been approved but not yet provided to the participant shall be subject to the requirements of Chapter 16 and Chapter 39 including any available sanctions.

(xi) The Division shall review and approve individual plans of care at least annually or more frequently at the option of the Division.

(c) Modification of individual plan of care requiring approval of the Division;

(i) Modifications to the pre-approval page of the individual plan of care shall be submitted for approval to the Division when there is a change in service rates, a change in service units or a change in providers.

(ii) If the change does not require an increase in the individualized budget amount the Division shall approve, deny, or make recommendations to modify the plan;

(iii) If the change requires an increase in the individualized budget amount, the modification to the plan shall be due to an emergency, a material change in circumstance, a potential emergency, or other condition justifying an increase in funding and the modification shall be reviewed by the Extraordinary Care Committee in accordance with Section 12 of this Chapter.

(iv) The Division shall have 7 calendar days to review and approve modifications to the pre-approval page of the individual plan of care contingent upon the individually-selected service coordinator submitting all the requested information to the Division.

(v) The effective date of the modification shall be the date indicated on the pre-approval page by the signature of a Division representative.

(vi) When the level or intensity of services is permanently decreased, modifications to the individual plan of care shall be submitted for approval to the Division. The rates on the modification shall reflect the decrease in need of services. The decrease in services may include but is not limited to decreases in staffing levels or decreases in total hours of service provided in a day.

(d) Modifications to the individual plan of care that do not require Division approval.

(i) The individual plan of care shall be updated by the individually-selected service coordinator whenever there are significant changes to the participant's needs, including:

(A) Changes in health and safety needs.

(B) Changes in employment status.

(C) Changes in medication.

(D) Changes in adaptive equipment.

(E) Changes in diagnoses.

(F) Changes in mealtime needs.

(G) These changes do not need to be submitted to the Division unless the changes result in a change listed in (c) of this Section.

(e) Participant no longer receiving waiver services.

(i) The individually-selected service coordinator shall submit a modification ending the plan within 45 calendar days of the last date of service.

Section 10. Reassessments. A participant shall be reassessed for clinical eligibility at least every five years, and more frequently at the option of the Division. The reassessment shall include a review of the Inventory for Client and Agency Planning and the neuropsychological evaluation.

Section 11. Transitions.

(a) Participants and/or guardians shall have the right to informed choices in providers and services.

(b) Participants and/or guardians may choose to change individually-selected service coordinators pursuant to Chapter 1, Rules for Individually-selected Service Coordinators of the Rules of the Developmental Disabilities Division.

(c) Participants may choose to change any providers, other than individually-selected service coordinators, anytime during the plan year pursuant to Chapter 45, Section 11.

(d) Applicants for the waiver may change individually-selected service coordinators at any time during the application process.

(e) When a participant or guardian chooses to change providers, they shall inform the individually-selected service coordinator of the decision. The individually-selected service coordinator shall then complete the required steps pursuant to Chapter 45, Section 11.

(f) If a provider providing residential services to a participant requires a participant to move to another residential location, the provider and participant's individually selected service coordinator shall complete the required steps pursuant to Chapter 45, Section 11.

(g) Providers who are terminating services with a participant shall notify the participant/guardian in writing at least 30 days prior to ending services unless a shorter transition period is approved in advance by the Division. Failure to provide services during this 30 day period shall be considered abandonment of services and may result in decertification of the provider.

Section 12. Extraordinary Care Committee.

(a) The Extraordinary Care Committee has the following authority:

(i) Determining if a funding request for an emergency case or an emergency referral shall be funded.

(ii) Determining if a funding request due to a material change in circumstance, a potential emergency, or other condition justifying an increase in funding shall be funded.

(iii) Approving or rejecting rates for services that are not commensurate with the average rates as defined in the Acquired Brain Injury Waiver Document approved by the Centers for Medicare and Medicaid Services.

(iv) Approving rate changes due to increased or decreased funding from Legislative Appropriations or under utilization of approved individualized budgeted amounts.

(b) The Extraordinary Care Committee shall review the requests to determine if the request meets criteria, has necessary documentation, and if funding is available.

(c) The Extraordinary Care Committee shall make the following determinations:

(i) Request further information.

(ii) Approve the request for one year or less.

(iii) Approve the request as a long term individually budgeted amount pursuant to Section 8 (c)(ii).

(iv) Deny the request.

(d) The individually-selected service coordinators shall present funding requests due to a material change in circumstance, a potential emergency, or other conditions justifying an increase in funding to the Extraordinary Care Committee by conference call, compressed video, or physical presence. The individually-selected service coordinators shall have previously sent written documentation to their waiver specialist of the emergency criteria, material change in circumstance, or other conditions required for the case.

(e) Membership of the Extraordinary Care Committee shall include a representative of the Division, a representative of the State Medicaid Program and a representative of the Department's Fiscal Office.

(f) Decisions of the Extraordinary Care Committee shall be by majority and shall be rendered in writing.

(i) The Division shall notify the individually-selected service coordinator of the decision in writing within 10 business days of the decision.

Section 13. Waiting List Process.

(a) Waiting list. When there is insufficient funding to add additional participants, the Division shall maintain one waiting list for the Acquired Brain Injury Home and Community Based Waiver as specified below.

(b) Factors. The Division shall assign two rankings to each person on the waiting list based on the following two factors:

(i) The severity of the person's condition based on weighted scores of all 4 eligibility tests.

(ii) The person's placement date on the waiting list.

(c) When covered services become available, the Division shall alternate between the two factors listed in (b) of this section, beginning with the waiting list based

on severity, in selecting the next person to whom covered services shall be provided. Before being added to the waiting list, the person shall be otherwise eligible as determined in Section 6 of this Chapter.

(d) In cases when the severity levels are the same or when the placement date on the waiting list is the same, the Division shall use the date that the Selection of Individually-selected Service Coordinator form was received by the Division to determine which name goes first on the waiting list.

(e) The Division shall determine the availability of funding for the approved individualized budget amounts for applicants on the waiting lists waiting for funding opportunities.

(f) The Extraordinary Care Committee shall review information on an applicant who meets the eligibility requirements in Section 6 of this Chapter and who is potentially an emergency referral to determine if he/she shall be funded as an emergency as specified in Section 14 of this Chapter.

Section 14. Emergency services.

(a) The emergency criteria used by the Division includes:

(i) A substantial threat to a person's life or health caused by:

(A) The loss of the person’s primary caregiver.

(B) Homelessness.

(C) Abuse or neglect that is either substantiated by DFS, Wyoming Department of Family Services or corroborated by the Division or Protection and Advocacy of Wyoming.

(ii) Situations where the person’s condition poses a substantial threat to a person’s life or health and is documented, in writing, by a physician.

(iii) Situations where a person:

(A) Has caused serious physical harm to the person or someone else, or a person whose condition presents a substantial risk of physical threat to the person or others, and

(B) The harm or threat of harm is verified, in writing, by a psychologist or a psychiatrist.

(C) The use of covered services would be an appropriate response to the person’s condition, and

(D) Other resources to provide appropriate services are not available.

~~(b) Identification of emergency referrals and emergency cases.~~

~~(i) Any person may request that the Division consider whether an individual has an emergency.~~

~~(ii) The Division may identify persons on the waiting lists who have an emergency.~~

~~(c) Once a potential emergency case or emergency referral has been identified:~~

~~(i) The individually-selected service coordinator shall submit in the form specified by the Division specific information on the potential emergency. The information shall include:~~

~~(A) Description of the factors or condition that have created an emergency and their expected duration.~~

~~(B) Description of the covered services that are functionally necessary.~~

~~(C) Copies of incident reports, physician reports, assessments or other documentation that relate to the factors or conditions that have created an emergency.~~

~~(D) A detailed plan of how the funds shall be spent, the expected outcome and how the results shall be monitored with respect to the funds.~~

~~(ii) For emergency referrals, determination of eligibility as defined in Section 6 of this Chapter, shall be completed within 14 calendar days after receipt of the Inventory for Client and Agency Planning and the neuropsychological assessment.~~

~~(d) The Extraordinary Care Committee shall review specific information on the potential emergency referral or emergency case to determine if the case meets the emergency criteria as defined in (a) of this section. Such persons shall receive covered services, subject to available funding.~~

~~(e) An emergency plan may be submitted to the Division by the participant's individually-selected service coordinator to cover services until the complete individual plan of care is submitted and approved by the Division.~~

~~(i) The emergency plan shall include significant health and safety information and shall be approved by the Division in order for services to be reimbursed.~~

~~(ii) The Division shall have 3 business days to review and approve the plan.~~

(f) In no event shall the Division be required to provide or fund covered services in the absence of available funding or in the absence of clinical and financial eligibility.

Section 15. Provider Participation.

(a) Payments only to providers. No person or entity that furnishes covered services to a participant shall receive Medicaid funds unless the person or entity has signed a provider agreement, is enrolled, and is certified by the Division as a provider at the time of service delivery.

(b) Compliance with Chapter 3, Provider Participation, of the Wyoming Medicaid Rules. A provider that wishes to receive Medicaid reimbursement for services furnished to a participant shall meet the provider participation requirements of Chapter 3, Provider Participation, of the Wyoming Medicaid Rules, Sections 4 through 6, which are incorporated by this reference.

(c) Compliance with Chapter 45, Provider Certification and Sanctions, of the Wyoming Medicaid Rules. A provider that wishes to provide Waiver services shall also meet the applicable criteria for Division certification set forth in Chapter 45, which is incorporated by this reference.

Section 16. Provider Records.

(a) A provider shall comply with Chapter 3, Provider Participation, of the Wyoming Medicaid Rules, Section 7, which is incorporated by this reference.

(b) Individually-selected service coordinators shall maintain copies of documentation from other providers for a twelve month period.

(c) For documentation of case management services, individually-selected service coordinators shall comply with Chapter 3, Section 7, which is incorporated by this reference.

Section 17. Verification of Participant Data. A provider shall comply with Chapter 3, Section 8, which is incorporated by this reference.

Section 18. Medicaid Waiver Allowable Payment. Medicaid payments shall be pursuant to and limited to each approved individual plan of care.

Section 19. Excluded Services.

(a) Services not covered under the waiver include:

(i) Services furnished to a participant while in an institution;

(ii) Room and board of participant, which are the responsibility of the participant or representative payee;

(iii) Room and board expenses of a live-in personal caregiver or provider.

Section 20. Third-party Liability.

(a) Submission of claims. Claims for which third-party liability exists shall be submitted in accordance with Chapter 35.

(b) Medicaid payment. The Medicaid payment for a claim for which third-party liability exists shall be the difference between the Medicaid allowable payment and the third party payment. In no case shall the Medicaid payment exceed the payment otherwise allowable pursuant to this Chapter.

Section 21. Submission and Payment of Claims. The submission and payment of claims shall be pursuant to the provisions of Chapter 3.

Section 22. Recovery of Excess Payments or Overpayments.

(a) The Department may recover excess payments pursuant to Chapter 39.

(b) The Department may recover overpayments pursuant to Chapter 16.

Section 23. Audits.

(a) The Division or the Centers for Medicare and Medicaid Services may audit a provider's financial records, medical records or employment records, at any time to determine whether the provider has received excess payments or overpayments.

(b) The Division or the Centers for Medicare and Medicaid Services may perform audits through employees, agents, or through a third party. Audits shall be performed in accordance with generally accepted auditing standards.

(c) Disallowance. The Division shall recover excess payments or overpayments pursuant to Section 22 of this Chapter.

(d) Reporting audit results. If at anytime during a financial audit or a medical audit, the Division discovers evidence suggesting fraud or abuse by a provider, that evidence, in addition to the Division's final audit report regarding that provider, shall be referred to the Medicaid Fraud Control Unit.

(e) The Division shall share the results of the audit with the provider before excess payments or overpayments are recovered. However, nothing in this section shall abrogate the rights of the State to recover excess payments or overpayments in accordance with Chapter 16 or Chapter 39.

Section 24 Reconsideration. A provider may request that the Department reconsider a decision to recover excess payments or overpayments. The request for reconsideration, the reconsideration, and any administrative hearing shall be pursuant to the reconsideration provisions of Chapter 3, Chapter 16 or Chapter 39 as applicable.

Section 25. Disposition of Recovered Funds. The Department shall dispose of recovered funds pursuant to the provisions of Chapter 16.

Section 26. 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 27. 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, except Chapter 1, Rules for Individually-selected Service Coordinators of the Rules of the Developmental Disabilities Division, which remains in effect.

Section 28. Severability. If any portion of this Chapter is found to be invalid or unenforceable, the remainder shall continue in full force and effect.

CHAPTER 44

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

Section 1, Authority.

This Chapter is promulgated by the Department of Health pursuant to Wyo. Stat. Ann. § 9-2-102, the Medical Assistance and Services Act at Wyo. Stat. Ann. §§ 42-4-104 through -120, 2013 Wyo. Sess. Laws, 322-25, and the Wyoming Administrative Procedure Act at Wyo. Stat. Ann. §§ 16-3-101 through -115.

Section 2, Purpose and Applicability.

(a) This Chapter shall apply to and govern Medicaid reimbursement of environmental modification services, specialized equipment services, and self-directed goods and services provided under the Wyoming Medicaid Comprehensive Waiver and the Wyoming Medicaid Supports Waiver.

(b) The Behavioral Health Division, hereafter referred to as the "Division," may issue Provider Manuals, Provider Bulletins, or both, 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 or Provider Bulletins shall be subordinate to the provisions of this Chapter.

Section 3, General Provisions.

(a) Terminology. Unless otherwise specified, the terminology used in this Chapter is the standard terminology and has the standard meaning used in accounting, health care, Medicaid, and Medicare.

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

(c) Incorporation by reference:

(i) Any code, standard, rule or regulation incorporated by reference does not include any later amendments or editions of the incorporated matter beyond the effective date of this Chapter. These materials may be obtained at cost from the Department.

(ii) The following items are incorporated by reference:

(A) Title XIX of the Social Security Act. 42 C.F.R. Part 441, Subpart G, found at http://www.ecfr.gov/cgi-bin/ECFR.

(B) Wyoming's Medicaid State Plan found at http://www.health.wyo.gov/healthcarefin/medicaid/spa.html.

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, Environmental Modifications – Scope and Limitations.

(a) Environmental modifications requests 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 ICF/ID setting,

(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 modification of a bathroom, which adds 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.

(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 must be consistent with the neighborhood standard.

(c) Environmental modifications shall not include:

(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 and are not of direct medical or functional benefit to the participant.

(ii) Installation or replacement of carpeting.

(iii) Roof repair or replacement.

(iv) Central air conditioning.

(v) New carports, porches, patios, garages, porticos, decks, or repairing such structures.

(vi) Pools, spas, hot tubs or modifications to install pools, spas or hot tubs.

(vii) Landscaping or yard work, landscaping supplies, pest exterminations or removal of yard items.

(viii) Modifications that are part of new construction costs.

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

(x) Window replacements.

(xi) Repairs or replacement of structural building components.

(xii) Modifications to a residence when the cost of such modifications exceeds the value of the residence before the modification.

(xiii) 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 may 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, Environmental Modifications Approval Process.

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

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

(iii) How addressing the environmental concern 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 guardian 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 must submit the service authorization section of the individual 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.

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

(A) If two quotes cannot be obtained, 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. The Division may use a third party to assess the proposed modification, and need for the modification to ensure cost effectiveness. The assessment shall include:

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

(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 individual 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) Case Manager shall not give copies of the individual 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, who 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 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) Relative providers (including parents and stepparents) may also become certified to provide this service in accordance with Wyoming Medicaid Rules Chapter 45, Waiver Provider Certification and Sanctions. If a relative provider quotes an environmental modification, the Case Manager must always include one (1) other quote from another, non-relative, environmental modification provider.

(k) Provider agencies must be certified by the Division to provide Environmental Modifications prior to providing the service.

(i) Any individual employed by an agency certified to provide environmental modification services is required to assure that he or she has the applicable building, electrical, or plumbing contractor's license as required by local or state regulations.

(ii) Individuals certified to provide environmental modifications services must also complete training on incident reporting, recertification, the Health Insurance Portability and Accountability Act (HIPAA), and confidentiality.

(iii) The Agency must meet all other applicable Medicaid rules and regulations.

(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.

Section 7, Specialized Equipment – Scope and Limitations.

(a) Specialized equipment must 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;

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

(b) The individual 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) The Medicaid Waiver is a payer of last resort.

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

(i) Devices, controls, or appliances, specified in the 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 durable and non-durable medical equipment not available under the Medicaid state plan that is necessary to address participant functional limitations.

(v) Necessary medical supplies not available under the Medicaid state plan or other insurance held by the participant. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the 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.

(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, and motor homes.

(iv) Pools, spas, 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.

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

(e) Repairs shall be completed by the manufacturer, if a warranty is in place.

(f) Requests for repairs not covered by warranty may be submitted to the Division for approval.

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

Section 8, Specialized Equipment Approval Process.

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

(b) Approval for specialized equipment shall require:

(i) 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/ID), 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 an estimate of a quote of the equipment, including a maximum markup on the equipment of 20%, up to a maximum of $200.

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

(ii) 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.

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

(iv) If the participant has an Individualized Education Plan (IEP) or Individual Family Service Plan (IFSP), the Case Manager must 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.

(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.

(d) Equipment purchases have an annual cap of $2,000. 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.

(e) Electronic technology devices are only allowed once every five (5) years and like items cannot 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.

(f) Provider Agencies must be certified by the Division to provide Specialized Equipment. Employees of the Agency must possess applicable license and certifications for the type of equipment purchased for a participant.

Section 9, Self-Directed Goods and Services.

(a) Goods and services are services, equipment, and supplies that provide direct benefit to the participant and support specific outcomes in the individual plan of care.

(b) The service, equipment or supply must:

(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 and Services may include:

(i) Equipment not otherwise available through 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. Self-Directed Goods and Services 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. Service includes vehicle modifications, but does not include items of direct medical or remedial benefit to the individual. All items must meet applicable standards of manufacture, design, and installation.

(iii) Transportation provided by family members (excluding parents, step-parents, guardians, or spouses), friends, and other licensed drivers for using non-agency vehicles to transport the person to services and activities specified in the person's individual plan of care.

(A) This is not available if the service to which the participant is being transported includes transportation.

(B) The unit of service is one mile. The rate may not exceed the current state rate for mileage reimbursement and cannot include medical transportation covered by the Medicaid State Plan.

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

(v) The cost of the participant attending a camp. This may also include the cost for an attendant to accompany the person to a camp that he or she could not attend alone if additional staffing is not available at the camp to ensure the participant's health and safety.

(vi) Consultation, evaluation and training. This should include a written document that evaluates and identifies the participant's strengths, needs, current availability and potential capacity of natural supports, and the need for service and financial resources, if appropriate. As appropriate for the participant, a consultation shall include:

(A) Participant preferences;

(B) Health status;

(C) Medications;

(D) Conditions and treatments;

(E) Functional performance, including Activities of Daily Living (ADLs), level of assistance needed, and assistive devices used or needed;

(F) Behavior and emotional factors, including pertinent history, coping mechanisms, and stressors;

(G) Cognitive functioning, including memory, attention, judgment, and general cognitive measures;

(H) Environmental factors, including architectural, transportation, other barriers;

(I) Social supports and networks, including natural supports; and

(J) Financial factors, including guardianship or conservatorships, or entitlements that influence the array of supports and services that are needed.

Section 10, Self-Directed Goods and Services, Limits on the Amount, Frequency, or Duration.

(a) Self-Directed Goods and Services have a $2,000 annual limit.

(b) All goods and services must be prior authorized by the Division and cannot be available through Specialized Equipment or Environmental Modifications.

(c) The Extraordinary Care Committee may approve requests above the limit if the request meets the following criteria:

(i) The participant loses eligibility for other resources because of age and provides documentation that vocational rehabilitation services are not available to meet those needs;

(ii) The participant has increased health concerns that require more services;

(iii) The participant has increased behavioral concerns that require more intervention; or

(iv) The participant's unpaid caregiver cannot continue the historical level of support due to the health condition of the unpaid caregiver.

(d) The Division may require an assessment for an equipment purchase by a 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 cannot 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 goods and services, will only pay the actual costs for purchasing the device.

(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.

(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 may 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 must be those extraordinary alterations that are uniquely needed by the individual and for which the property owner would not ordinarily be responsible. Service 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;

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

(i) Prior to requesting any Self-Directed Goods or Services, the Fiscal/Employer Agent must verify and document that the individual hired to provide a direct service to participant:

(i) Is at least eighteen (18) years of age;

(ii) Has completed a successful criminal background check;

(iii) Has the ability to communicate effectively with the participant and family;

(iv) Has the ability to complete record keeping as required by the employer;

(v) Has a current CPR and First Aid Certification; and

(vi) Has a current driver's license and appropriate automobile insurance, including commercial insurance, if transporting the participant.

(j) Before a person may work with a participant to provide Self-Directed Goods and Services, the case manager shall verify with the Employer of Record that the required training has occurred and is documented for the following:

(i) Recognizing abuse/neglect;

(ii) Incident reporting;

(iii) Participant rights and confidentiality;

(iv) Emergency drills/situations;

(v) Documentation standards; and

(vi) Demonstrates competence and knowledge in participant's needs outlined in the individual plan of care.

Section 11, 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, 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, Severability.

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

CHAPTER 44

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

Section 1, Authority.

This Chapter is promulgated by the Department of Health pursuant to Wyo Stat. Ann. § 9-2-102, the Medical Assistance and Services Act at Wyo Stat. Ann. §§ 42-4-10~~4~~1 ~~et seq.~~ through 42-4-120, 2013 Wyo. Sess. Laws 322-25, and the Wyoming Administrative Procedure~~s~~ Act at Wyo Stat. Ann. §§ 16-3-101 ~~et seq~~ through 16-3-115.

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 and services provided under the Wyoming Medicaid ~~Adult Developmental Disabilities Home and Community Based Waiver, the Wyoming Children's Developmental Disabilities~~ Comprehensive Waiver and the Wyoming Medicaid Supports Waiver ~~Home and Community-Based Waiver, and the Wyoming Acquired Brain Injury Home and Community-Based~~ Waiver ~~on or after June 1, 2006~~.

~~(b) The provisions contained in this Chapter shall be subordinate to the provisions in the Wyoming Medicaid Adult Developmental Disabilities Home and Community Based Waiver, the Wyoming Medicaid Children's Developmental Disabilities Home and Community Based Waiver, and the Wyoming Medicaid Acquired Brain Injury Home and Community Based Waiver submitted to the Centers for Medicare and Medicaid Services pursuant to Section 1915(c) of the Social Security Act codified as 42 U.S.C. § 1396n.~~

(b~~c~~) The Behavioral Health Division, hereafter referred to as the "Division," may issue Provider Manuals, Provider Bulletins, or both, to providers ~~and/~~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 or Provider Bulletins shall be subordinate to the provisions of this Chapter.

Section 3, General Provisions.

(a) Terminology. Unless ~~Except as~~ otherwise specified, the terminology used in this Chapter is the standard terminology and has the standard meaning used in accounting, health care, Medicaid, and Medicare.

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

(c) Incorporation by reference:

(i) Any code, standard, rule or regulation incorporated by reference does not include any later amendments or editions of the incorporated matter beyond the effective date of this Chapter. These materials may be obtained at cost from the Department.

(ii) The following items are incorporated by reference:

(A) Title XIX of the Social Security Act. 42 C.F.R. Part 441, Subpart G, found at http://www.ecfr.gov/cgi-bin/ECFR.

(B) Wyoming's Medicaid State Plan found at http://www.health.wyo.gov/healthcarefin/medicaid/spa.html.

~~(c) This Chapter is intended to be read in conjunction with the Wyoming Medicaid Adult Developmental Disabilities Home and Community Based Waiver, the Children's Developmental Disabilities Home and Community Based Waiver, and the Acquired Brain Injury Home and Community Based Waiver, submitted to Centers for Medicare and Medicaid Services pursuant to Section 1915(c) of the Social Security Act, Chapter 41, Chapter 42 and Chapter 43 of the Medicaid Rules, and Chapter 1, Rules for Individually-selected Service Coordinators of the Rules of the Developmental Disabilities Division.~~

~~(d) Unless otherwise specified, the incorporation by reference of any external standard is intended to be the incorporation of that standard as it is in effect on the effective date of this Chapter, including any applicable amendments, corrections, or revisions, but excluding any subsequent amendments or changes.~~

~~Section 4. Definitions.~~

~~The following definitions shall apply in the interpretation and enforcement of these rules. Where the context in which words are used in these rules indications that such is the intent, words in the singular number shall include the plural and vice versa. Throughout these rules gender pronouns are used interchangeably. The drafters have attempted to utilize each gender pronoun in equal numbers, in random distribution. Words in each gender include individuals of the other gender.~~

~~(a) "Acquired brain injury." Acquired brain injury as defined in Chapter 43.~~

~~(b) "Acquired Brain Injury Home and Community Based Waiver." The Acquired Brain Injury Home and Community Based Waiver submitted to and approved by the Centers for Medicare and Medicaid Services pursuant to Section 1915(c) of the Social Security Act.~~

~~(c) "Adult." A person twenty-one years of age or older for purposes of the Adult Developmental Disabilities Home and Community Based Waiver. Participants between the ages of 18 and 21 receive services on the Children's Developmental Disabilities Home and Community Based Waiver but are considered an adult in the State of Wyoming.~~

(d) "Adult Developmental Disabilities Home and Community Based Waiver." The Adult Developmental Disabilities Home and Community Based Waiver submitted to and approved by the Centers for Medicare and Medicaid Services pursuant to Section 1915(c) of the Social Security Act.

(e) "Advocate." A person, chosen by the participant or legal guardian, who supports and represents the rights and interests of the participant in order to ensure the participant's full legal rights and access to services. The advocate can be a friend, a relative, or any other interested person. An advocate has no legal authority to make decisions on behalf of a participant.

(f) "Case Management." Covered service on the Adult Developmental Disabilities Home and Community Based Waiver, the Children's Developmental Disabilities Home and Community Based Waiver, and the Acquired Brain Injury Home and Community Based Waiver, as defined in Chapter 41, Chapter 42, and Chapter 43.

(g) "Centers for Medicare and Medicaid Services (CMS)." The Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services, its agent, designee, or successor.

(h) "Chapter 1." Chapter 1, Rules for Medicaid Administrative Hearings, of the Wyoming Medicaid Rules.

(i) "Chapter 3." Chapter 3, Provider Participation, of the Wyoming Medicaid Rules.

(j) "Chapter 16." Chapter 16, Medicaid Program Integrity, of the Wyoming Medicaid Rules.

(k) "Chapter 26." Chapter 26, Medicaid Covered Services, of the Wyoming Medicaid Rules.

(l) "Chapter 35." Chapter 35, Medicaid Benefit Recovery, of the Wyoming Medicaid Rules.

(m) "Chapter 39." Chapter 39, Recovery of Excess Payments, of the Wyoming Medicaid Rules.

(n) "Chapter 41." Chapter 41, DD Adult Waiver Services, of the Wyoming Medicaid Rules.

(o) "Chapter 42." Chapter 42, DD Child Waiver Services, of the Wyoming Medicaid Rules.

(p) "Chapter 43." Chapter 43, Acquired Brain Injury Waiver Services, of the Wyoming Medicaid Rules.

(q) "Chapter 45." Chapter 45, Waiver Provider Certification and Sanctions, of the

Wyoming Medicaid Rules.

(r) "Child." A person under 21 years of age for participants receiving services on the Children's Developmental Disabilities Home and Community Based Waiver. Participants between the ages of 18 and 21 receive services on the Children's Developmental Disabilities Home and Community Based Waiver but are considered an adult in the State of Wyoming and shall sign their own documents unless they have a legal guardian.

(s) "Children's Developmental Disabilities Home and Community Based Waiver." The Children's Developmental Disabilities Home and Community Based Waiver submitted to and approved by the Centers for Medicare and Medicaid Services pursuant to Section 1915(c) of the Social Security Act.

(t) "Claim." A request by a provider for Medicaid payment for covered services provided to a participant.

(u) "Covered services." Those services that are Medicaid reimbursable pursuant to Chapter 41, Chapter 42, and Chapter 43.

(v) "Department." The Wyoming Department of Health, its agent, designee, or successor.

(w) "Developmental disability." Developmental disability as defined in Chapter 41 and Chapter 42.

(x) "Director." The Director of the Department or the Director's agent, designee, or successor.

(y) "Division." The Developmental Disabilities Division of the Department, its agent, designee, or successor.

(z) "Enrolled." Enrolled as defined in Chapter 3.

(aa) "Environmental modification." Covered service on the Adult Developmental Disabilities Home and Community Based Waiver, the Acquired Brain Injury Home and Community Based Waiver, and the Children's Developmental Disabilities Home and Community Based Waiver. The physical modification of a residence of a participant, pursuant to this Chapter.

(bb) "EPSDT." Early and periodic screening, diagnosis, and treatment services for participants under the age of 21 pursuant to Chapter 6 of the Wyoming Medicaid Rules, Health Check.

(cc) "Excess payments." Excess payments as defined in Chapter 39.

(dd) "Extraordinary Care Committee (ECC)." A committee that has the authority to approve or deny individual plans of care, emergency funding, and funding due to a material

change in circumstance or other condition justifying an increase in funding as defined in Chapter 41, Chapter 42, and Chapter 43.

(ee) "Financial records." All records, in whatever form, used or maintained by a provider in the conduct of its business affairs and which are necessary to substantiate or understand the information contained in the facility's cost reports or a claim.

(ff) "Functionally necessary." A waiver service that is:

(i) Required due to the diagnosis or condition of the participant, and

(ii) Recognized as a prevailing standard or current practice among the provider's peer group, or

(iii) Intended to make a reasonable accommodation for functional limitations of a participant, to increase a participant's independence, or both.

(iv) Provided in the most efficient manner and/or setting consistent with appropriate care required by the participant's condition.

(v) For the purposes stated, utilization is not experimental or investigational and is generally accepted by the medical community.

(gg) "Funding." That combination of federal and state funds available to pay for covered services. Funding does not include any other funds available to the Department that are not designated for covered services.

(hh) "Generally Accepted Auditing Standards (GAAS)." Current auditing standards, practices, and procedures established by the American Institute of Certified Public Accountants.

(ii) "Guardian." A person lawfully appointed by the courts to act on the behalf of the participant or applicant.

(jj) "Health and Human Services (HHS)." The United States Department of Health and Human Services, its agent, designee, or successor.

(kk) "ICF/MR." An intermediate care facility for people with mental retardation as defined in 42 U.S.C. § 1396d(d), which is incorporated by this reference.

(ll) "Individualized Budget Amount (IBA)." The Division's allocation of Medicaid waiver funds that may be available to a participant to meet his or her needs pursuant to Chapter 41, Chapter 42, and Chapter 43.

(mm) "Individual Plan of Care (IPC)." Individual Plan of Care as defined in Chapter 41, Chapter 42, and Chapter 43.

(nn) "Individual Plan of Care (IPC) team." Individual Plan of Care team as defined in Chapter 41, Chapter 42, and Chapter 43.

(oo) "Individually selected Service Coordinator (ISC)." Individually selected service coordinator as defined in Chapter 41, Chapter 42, and Chapter 43.

(pp) "Institution." An Intermediate Care Facility for people with Mental Retardation (ICF/MR), nursing facility, hospital, prison, or jail.

(qq) "Medicaid." Medical assistance and services provided pursuant to Title XIX of the Social Security Act and/or the Wyoming Medical Assistance and Services Act. "Medicaid" includes any successor or replacement program enacted by Congress and/or the Wyoming Legislature.

(rr) "Medicaid allowable payment." Medicaid reimbursement for covered services as determined pursuant to this Chapter.

(ss) "Medicaid Fraud Control Unit (MFCU)." The Medicaid Fraud Control Unit of the Wyoming Attorney General's Office, its agent, designee, or successor.

(tt) "Medical records." All documents, in whatever form, in the possession of or subject to the control of a provider, which describe the participant's diagnosis, condition or treatment, including, but not limited to, the individual plan of care.

(uu) "Medically necessary" or "medical necessity." A health service that is required to diagnose, treat, cure, or prevent an illness, injury, or disease which has been diagnosed or is reasonably suspected, to relieve pain or to improve and preserve health and be essential to life. The services must be:

(i) Consistent with the diagnosis and treatment of the participant's condition.

(ii) Recognized as the prevailing standard or current practice among the provider's peer group.

(iii) Required to meet the medical needs of the participant and undertaken for reasons other than the convenience of the participant and the provider, and

(iv) Provided in the most efficient manner and/or setting consistent with appropriate care required by the participant's condition.

(vv) "Medicare." The health insurance program for the aged and disabled established pursuant to Title XVIII of the Social Security Act.

(ww) "Mental retardation." A diagnosis as determined by a psychologist per the American Association on Mental Deficiency, *Classification in Mental Retardation* (Herbert J. Grossman ed., 8th ed. 1983).

~~(xx) "Modification to individual plan of care." A change to an individual plan of care. A modification may include the addition, substitution, or deletion of providers, covered services, or both. Modifications may increase or decrease the Medicaid waiver allowable payment.~~

~~(yy) "Overpayments." Overpayments as defined in Chapter 39.~~

~~(zz) "Participant." An individual who has been determined eligible for covered services on a Waiver.~~

~~(aaa) "Physician." A person licensed to practice medicine or osteopathy by the Wyoming Board of Medical Examiners or a similar agency in a different state.~~

~~(bbb) "Prior authorization." Prior authorization as defined in Chapter 3.~~

~~(ccc) "Provider." A person or entity that is certified by the Division to furnish covered services and is currently enrolled as a Medicaid Waiver provider.~~

~~(ddd) "Related condition." A condition that results in a severe, chronic disability affecting an individual which manifests before he or she reaches age twenty-two and that is attributable to cerebral palsy, seizure disorder, or any condition other than mental illness that is closely related to mental retardation and that requires similar services, as determined by a licensed psychologist or physician.~~

~~(eee) "Services." Medical, habilitation, or other services, equipment, or supplies, appropriate to meet the needs of a participant.~~

~~(fff) "Specialized equipment" New or used devices, controls, or appliances that enable a participant to increase his or her ability to perform the activities of daily living or to perceive, control, or communicate with the environment.~~

~~(ggg) "Third-party liability." Third-party liability pursuant to Chapter 35.~~

Section ~~5~~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~~, and which are included as Appendix A to this Chapter~~.

(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 ~~6~~5, Environmental Modifications – Scope and Limitations.

(a) Environmental modifications requests shall meet at least two of the following criteria for approval by the Division:

(i) Be functionally necessary, ~~and~~.

(ii) Contribute to a person's ability to remain in or return to his or her home and out of an ICF/ID~~MR~~ setting~~, or~~.

(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 m~~M~~odification of a bathroom, which ~~that~~ adds square feet to the home, shall only be covered ~~only~~ if it is the most cost effective modification that meets the needs of the participant.

~~A. Modification of a bathroom that adds square feet to the home shall be covered only 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 ~~necessary~~ 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.

(viii) Fences for health or safety concerns.

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

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

(c) Environmental modifications shall not include:

(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 and are not of direct medical or functional benefit to the participant.

(ii) Installation or replacement of carpeting.

(iii) Roof repair or replacement.

(iv) Central air conditioning.

(v) New carports, porches, patios, garages, porticos, ~~or~~ decks, or repairing such structures.

(vi) Pools, spas, hot tubs or modifications to install pools, spas or hot tubs.

(vii) Landscaping or yard work, landscaping supplies, pest exterminations or removal of yard items.

(viii) Modifications that are part of new construction costs.

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

(x) Window replacements.

(xi) Repairs or replacement of structural building components.

(xii) Modifications to a residence when the cost of such modifications exceeds the value of the residence before the modification.

(xiii) 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 may 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) Sale of environmental modifications shall not profit the participant or family.~~

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

Section ~~7~~6, Environmental Modifications Approval Process.

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

(b) When the individual plan of care team identifies an environmental concern or need, the ~~individually selected service coordinator~~ 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) Based on an assessment from an occupational or physical therapist, a description of h~~H~~ow the environmental concern is related to the participant's diagnosed disability~~.~~; and

(iii) How addressing the environmental concern 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 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 or instruct the ISC to proceed to section (d).~~

~~(i) The assessment shall include:~~

~~(A) A statement verifying that the request meets at least two of the criteria pursuant to Section (6)(a) of this Chapter.~~

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

(~~d~~c) The ~~individually selected service coordinator~~ Case Manager shall work with the participant or guardian 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.

(~~e~~d) The ~~individually selected service coordinator~~ Case Manager ~~shall~~ must submit the service authorization ~~pre-approval~~ section of the individual 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.

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

(A) If two quotes cannot be obtained, 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. The Division may use a third party to assess the proposed modification, and need for the modification to ensure cost effectiveness. The assessment shall include:

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

(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 ~~individually selected service coordinator~~ Case Manager of the approval, including the quote that was approved.

(i) Modifications shall be completed by the date stated in the individual 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 ~~individually-selected service coordinator~~ Case Manager shall submit a revised quote detailing the change in cost.

(iii) Case Manager shall not give copies of the individual 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 ~~individually-selected service coordinator~~ Case Manager.

(ii) If the homeowner has concerns with the modification they shall contact the ~~individually-selected service coordinator~~ Case Manager, who shall inform the Division of the concerns.

(iii) ~~(A)~~ The Division or its representative agent shall complete an on-site review of the modification to determine if 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) Relative providers (including parents and stepparents) may also become certified to provide this service in accordance with Wyoming Medicaid Rules Chapter 45, Waiver Provider Certification and Sanctions. If a relative provider quotes an environmental modification, the Case Manager must always include one (1) other quote from another, non-relative, environmental modification provider.

(k) Provider agencies must be certified by the Division to provide Environmental Modifications prior to providing the service.

(i) Any individual employed by an agency certified to provide environmental modification services is required to assure that he or she has the applicable building, electrical, or plumbing contractor's license as required by local or state regulations.

(ii) Individuals certified to provide environmental modifications services must also

complete training on incident reporting, recertification, the Health Insurance Portability and Accountability Act (HIPAA), and confidentiality.

(iii) The Agency must meet all other applicable Medicaid rules and regulations.

(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.

Section ~~8~~7, Specialized Equipment – Scope and Limitations.

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

~~(i) Be functionally necessary, and~~

(i~~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;~~, or~~

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

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

(b) The individual plan of care shall reflect the need for equipment, how the equipment addresses health, ~~and~~ 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) The Medicaid Waiver is a payer of last resort.

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

(i) Devices, controls, or appliances, specified in the 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 durable and non-durable medical equipment not available under the

Medicaid state plan that is necessary to address participant functional limitations.

(v) Necessary medical supplies not available under the Medicaid state plan or other insurance held by the participant. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the 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.

~~(i) Lifts.~~

~~(ii) Communication devices, including computers for communication when there is substantial documentation that a computer will meet the needs of the person more appropriately than a communication board.~~

~~(iii) Computer adaptations and software used for skill building.~~

~~(iv) Adaptations of items of general use that are specifically required to accommodate the participant's diagnosed disability.~~

~~(v) Items that are normally available through public resources but that are not available to the participant due to geographic constraints and that are necessary to address specific health needs, such as exercise equipment.~~

~~(vi) Games or items that are specifically for skill building and related to the participant's diagnosed disability.~~

~~(A) The individual plan of care limit shall be $500 per plan year for items.~~

~~(vii) One car seat for participants age 9 years or older.~~

~~(A) Requests for car seats with specialized seating or positioning for a participant of any age shall be reviewed for functional necessity.~~

~~(viii) One additional mobility item such as a wheelchair or stroller every 3 years that is not covered under the Wyoming Medicaid state plan.~~

~~(ix) One pair of eye glasses every 3 years for adult participants.~~

(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, ~~and~~ 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, trampolines, bicycles, health club memberships, merry-go-rounds, golf carts, four wheelers, go-carts, scooters, and motor homes.

(iv) Pools, spas, 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)~~(ii)~~ of this Section.

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

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

(e) Repairs shall be completed by the manufacturer, if a warranty is in place.

(f) Requests for repairs not covered by warranty may be submitted to the Division for approval.

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

~~(h) Participants, families, and/or guardians are encouraged to share equipment that is no longer in use with an equipment lending library such as the Weston Center at the Wyoming State Training School.~~

Section ~~9~~8, Specialized Equipment Approval Process.

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

(b) Approval for specialized equipment shall require:

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

(A) A d~~D~~escription 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/MR~~ Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID), 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, ~~and/~~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 an estimate of a quote of the equipment, including a maximum markup on the equipment of 20%, up to a maximum of $200.

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

(ii) 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.

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

(iv) If the participant has an Individualized Education Plan (IEP) or Individual Family Service Plan (IFSP), the Case Manager must 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.

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

(d) Equipment purchases have an annual cap of $2,000. 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.

(e) Electronic technology devices are only allowed once every five (5) years and like items cannot 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.

(f) Provider Agencies must be certified by the Division to provide Specialized Equipment. Employees of the Agency must possess applicable license and certifications for the type of equipment purchased for a participant.

~~Section 10. Provider Participation.~~

~~(a) Payments only to providers. No person or entity that furnishes covered services to a participant shall receive Medicaid funds unless the person or entity has signed a provider agreement, is enrolled, and is certified by the Division as a provider at the time of service delivery.~~

~~(b) Compliance with Chapter 3, Provider Participation, of the Wyoming Medicaid Rules. A provider that wishes to receive Medicaid reimbursement for services furnished to a participant shall meet the provider participation requirements of Chapter 3, Provider Participation, of the Wyoming Medicaid Rules, Sections 4 through 6, which are incorporated by this reference.~~

~~(c) Compliance with Chapter 45, Provider Certification and Sanctions, of the Wyoming Medicaid Rules. A provider that wishes to provide Waiver services shall also meet the applicable criteria for Division certification set forth in Chapter 45, which is incorporated by this reference.~~

~~Section 11. Provider Records.~~

~~(a) A provider shall comply with Chapter 3, Provider Participation, of the Wyoming Medicaid Rules, Section 7, which is incorporated by this reference.~~

~~(b) Individually selected service coordinators shall maintain copies of documentation from other providers for a twelve month period.~~

~~Section 12. Verification of Participant Data A provider shall comply with Chapter 3, Section 8, which is incorporated by this reference.~~

~~Section 13. Medicaid Waiver Allowable Payment Medicaid payment under this Chapter shall not exceed the provider's usual and customary charge for like or similar services to non-waiver clients.~~

~~Section 14. Third-party Liability.~~

~~(a) Submission of claims. Claims for which third-party liability exists shall be submitted in accordance with Chapter 35.~~

~~(b) Medicaid payment. The Medicaid payment for a claim for which third- party liability exists shall be the difference between the Medicaid allowable payment and the third-party payment. In no case shall the Medicaid payment exceed the payment otherwise allowable pursuant to this Chapter.~~

~~Section15. Submission and Payment of Claims. The submission and payment of claims shall be pursuant to the provisions of Chapter 3.~~

~~Section 16. Recovery of Excess Payments or Overpayments.~~

~~(a) The Department may recover excess payments pursuant to Chapter 39.~~

~~(b) The Department may recover overpayments pursuant to Chapter 16.~~

~~Section 17. Audits.~~

~~(a) The Division or the Centers for Medicare and Medicaid Services may audit a provider's financial records, medical records, or employment records, at any time to determine whether the provider has received excess payments or overpayments.~~

~~(b) The Division or the Centers for Medicare and Medicaid Services may perform audits through employees, agents, or through a third party. Audits shall be performed in accordance with generally accepted auditing standards.~~

~~(c) Disallowance. The Division shall recover excess payments or overpayments pursuant to Section 16 of this Chapter.~~

~~(d) Reporting audit results. If at any time during a financial audit or a medical audit, the Division discovers evidence suggesting fraud or abuse by a provider, that evidence, in addition to the Division's final audit report regarding that provider, shall be referred to the Medicaid Fraud Control Unit.~~

~~(e) The Division shall share the results of the audit with the provider before excess payments or overpayments are recovered. However, nothing in this section shall abrogate the rights of the State to recover excess payments or overpayments in accordance with Chapter 16 or Chapter 39.~~

~~Section 18. Reconsideration. A provider may request that the Department reconsider a decision to recover excess payments or overpayments. The request for reconsideration, the reconsideration, and any administrative hearing shall be pursuant to the reconsideration provisions of Chapter 3, Chapter 16, or Chapter 39 as applicable.~~

~~Section 19. Disposition of Recovered Funds. The Department shall dispose of recovered funds pursuant to the provisions of Chapter 16.~~

Section 9, Self-Directed Goods and Services.

(a) Goods and services are services, equipment, and supplies that provide direct benefit to the participant and support specific outcomes in the individual plan of care.

(b) The service, equipment or supply must:

(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 and Services may include:

(i) Equipment not otherwise available through 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. Self-Directed Goods and Services 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. Service includes vehicle modifications, but does not include items of direct medical or remedial benefit to the individual. All items must meet applicable standards of manufacture, design, and installation.

(iii) Transportation provided by family members (excluding parents, step-parents, guardians, or spouses), friends, and other licensed drivers for using non-agency vehicles to transport the person to services and activities specified in the person's individual plan of care.

A. This is not available if the service to which the participant is being transported includes transportation.

B. The unit of service is one mile. The rate may not exceed the current state rate for mileage reimbursement and cannot include medical transportation covered by the Medicaid State Plan.

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

(v) The cost of the participant attending a camp. This may also include the cost for an attendant to accompany the person to a camp that he or she could not attend alone if additional staffing is not available at the camp to ensure the participant's health and safety.

(vi) Consultation, training, and evaluation. This should include a written document that evaluates and identifies the participant's strengths, needs, current availability and potential capacity of natural supports, and the need for service and financial resources, if appropriate. As appropriate for the participant, a consultation shall include:

(A) Participant preferences;

(B) Health status;

(C) Medications;

(D) Conditions and treatments;

(E) Functional performance, including Activities of Daily Living (ADLs), level of assistance needed, and assistive devices used or needed;

(F) Behavior and emotional factors, including pertinent history, coping mechanisms, and stressors;

(G) Cognitive functioning, including memory, attention, judgment, and general cognitive measures;

(H) Environmental factors, including architectural, transportation, other barriers;

(I) Social supports and networks, including natural supports; and

(J) Financial factors, including guardianship or conservatorships, or entitlements that influence the array of supports and services that are needed.

Section 10, Self-Directed Goods and Services, Limits on the Amount, Frequency, or Duration.

(a) Self-Directed Goods and Services have a $2,000 annual limit.

(b) All goods and services must be prior authorized by the Division and cannot be available through Specialized Equipment or Environmental Modifications.

(c) The Extraordinary Care Committee may approve requests above the limit if the request meets the following criteria:

(i) The participant loses eligibility for other resources because of age and provides documentation that vocational rehabilitation services are not available to meet those needs;

(ii) The participant has increased health concerns that require more services;

(iii) The participant has increased behavioral concerns that require more intervention; or

(iv) The participant's unpaid caregiver cannot continue the historical level of support due to the health condition of the unpaid caregiver.

(d) The Division may require an assessment for an equipment purchase by a 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 cannot 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 goods and services, will only pay the actual costs for purchasing the device.

(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.

(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 may 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 must be those extraordinary alterations that are uniquely needed by the individual and for which the property owner would not ordinarily be responsible. Service 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;

iii. Adaptations that are covered as an environmental modification.

(i) Prior to requesting any Self-Directed Goods or Services, the Fiscal/Employer Agent must verify and document that the individual hired to provide a direct service to participant:

(i) Is at least eighteen (18) years of age;

(ii) Has completed a successful criminal background check;

(iii) Has the ability to communicate effectively with the participant and family;

(iv) Has the ability to complete record keeping as required by the employer;

(v) Has a current CPR and First Aid Certification; and

(vi) Has a current driver's license and appropriate automobile insurance, including commercial insurance, if transporting the participant.

(j) Before a person may work with a participant to provide Self-Directed Goods and Services, the case manager shall verify with the Employer of Record that the required training has occurred and is documented for the following:

(i) Recognizing abuse/neglect;

(ii) Incident reporting;

(iii) Participant rights and confidentiality;

(iv) Emergency drills/situations;

(v) Documentation standards; and

(vi) Demonstrates competence and knowledge in participant's needs outlined in the individual plan of care.

Section ~~20~~11, 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 ~~21~~12, 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~~, except Chapter 1, Rules for Individually-selected Service Coordinators of the Rules of the Developmental Disabilities Division which remain in effect~~.

Section ~~22~~13, Severability.

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

CHAPTER 45

WAIVER PROVIDER CERTIFICATION AND SANCTIONS

Section 1, **Authority.**

This Chapter is promulgated by the Department of Health pursuant to Wyo. Stat. Ann. § 9-2-102, the Medical Assistance and Services Act at Wyo. Stat. Ann. §§ 42-4-104 through -120, 2013 Wyo. Sess. Laws 322-25, and the Wyoming Administrative Procedure Act at Wyo. Stat. Ann. §§ 16-3-101 through -115.

Section 2, Purpose and Applicability.

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

(b) The Behavioral Health Division, hereafter referred to as the "Division," may issue Provider Manuals, Provider Bulletins, or both, 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.

Section 3, General Provisions.

(a) Terminology. Unless otherwise specified or as defined in Chapter 1, the terminology used in this Chapter is the standard terminology and has the standard meaning used in accounting, health care, Medicaid, and Medicare.

Incorporation by reference:

(i) Any code, standard, rule or regulation incorporated by reference does not include any later amendments or editions of the incorporated matter beyond the effective date of this Chapter. These materials may be obtained at cost from the Department.

(ii) The following items are incorporated by reference:

(A) Title XIX of the Social Security Act, 42 C.F.R. Part 441, Subpart G, found at http://www.ecfr.gov/cgi-bin/ECFR.

(B) Wyoming's Medicaid State Plan found at http://www.health.wyo.gov/healthcarefin/medicaid/spa.html.

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 may not be modified or suspended except in accordance with state or federal law.

(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 a right so they may advocate for the participant. Such notice 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 denies a restriction in a plan of care, this decision will apply to any provider offering services to the participant. Rights restrictions shall constitute a material change to the plan of care, requiring pre-approval by the Division. The following participant rights may not be denied or limited, except for the purpose of an identified health or safety need, which must be included in the participant's individualized plan of care (42 CFR § 441.301(c)(4)(iii)(A)):

(i) The right to privacy, dignity, and respect;

(ii) The right to freedom from coercion or restraint;

(iii) Privacy in their sleeping or living unit;

(iv) Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors;

(v) Individuals sharing units have a choice of roommates in that setting;

(vi) Freedom to furnish and decorate their sleeping or living units 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 to have visitors of their choosing at any time;

(x) All settings must be physically accessible to the individual;

(xi) The right to make and receive telephone calls. No person may 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);

(d) A participant's right to be free from physical, mechanical, and chemical restraints may not be denied or limited unless a court, the participant, or the participant's legally authorized representative authorizes the denial or limitation in writing based upon a board certified doctor's

authorization. Such denial or limitation shall be included in the participant's plan of care, which must address how other less restrictive interventions will be used prior to a restraint, and detail the manner in which a restraint may be used pursuant to Section 18. The authorizing document shall be made part of the participant's individual plan of care.

(e) Procedural requirements regarding rights. A provider that provides 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 participants have the right to refuse services and may not be disciplined or charged with a monetary fee for refusing Home and Community Based Waiver services;

(iii) Each participant served, parent of a minor, or legally authorized representative(s) is informed of the participant's rights and responsibilities;

(A) The information must 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 must 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 receiving services from the provider are supported in exercising their rights;

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

(vi) Retaliation against participants' services and supports due to the participant, family members, or legal representatives advocating on behalf of the participant, is prohibited. This includes initiating a complaint with outside agencies.

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

(g) Providers may 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 individual plan of care shall include a rights restriction protocol that must include the following:

(i) The reasons for the rights restriction(s), including the legal document, court order, or guardianship papers, or medical order, that allows a person other than the participant to

authorize a restriction to be imposed.

(ii) For any rights restriction imposed, the following items must be addressed and documented in the individual plan of care as follows:

(A) Identify the specific and individualized assessed need;

(B) Document the positive interventions and supports used prior to any modifications to the person-centered service plan;

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

(D) Include a clear description of the condition that is directly proportionate to the specific assessed need;

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

(F) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;

(G) Include the informed consent of the individual; and

(H) Include an assurance that interventions and supports will cause no harm to the individual.

(iii) In addition to the items mentioned above, a rights restriction must have a restoration plan that addresses the following:

(A) Minimize the effect of the restriction;

(B) Assist the participant with exercising their rights more fully;

(C) Ensure that a participants rights are not completely removed;

(D) Identify what part of the right is restricted;

(E) Set goals for restoration of rights (participant training); and

Establish time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

Section 5, Provider Qualifications for Each Waiver Service.

(a) All individual waiver providers and provider employees shall complete and maintain the following requirements unless otherwise specified in this section:

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

(ii) 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.

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

(i) Adult Day Services. A provider of Adult Day Services shall be either:

(A) Certified to provide Adult Day Services; or

(B) An agency licensed as an Adult Day Care as provided by the Wyoming Department of Health, Office of Healthcare Licensing and Surveys, and certified as a waiver provider with the Division.

(ii) 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 Psychology from the Wyoming Board of Psychology and have proof of specific training completed on positive behavior supports.

(iii) Case Management.

(A) After the effective date of this rule, all providers of case management services must 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 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 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 employed by an agency or certified prior to the effective date of this rule may continue to provide case management services, without meeting the criteria in subsection (b)(iii)(A), as long as the case manager demonstrates reasonable and ongoing efforts to obtain the required qualifications during a transition period that expires on June 30, 2017.

(I) The Division shall accept 60 credit hours with at least 24 credit hours in a related field, and five (5) years of work experience as a case manager on any of the Wyoming waivers as an exception for not meeting the required education requirements in (b)(iii)(A) of this section.

(II) Persons seeking to qualify as a case manager under this section shall obtain the additional education requirements prior to June 30, 2017.

(III) The Division shall terminate the certification of a case manager who fails to obtain the required education.

(C) 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.

(D) 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.

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

(I) Have policies and procedures for backup case management for each person's caseload, and ensure case managers meet with their designated backup to review all participant cases on a quarterly basis. The review must be documented in case notes.

(II) Initially, and annually thereafter, have each case manager obtain proof of competency demonstrated through successful completion of trainings on current Division waiver services, plan of care development, electronic Medicaid Waiver System processes, plan monitoring, billable services, and documentation.

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

(IV) Meet the following conflict free requirements:

(1.) The case management agency and any managing employee may 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 employee of a case management agency may not be related by blood or marriage to the owner, operator, or managing employee of any other waiver service provider on the participant's plan of care;

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

(5.) The case management agency may not:

a. Employ case managers that are related to the participant, the participant's guardian, or a legal representative served by the agency. If the case management agency is a sole proprietor, the case manager may not be related to the participant, the participant's guardian, or a legal representative 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 plan in which they provide case management service.

(V) 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.

(I) 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.

(II.) This approval shall be subject to notice to and approval by the Centers for Medicare and Medicaid Services.

(iv) 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.

(v) 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.

(vi) Crisis Intervention. A Crisis Intervention Support provider shall:

(A) Within one year of certification in this service, an accredited provider serving more than five (5) participants with restrictive interventions in their plans shall have one (1) staff employee obtain specific positive behavior supports training.

(B) An additional employee shall be certified for every ten (10) additional participants with restrictive interventions in their plan.

(C) A training curriculum that also teaches restraints, such as CPI or MANDT, is not sufficient to meet these requirements.

(vii) 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).

(viii) 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 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 must report critical incidents as defined in Section 20.

(ix) Employment Discovery and Customization. Within one (1) year of becoming certified in employment services, the Employment Discovery and Customization provider shall have one (1) employee certified in a Division approved supported employment curriculum for every ten (10) participants served.

(x) 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.

(xi) 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.

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

(xiii) 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).

(xiv) 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 National Provider Identifier (NPI).

(xv) Prevocational. Within one (1) year of certification in prevocational services, a provider shall have one (1) staff person in this service setting certified in a nationally recognized supported employment curriculum and demonstrate that a portion of their time each month is spent training other direct care staff on exploring employment interests, working on job readiness skills, or other employment-related activities with participants.

(xvi) Skilled Nursing. A skilled nursing provider or provider staff shall have a current RN License or greater from the Wyoming State Board of Nursing and a National Provider Identifier.

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

(xviii) 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.

(xix) 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.

(xx) Supported Employment. A Supported Employment provider shall, within one (1) year of becoming certified in employment services, have one (1) employee working at least half of their time as a job coach or job developer that is certified in a nationally recognized supported employment curriculum for every ten (10) participants served in this service.

(xxi) Transportation. A Transportation provider shall have a current, valid, Wyoming 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 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 their agency; and

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

(A) Available to staff, participants, and the general public;

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

(C) Reviewed at least annually with employees; and

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

(b) Providers shall establish and implement a quality assurance process for ongoing proactive internal review of the quality and individualization of services. Participants served and their families shall be involved in the quality assurance process.

(c) 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 their agency 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 service 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 may 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.

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

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

(f) 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.

(g) 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 plan of care.

(h) The provider shall implement reasonable and appropriate policies and procedures to comply with the standards, specifications, and requirements of this chapter. 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.

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 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 must 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 must comply with the requirements for hospital records identified in Wyo. Stat. Ann. § 35-2-607.

(h) Providers shall make all records maintained or controlled by the provider available upon request to the 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, Provider Participation, of the Wyoming Medicaid Rules, the following provisions shall apply to the documentation of services, 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 shall deem the documentation to be insufficient to substantiate the claim and Medicaid funds shall be withheld or recovered.

(ii) Documentation may 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) and include electronic signatures and automatic date stamps pursuant to Wyo. Stat. Ann. § 40-21-107, and must have automated tracking of all attempts to alter or delete information that was previously entered.

(i) Electronic records may not be altered or deleted prior to submission of payment unless incorrect, and the purpose of the correction must 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 must make a participant's electronic case file, specific to the case manager's caseload, available to a case manager in the electronic record, such as Therap, 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, once signed 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 must include:

(i) Full legal name of participant;

(ii) Individualized plan of care start date for participant;

(iii) Physical address of the location of services;

(iv) Date of service, including year, month, and day;

(v) Type of service provided and the service name, type, and billing code of service provided;

(vi) Time services begin, and time services end using either AM and PM or military time and documenting per calendar day, even when services are provided over a period longer than one calendar day;

(vii) Printed name of person performing the service;

(viii) At least one legible signature of each person performing a service, and the date of signature. Initials may subsequently be used on any page that bears the staff person's full signature;

(ix) A detailed description of services provided and:

(A) Consist of a personalized list of tasks or activities that describe a typical day, week, or month for a participant, in which the participant and guardian has provided input.

(B) Include specific objectives for habilitation services, support needs, health and safety needs, and approximate number of hours in service.

(f) Documentation for different services must be on separate forms, and must 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.

(g) A provider organization may 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.

(h) A provider may not round up total service time to the next unit.

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

(j) Services must meet the service definitions in these rules and be provided pursuant to a participant's individualized plan of care.

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

(l) The provider shall make service documentation and unit billing information for services rendered available to the case manager each month by the tenth (10th) business day of the month following the date that the services were rendered so the case manager can monitor budget utilization. If services are not delivered during a month, the provider shall report the zero units used to the case manager by the tenth (10th) calendar day of the following month.

(i) Failure to make documentation available by the tenth (10th) calendar 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.

Section 9, Case Management Services.

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

(b) 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 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.

(c) It is the case manager's responsibility to maintain the current physical and mailing addresses of the participant's and legally authorized representative(s) at all times, and update the Division and other providers as there are changes.

(d) 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 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) 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, 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 assist in coordinating transition plans when the participant chooses to change, stop, or add providers to his or her plan of care, or exit the waiver.

(C) If the case manager chooses to discontinue providing services, the case manager shall give thirty (30) 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) days or until a new case manager is approved, whichever is first.

(iv) The case manager shall involve and assist the participant's identified team members with developing a person-centered 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, for Division approval in the electronic Medicaid waiver system, 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 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 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) of this Chapter.

(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, and the participant's satisfaction with the supports and services on a quarterly basis in the report provided by the Division. After the evaluation, the case manager shall:

(A) 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. Significant concerns shall be reported to the Division through the incident reporting or complaint processes;

(B) 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 plan of care, or when documentation is not received by the tenth (10th) business day of the following month after services were provided;

(C) 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, even if the participant changes case managers; and

(D) Document all monitoring and evaluation activities, follow-up on concerns and actions completed, and make appropriate changes to the plan of care with team involvement, as needed.

(e) A case manager shall be the second-line monitor for participants receiving medications. Second-line monitoring is conducted to help 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.

(i) The case manager shall provide monitoring and oversight of the delivery of the participant's medication through monthly review of medication assistance records and timely review of medication error reports.

(ii) The case manager shall provide monitoring and oversight of the usage of the participant's over-the-counter and prescription medications through monthly review of medication assistance records and PRN medication usage records.

(iii) The case manager shall provide monitoring and oversight of the usage of the participant's psychotropic medications through monthly review of medication assistance records and PRN medication usage records, and timely review of incident reports. PRN psychotropic medication usage shall be validated by review of related documentation to verify the positive behavior support plan's non-pharmacological interventions were attempted prior to medication administration and medications were utilized as a last resort measure only.

(iv) The case manager shall provide monitoring and oversight of the participant's medical needs through ensuring appropriate and timely communication between provider and health care professionals as identified by need.

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

(c) The plan of care must 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;

(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, which will be 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, including why the restriction is imposed, how the restriction is imposed, and the plan to restore the right to 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) Schedules to document each direct care service provided. The purpose of the schedule shall be to provide information about the services and supports needed throughout a participant's day. Schedules shall be personalized and shall:

(A) Reflect the purpose of the services;

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

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

(D) Include all information required by this chapter in Section 8, Documentation standards;

(xviii) Informed consent of the participant in writing; and

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

(d) The 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.

(e) The individual plan of care must be written in plain language that is understandable to the participant, legal representative(s), and persons serving the participant.

Section 11, Rate Reimbursement Requirements.

(a) Providers shall be reimbursed for services through the Department's cost-based reimbursement system.

(b) Rates paid to providers for waiver services must be less than or equal to the usual and customary rates for similar services in the community.

(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) 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 the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services 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.

(iv) Providers shall also participate in reasonable audits of the data submitted.

Section 12, Service and setting requirements for social security recipients.

(a) One (1) month prior to the provider's annual scheduled recertification date, all residential service providers shall provide the Division with the following information:

(i) The accreditation category of each residential facility serving five (5) or more participants;

(ii) All services provided in each facility identified;

(iii) The maximum number of participants that may be served in the facility decided by state or local fire codes, HUD contracts, applicable city codes, or state standards for bedrooms and roommates; and

(iv) How each facility provides home-like character that allows the participants to furnish and decorate their living area according to their own preferences.

(b) This provision does not apply to a participant's private residence or other non-facility community living arrangements.

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

(a) All certified waiver providers that provide direct care services to participants in a facility they own or lease must meet all applicable federal and state, city, county, and tribal health and safety code requirements. A facility includes the provider's home, if services are provided in that setting.

(b) All 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 HCBS;

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

(iii) Assists the participant to self-advocate and participate in life-long learning opportunities;

(iv) Ensures an individual's rights of privacy, dignity and 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; and

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

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

(i) A non-residential facility located in an area that does not have established sidewalks, walking paths, or access to the broader community and other businesses where the participants may visit within a safe and reasonable walking distance from the facility;

(ii) Any other facility with characteristics that appear to be institutional in nature, adjacent to an institution, or have the effect of isolating the participants from the community; or

(iii) A non-integrated setting designed to provide multiple services on-site to the same participants, including housing, day services, medical, behavioral, therapeutic services, or social and recreational activities.

(iv) New provider owned or operated residential settings serving five (5) or more participants will not be certified after July 2013.

(v) Provider facilities certified prior to the effective date of this rule may continue to provide services in settings that do not meet this requirement, but must begin transition to home and community-based setting compliance by June 2018. Providers that don't start the transition process in good faith by June, 2018 may be decertified.

(d) Provider facility inspections.

(i) For each location where services are provided to a participant, except the participant's own home, the provider shall receive a facility inspection by an outside entity at least once every thirty six (36) months. The Division may require more frequent inspections if the Division suspects that the provider or employee's facility would not pass the inspection.

(ii) The facility inspection must be completed by one or more of the following outside entities:

(A) A fire marshal or designee, or

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

(C) Other appropriate contractor inspecting a part of the facility within the scope of the contractor's license.

(iii) Facility inspections required by this section must 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 is free of any other significant health or safety concerns, including structural concerns, wiring problems, plumbing problems, and any major system concerns.

(iv) Facility inspections must include a written report that describes the items checked and recommendations to address areas of deficiencies.

(v) If the facility inspection identifies deficiencies, the provider shall submit a written corrective action plan for any deficiencies identified by the inspector, and a complete copy of the inspection to the Division within thirty (30) calendar days.

(A) The corrective action plan should address all identified deficiencies and the intended completion dates.

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

(C) No services shall be provided in a facility that does not pass the initial inspection until all deficiencies have been corrected. The Division must also inspect the service location prior to services being rendered.

(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 inspection shall sign a form designated by the Division to verify they are not providing services in any provider-owned or leased facility.

(viii) Providers may not provide services in a facility 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 they are subsequently found to be providing services in a facility owned, or leased, by the provider or employee, which has not previously passed inspection.

(e) Self-Inspections. A provider providing services in a facility they own or lease shall complete an annual self-inspection of the facility to verify that the provider is in compliance with this section.

(f) Other service standards. All service settings owned or controlled by a provider must meet the following requirements.

(i) In residential service and day service facilities, the provider shall ensure participants have access to their food at all times, and provide nutritious meals and snacks options. Providers may not require a regimented meal schedule except where individually prescribed, in writing, by a physician.

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

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

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

(v) The walls, wall coverings, and ceilings must be maintained in good repair and may not be visibly soiled or damaged.

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

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

(viii) All chemicals, poisons, or household cleaners must be secured in a manner that prevents the risk of improper use or harm to individuals in the facility.

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

(x) Toilet facilities must be kept clean and sanitary, and maintained in good repair.

(xi) The overall condition of the home or facility must 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) The use of video monitors by providers in participant bedrooms or bathrooms is prohibited. Other forms of remote monitoring or sensors may be used, where appropriate.

(xiii) A provider facility with a private water supply shall have a bacterial test conducted every three (3) years, and the written results shall be submitted to the Division within thirty (30) days of receiving test results.

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

(A) A lease or residency agreement for the location in which they are agreeing to reside. The lease or agreement must be signed by the participant or legally authorized representative (if applicable), and the provider. The lease or agreement must allow the same

responsibilities and protections from eviction as all tenants under landlord tenant law of the state, county, and city where the facility is located. At no time may a participant be asked to leave their residence on a regular basis to accommodate the provider;

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

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

(D) A private bedroom with no more than one (1) person to a bedroom unless a more preferred situation is identified in their plans of care or one 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 are related and request to share a bedroom.

(E) An individual bed, unless the participants are legally related or joint sleeping accommodations are specifically requested by the participant, and specified in the approved plan of care;

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

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

(H) A key or other type of access to a lock for both the housing unit, the participant's bedroom, and any form of locked storage where the participant's personal belongings are kept; and

(I) 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 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 must 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.

(g) 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.

(h) 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.

(i) 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 current emergency information on each participant in the vehicle or demonstrate how emergency information is quickly accessible each time a participant is transported. If emergency information is kept in the vehicle, the provider shall develop and implement policies to protect the confidentiality and security of participant's health information;

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

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

(j) 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.

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

(l) Settings that include any restriction to a participant's right to visitors, communication, privacy or other standard in this Section may only be restricted as documented in an approved

plan of care with the restriction being time-limited and following the requirements listed in Sections 4 and 18 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 or to a participant's residence, shall complete and pass a background screening as referenced in this section. Persons who do not successfully pass a background screening may not supervise, provide, or bill for waiver services, or otherwise have unsupervised access to participants or to a participant's residence 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. Screenings must be maintained in the corporate name of the organization or entity, and any trade name(s) used in this State.

(c) Any person or entity that subsequently fails to pass a renewed background screening may not supervise, provide, or bill for waiver services following a failed background screening.

(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.

(e) Providers and self-direction employees must show evidence of current background screenings for all required persons as part of the provider or employee's recertification.

(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) A felony;

(B) A misdemeanor crime against morals, decency, or family;

(C) A misdemeanor crime against a person, including child or vulnerable adult;

(D) A misdemeanor crime involving violence, rape, sexual assault, or homicide;

(E) A misdemeanor crime relating to fraud, forgery, or identity theft; or

(F) A driving under the influence of alcohol, or driving while intoxicated, or related offense during the last three (3) years, if the individual may be driving with a participant in the vehicle.

(g) No person ages eighteen (18) or older may 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.

(h) An individual provider staff may provide services to a participant ages 18 or older following a successful Department of Family Services and Office of Inspector General screening while the state and national criminal history screenings are pending.

(i) Persons who do not successfully pass the criminal history screenings listed in subsection (f) may not be left unsupervised in the vicinity of any participant, except as provided by subsection (h).

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

(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). An OIG check is not required.

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

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

(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)(iii), the individual may not have any unsupervised access or provide billable services to participants until provider is able to provide proof of a successful background check.

(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.

(n) Any individual that has had a successful background screening may transfer their background check confirmation form from one provider entity to another as long as they have

submitted a signed and notarized release to the receiving provider entity and the background check confirmation form is no more than sixty (60) months old. The background check confirmation form belongs to the individual that was screened and can only be used for the purposes listed in the original request. Each time an individual terminates employment and goes to work for another provider where a gap in employment exists of more than thirty (30) calendar days, a full background check must be completed for the new employer.

(o) Only one (1) provider or employee may be listed on the DFS central release forms and criminal history records requests. The background screening notification may not be altered in any manner, including the crossing out of names or use of whiteout. If altered, the release forms shall be determined as null and voided.

(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 training in the areas specified in this Section prior to working unsupervised with participants in services.

(b) Staff responsible for providing direct services shall demonstrate the competence to support participants as part of a required and on-going training program. The provider shall ensure staff receive training and demonstrate competencies under the guidance of an already trained and proficient 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 was completed, who provided the training, and how the employee demonstrated competency. The provider shall ensure that training is performed 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 through traditional services or self-directed services shall complete training in the following areas within one month of an employee’s hire or provider certification date. 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. Providers of only environmental modification services, specialized equipment, or homemaker services are exempt from this training requirement;

(iii) Confidentiality;

(iv) Dignity and respectful interactions with participants;

(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, guardians, provider employees, and community members; and

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

(e) To verify each provider, provider staff, and self-directed employee meets the qualification standards, evidence of a completed training summary or test of each training topic must be retained in the employer's files, or the Employer of Record's files for self-direction.

(f) One representative from the provider agency shall receive training on the provider recertification 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.

(h) Participant specific training.

(i) A provider of waiver services must 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.

(ii) Each provider, provider staff, and self-directed employee shall receive participant specific training prior to the plan of care start date and whenever there are changes to the individualized plan of care.

(iii) All case managers shall train one employee from each provider on the plan of care and that employee will ensure 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 plan of care start date and before each employee provides services.

(i) Documentation of participant specific training and general training must 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.

Section 16, Medical Management System Standards.

(a) A provider who is responsible for providing services to meet the health, medical, or medication support needs of a participant, which are identified in the plan of care, shall implement a medical management system to ensure services are provided in accordance within the standard of care.

(b) The designated provider, as identified by the participant's team, shall take reasonable steps to assist and support participants in obtaining health services consistent with the participant's needs, unless otherwise assigned in the individualized plan of care to a non-waiver provider.

(i) Participant health services include: medication assistance and monitoring, medical services, dental services, nutritional services, health monitoring and supervision, assistance with personal care, personal health care, education, exercise, and therapies.

(ii) Services also include arranging for and assisting the participant as needed to obtain evaluations and services, such as physical exams, dental services, psychological services, physical and occupational therapy, speech therapy, audiological services, vision services, nutrition therapy, and other related evaluations and services.

(c) Unless otherwise directed by the participant's physician, nurse practitioner, or physician assistant, each participant shall receive the following evaluations:

(i) A medical evaluation every twelve (12) months;

(ii) A dental cleaning every twelve (12) months; and

(iii) An eye exam every three (3) years, or more frequently if required by a medical professional.

(d) The provider's medical management system must include written protocols for medication assistance, treatments, and therapies as appropriate for each participant. The system must also include a process for maintaining health-related records on each participant to document the provision of services and the participant's response to services. The records must include:

(i) Any health related assessments;

(ii) Documentation of an illness, injury, and other health concerns of care, treatment, and medication;

(iii) Documentation of provision of health-related services, including observations of the participant's response, progress, or lack of response or progress in provision of service;

(iv) Current physician orders for medication, treatments, and therapies;

(v) Records of visits to the physician or other health care professionals, their recommendations, and any other consultation or therapy provided; and

(vi) Information related to hospitalization, nursing facility stays, and other types of health care providers.

(e) Any provider of direct care services shall ensure that the health status and physical conditions are observed, reported, and responded to in a timely and appropriate manner as needed. For a participant, whose responsibility for obtaining health services has been assigned to someone other than the provider, the assigned person, party, or provider shall observe, report, and respond to the participant's health service needs to ensure needs can be appropriately met.

(f) Any provider of direct care services shall ensure a participant receives care, treatment, and medications in accordance with orders from a medical practitioner. Responsibilities of each provider on a participant's plan must be discussed and documented during the participant's plan of care meeting. Recommendations from other health care professionals must be reviewed by the participant's plan of care team and incorporated into the plan of care as determined by the team.

(g) A provider assisting a participant with any type of medication must develop and complete medication assistance records.

(h) For services delivered in a provider owned, operated, or controlled facility, all prescription and over-the-counter medications, vitamins, and supplements must be stored securely in a manner that prevents improper access, use, or threat of harm to any individual in the facility. Secure medications storage may be individualized for a participant in the plan of care.

(i) Any provider of direct care services shall assist participants with the utilization of assistive and adaptive devices as needed and as identified on the plan of care.

(j) Any provider of direct care services shall have policies and procedures to assist participants with medications in compliance with this Chapter, using staff with current and valid certification through the Division's Medication Assistance curriculum and standards.

(i) A provider shall obtain written consent from a participant or guardian to assist the participant with medications. The consent shall be documented on a form designated by the Division and obtained annually.

(ii) The participant's individualized plan of care shall identify the level and type of medication assistance that must be provided by specific providers on the plan.

Section 17, Positive Behavior Supports.

(a) Treatment and habilitation services must be designed to maximize the potential of the participant. Services shall be provided in the setting that is the least restrictive of the participant's personal liberty.

(b) Providers must implement positive behavior supports as behavioral intervention prior to the use of any restrictive intervention.

(c) A participant with a challenging behavior identified by the team shall have a current functional behavioral analysis conducted within the last year to learn what the person is trying to communicate through the behavior(s), 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 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, must be developed for a participant in order for employees working with the person to understand and recognize the communication and behaviors exhibited by the person. The positive behavior support plan must describe agreed upon supports to assist the participant using proven support techniques and non-restrictive interventions. A positive behavior support plan must include the components included on the template provided on the Department's website. At a minimum, a positive behavior support plan must:

(i) Maintain the dignity, respect, and values of the participant;

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

(iii) Prevent the use of restrictive interventions. 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;

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

(v) Be approved by verification of a signature by the participant or any legally authorized representative(s) through informed consent;

(A) As part of the informed consent process, education must be given by the provider to the participant and any legally authorized representative(s);

(B) This education must include information about positive behavior supports that may be used and the risks and benefits of any supplemental plan for the use of a restrictive intervention or prescribed psychoactive medication if the positive behavior support plan fails.

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

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

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

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

(x) Include the protocols, or reference the separate 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 must comply with Section 19(b) of this Chapter;

(xi) Be reviewed quarterly by the provider(s) and the case manager to assess the effectiveness of the plan, or more frequently if needed; and

(xii) 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.

(e) A provider employee implementing a positive behavior support plan shall receive participant specific competency-based 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 providers shall maintain and analyze trend data relative to the occurrences of behaviors, antecedents, and the interventions used. When appropriate, the provider shall change strategies or interventions, modify the plan when it is no longer effective, or eliminate the plan when it is no longer needed.

Section 18, Restrictive Intervention Standards.

(a) Restrictive intervention is an artificial or temporary limitation which is imposed on a person's freedom to engage or not engage in activities of daily living or choice, or to ensure the health, safety and wellbeing of the person or others.

(b) Use of restrictive interventions must be chosen and deemed appropriate and effective by the entire plan of care team, confirmed with a signature from the participant, legally authorized representative and all providers involved, and be consistent with subsection (g) of 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 restrictive intervention protocol to supplement the positive behavior support plan, subject to the provisions of this section. Participants who need support from providers to accomplish activities of daily living that may have perceived restrictions on privacy or communication do not need a restrictive intervention protocol since other parts of the plan of care will describe the supports needed.

(d) Providers may 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 restrictive interventions in their plans are required to have a supervisor complete training on positive behavior supports through any program approved by the Division. An additional supervisor shall be certified for every ten (10) additional participants with restrictive interventions in their plan.

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

(g) When restrictive interventions are deemed necessary, the individual plan of care shall include a restrictive intervention protocol that must include the following:

(i) The reasons for the restriction(s), including the legal document, court order, or guardianship papers, or medical order, that allows a person other than the participant to authorize a restriction to be imposed.

(ii) For any restrictive intervention imposed, the following items must be addressed and documented in the individual plan of care as follows:

(A) Identify the specific and individualized assessed need;

(B) Document the positive interventions and supports used prior to any modifications to the person-centered service plan;

(C) Document less intrusive methods of meeting the need that have been tried

but did not work;

(D) Include a clear description of the condition that is directly proportionate to the specific assessed need;

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

(F) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;

(G) Include the informed consent of the individual; and

(H) Include an assurance that interventions and supports will cause no harm to the individual.

(iii) In addition to the items mentioned above, a restriction must have a restoration plan that addresses the following:

(A) Minimize the effect of the restriction;

(B) Assist the participant with exercising their rights more fully;

(C) Ensure that a participants rights are not completely removed;

(D) Identify what part of the right is restricted;

(E) Set goals for restoration of rights (participant training); and

(F) Establish time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(h) The case manager shall reconvene the participant's plan of care team if any restrictive interventions are used in the previous calendar quarter. When convened under this section, the team shall review all restrictive interventions for the previous quarter and make plans for reducing the number of restrictions imposed. On a quarterly basis, the case manager shall report data received from the provider concerning the number of restrictions imposed on the participant.

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

(j) Providers may only use restrictive interventions when the risk of injury without intervention is greater than the risk associated with the restrictive intervention.

(k) Restraints employed as a form of restrictive intervention may only be imposed by an individual trained and certified to impose the restriction.

(l) Providers employing restraints as a form of restrictive intervention must:

(i) Adopt policies and procedures that:

(A) Identify the provider's chosen certifying entity consistent with subsection (m);

(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 (m) unless the restraints are prohibited in subsection (d).

(m) The provider shall maintain certification and provide 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.

(n) All provider staff trained to use restrictive interventions shall also receive training in:

(i) The needs and behaviors of the population served;

(ii) Relationship building;

(iii) Alternatives to restrictive interventions;

(iv) The difference between natural consequences and punitive consequences;

(v) Avoiding power struggles;

(vi) Thresholds for restraint and seclusion;

(vii) Monitoring signs of distress and obtaining medical assistance;

(viii) Legal issues related to restrictive interventions;

(ix) Position related asphyxia;

(x) Escape and evasion techniques;

(xi) Time limits;

(xii) The process for obtaining approval for continued restraints;

(xiii) Procedures to address problematic restrictive interventions;

(xiv) Documentation;

(xv) Any participant specific medical concerns and processes;

(xvi) Follow-up with staff and the participant; and

(xvii) Investigation of injuries and complaints.

(o) Restrictive interventions may 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. Restrictive interventions may include but are not limited to the following:

(i) A "Cooling down Period" which is a time limited behavior management technique which involves the provider separating a resident from his or her peers, in a non-locked setting, for the purpose of calming. Any isolation of the participant that does not meet this definition shall be deemed seclusion, which is prohibited and shall result in recovery of funds and additional sanctions against the provider.

(ii) A chemical restraint, which is the use of a psychotropic medication given against a person's will in an attempt to exert control over a person's behavior.

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

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

(C) If a provider uses three (3) or more instances of a chemical restraint on a participant in six (6) consecutive months, the participant's team must 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 must meet to determine if the positive behavior support plan or crisis intervention protocol needs to change. The formal medical review must be documented in the participant's file with the restraining provider, and the case manager. If it is determined that the treatment plan or plan of care will not be changed, then the case manager shall document the reasons it is not being changed in the electronic plan of care.

(D) The use of chemical restraints on persons under the age of 18 is prohibited.

(iii) A mechanical restraint, which includes any device attached or adjacent to a participant's body that he or she cannot easily move or remove, restricts freedom of movement or normal access to the body. Mechanical restraints may only be used under the direct supervision of a physician for the purpose of medical treatment procedures when compliance is deemed necessary to protect the health of the participant. The use of mechanical restraints on person under the age of 18 is prohibited.

(iv) A physical restraint.

(A) Physical restraint includes:

(I) The application of physical force or physical presence without the use of any device for the purposes of manually holding all or part of a person's body in a way that restricts the person's free movement;

(II) The use of any approved physical maneuvers, such as a physical escort, team positions, or other holds to move a participant to another place or position; or

(III) Any other physical or manual technique intended to interrupt or stop a behavior from occurring, except holding a participant's hand to safely escort him or her from one area to another due to a potentially dangerous environmental concern that is not a result of the participant's behavior.

(B) Before physical restraints may be used, the participant's crisis intervention plan must include a physician letter specifying that the use of a physical restraint will likely do no harm to the participant if used in accordance with the crisis intervention plan.

(v) Actions that seek to modify behavior resulting in a restriction of a participant's right to possessions, property, money, communication with others, or privacy;

(vi) A community access restriction: Community access may not be restricted as a consequence due to non-compliance with attending a service or not completing a goal or training activity. If the community access restriction is imposed, the protocol must also include:

(A) Specific target behaviors that must be present in order for a restriction to the community to be imposed, a description of the risk to the community, the specific measureable and observable criteria for restoring access to the community, and not exceed 36 hours unless the plan includes information from a psychologist on the health, safety or therapeutic reasons for a longer restriction.

(B) Community access restrictions may not be imposed by a person who is also designated to reassess the participant throughout the day to ensure health and safety needs

are being met. The reassessment must include measureable progress made on restoring access to the community.

(C) Opportunities for the participant to reduce the length of time of restriction.

(D) The provider may not restrict community access for any other participant for which the restriction is not directly imposed.

(E) The provider may not charge a participant for services missed as a result of a community access restriction.

(p) Seclusion is the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving, or physically restrain a person back to such a room once he or she leaves during the provision of the waiver services. Seclusion is prohibited, and may result in repayment of funds for waiver services, and other sanctions.

(q) A provider using restraints as a restrictive intervention shall:

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

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

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

(iv) Address and correct staff using any incorrect or inconsistent support or intervention;

(v) Hold a debriefing meeting with the participant and guardian as soon as practicable after an incident to discuss the use of the restriction. Guardians shall be part of the participant's debrief discussion either by phone or in person;

(vi) Within one (1) business day 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;

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

(viii) Submit a critical incident report to the Division for each instance when a restraint is used as a restrictive intervention;

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

(x) The case manager shall follow up on each incident within two (2) business days to ensure the participant is safe, uninjured, and to ensure the restrictive intervention protocol, and participant's positive behavior support plan was implemented appropriately and 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**.**

(xi) The Division may request an interdisciplinary team meeting with the provider, case manager, and legally authorized representative to review a participant's restrictive interventions.

(r) Restrictive interventions may 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;

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

(iv) Restraint that is contraindicated by the person's medical or psychological condition;

(v) Restraint procedures or devices that obstruct a person's airway or constrict the person's ability to breathe;

(vi) The use of any 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

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

(s) Any restrictive intervention used, including a restraint, must be time-limited and removed immediately when the participant no longer presents a risk of immediate harm to self or others.

Section 19, Psychoactive Medication Usage Standards.

(a) If a participant is prescribed psychoactive medication as standard treatment, then the plan of care must include information from the attending medical provider with prescription authority to ensure the following:

(i) The participant is diagnosed with a medical condition by a licensed psychiatrist or physician and may benefit from the use of psychoactive medications; and

(ii) The medical section of the participant's approved individualized plan of care must:

(A) Describe the medical conditions or behaviors for which the medication is prescribed;

(B) Justify use of the medication(s), including the benefits and potential side effects;

(C) State the length of time considered sufficient to determine if the medication is effective (i.e., treatment trial);

(D) Identify the behavioral criteria to determine whether the medication is effective, such as the changes in behavior, mood, thought, or functioning that may be considered evidence the medication is effective;

(E) Describe the plan to monitor medication side effects; and

(F) Describe the plan to simplify the number and types of medications and to reduce dosages and discontinue medications, unless otherwise contraindicated.

(b) If the attending medical physician prescribes a psychoactive medication PRN that may be used during the provision of waiver services, a PRN protocol for use of the medication must be developed to supplement the positive behavior support plan pursuant to the Sections 17 of this Chapter. In addition:

(i) The prescription or other medical orders must be specific to the participant's condition and be considered the standard of treatment for the participant's condition;

(ii) The participant must receive assistance with a prescribed psychoactive medication in order to manage the participant's behavior with the approval of the participant or the participant's legally authorized representative(s);

(iii) Any psychoactive medication given against the participant's will is considered a chemical restraint;

(iv) Upon notice of a medication change, the participant's individualized plan of care must be updated;

(v) The use of such drugs and medications must be in the best interest of the participant to improve his or her quality of life;

(vi) The use or threat of physical force for the administration of psychoactive medications is prohibited; and

(vii) Providers must document the non-pharmacological interventions which will be used prior to the use of a psychoactive medication PRN.

(c) Psychoactive medication monitoring requires the provider to monitor the participant's response to one or more prescribed medications, to observe the participant for side effects, correct dosage and intervals, and follow other medically approved best practice monitoring methods, in conjunction with orders from the treating physician.

(d) If PRN psychoactive medications are given four (4) or more times in one month, then the provider shall notify the prescribing medical professional and report all psychoactive medication usage by a participant, including any instances of PRN administration and chemical restraints. A change to the participant's treatment plan, medication regimen, or plan of care must be considered if possible to reduce the use of any PRN or restrictive intervention.

(e) Any participant's medication regimen that includes psychoactive medications, contraindicated medications, or other classifications of medications that are intended to have a psychotropic effect may be subject to a polypharmacy referral to Medicaid.

(f) If a scheduled psychoactive medication dosage is missed, it must be reported as a medication error.

Section 20, Notification of Incident Process.

(a) A provider 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 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) All providers shall report the following non-critical incidents to the Division, Protection & Advocacy Systems, Inc., the case manager, and any legally authorized representative(s) within one 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 restrictive interventions;

(iii) Any use of seclusion;

(iv) Injuries caused by restraints;

(v) Elopement, which is defined as the unexpected or unauthorized absence of an participant for more than is approved in the participant's 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;

(vi) Medication errors, 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 accepted standard time frame for the medication assistance; and

(vii) Medical or behavioral admission and Emergency Room or Urgent Care visits that are not scheduled medical visits.

(c) In addition to provisions of subsection (a) and (b), if, at any time, a significant risk to a waiver participant's health and safety is found, the provider shall report the incident to the Division.

(d) Medication error reports, that do not result in emergency medical attention, must be filed no later than one (1) business day after the event is discovered, in order to give the provider time to complete all follow-up listed in subsection (e) prior to reporting.

(e) Providers shall have incident reporting policies and procedures that include the requirements of this section and maintain internal incident reports for all critical and non-critical

incidents identified in this section. 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.

(f) A provider shall comply with Division, or other agency requests, for additional information relating to the incidents upon request.

Section 21, Complaint Process.

(a) Accredited Providers. All accredited providers shall adhere to the current accreditation requirements for complaints or grievances.

(b) A provider who believes a participant's health or safety is in jeopardy, shall immediately contact the Division, and other governmental agencies, such as law enforcement or DFS.

(c) Upon receipt of a complaint from any person, the Division shall:

(i) Notify the complainant within ten (10) calendar days in writing that the complaint is received. The notification must address:

(A) Anticipated timeframe for completing complaint investigation, and

(B) The authority for taking actions.

(ii) Notify the provider in writing when a complaint 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 investigation that a complaint has been received, the nature of the complaint, and that the complaint is being investigated.

(iii) Notify the complainant when the complaint has been investigated and closed.

(iv) Submit a written report to the provider(s) involved in the complaint summarizing the results of the complaint investigation. The report may include findings, recommendations, and timeframes to address the recommendations through a corrective action plan.

(v) A provider's failure to complete a corrective action plan may result in sanctions.

Section 22, Transition Process.

(a) The participant 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 participant in writing at least thirty (30) days prior to ending services, unless the Division approves a shorter transition period in advance. Failure to provide services during this thirty (30) 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(s), chooses to change providers, they shall inform the participant's case manager of the decision.

(d) When a transition occurs, the case manager shall:

(i) Notify the Division of the request for change within five (5) business days of request;

(A) If the participant, or any legally authorized representative(s), requests a change of case manager, the Division shall review choice and provider lists with the participant and guardian.

(B) If the participant or legally authorized representative(s) 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(s).

(ii) Complete the Transition Checklist as required by the Division;

(iii) Gather and share appropriate information as outlined in the Transition Checklist;

(iv) Schedule individualized plan of care team meetings and notify all current and new providers, the participant, any legally authorized representative(s), and the Division at least two (2) weeks prior to the meeting. Team meetings may be scheduled sooner than two (2) weeks due to an emergency situation. Case managers shall notify the Division of any emergency requiring a faster transition schedule; and

(v) Modify the participant's plan of care.

(A) If a revised individual plan of care is required, the case manager shall complete the revised plan and submit it to the Division at least thirty (30) days before the new provider(s) is scheduled to begin providing services.

(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) days prior to the scheduled start date of the new services.

(e) All providers on the plan of care shall share pertinent information with the case manager and the individualized plan of care team in a timely manner.

(f) If a provider providing residential services to a participant requires a participant to move to another residential location, 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 supported living.

(ii) The provider shall notify the participant, family, case manager, and any legally authorized representative(s) of the move at least thirty (30) days in advance so the participant can exercise the choice to find a new residence or provider.

Section 23, Notice of Costs to the Participant.

(a) The provider shall develop and implement a system to notify participants and legal representatives of any associated cost to the participant for a service or item and the terms of payment, which are the responsibility of the participant or the legally authorized representative(s).

(b) Written notice must be given to the participant before initiation of service and before any change. Providers shall allow participants and their legal representative(s) 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 must 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 must 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 may not charge participants for changes to the provider's staffing, facilities, 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 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 must be communicated to the participant or legally authorized representative(s), including:

(i) How the participant or any legally authorized representative(s) will give informed consent for the expenditure of funds;

(ii) How the participant or legal representative(s) may access the records of the funds;

(iii) How funds are segregated for accounting and reporting purposes to the participant, guardian, 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 services 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 or during the provider's provision of services.

(c) Providers may not use or allow participant funds or personal property to be used:

(i) As a reward or punishment, unless specified in the 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 showing the charge is appropriate for the participant to make restitution, the rationale is documented, and the participant or legal 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 loan to the provider or the provider's employees.

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, any Supported Employment Service, and are on plans of care for three (3) or more participants shall receive national accreditation in the accreditation areas specific to the service being provided, and if the provider's waiver income equals or exceeds $125,000 collectively per calendar year. Providers shall obtain accreditation in the area applicable to each service within eighteen (18) months of qualifying under this provision.

(b) Provider accreditation options include Commission on Quality and Leadership (CQL) or Commission on Accreditation of Rehabilitation Facilities (CARF). Regardless of the accreditation attained, all references to accredited providers in this rule apply to the provider.

(c) A provider shall maintain accreditation as long as they provide qualifying services to three (3) or more participants for one of these services.

(i) The Division shall decertify a provider who fails to obtain or maintain accreditation.

(ii) If a provider fails to obtain or maintain accreditation, a transition plan must be implemented for each participant who is leaving the provider's services.

(A) 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.

(B) 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.

(d) An accredited provider shall establish a human rights committee that meets no less than semi-annually. The accredited provider's human rights committee shall review trend data on the use of PRN psychotropic medication as outlined in Section 19, participant trend data on restrictive intervention usage identified in Section 18, and situations where violation of a participant's rights has or may have occurred.

(i) The review must include obtaining additional information and gathering input from the affected participant and his or her legally authorized representative(s), if applicable, to make recommendations to the provider.

(ii) The human rights committee shall document its case reviews, findings, recommendations, and other activities.

(iii) Membership of the human rights committee shall include, at a minimum, a representative from the provider organization, a person with a developmental disability, a family member or legally authorized representative(s) of a person with a developmental disability, and a certified waiver case manager.

(A) The human rights committee shall maintain the confidentiality of information related to the participants discussed through signed confidentiality agreements. Information on cases may be redacted or scrubbed of personal identifying information.

(B) The affected participant and the participant's legally authorized representative(s) shall be permitted to participate in the meeting when their case is discussed.

(C) Minutes from the human rights committee must be made available to the Division upon request.

(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 Committee.

(a) The Division shall maintain a Mortality Review Committee to review deaths of participants receiving waiver services.

(b) Providers shall provide information requested by the Mortality Review Committee. 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, and results of physicians' office visits and hospital visit.

(c) The Committee 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 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) After the effective date of this rule, the Division will only certify one provider per physical location.

(c) The Division may 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 any open cases with the Medicaid Fraud Control Unit.

(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) Any person who has been convicted of Medicaid fraud may not be certified.

(f) The Division may refuse to certify or 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 falsifications of statements, documents, or any concealment of material fact may result in a denial or 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 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).

(i) The Division shall initially certify a new provider agency providing any service for one year. The agency must complete an on-site recertification at the end of the first year to continue providing services

Section 28, Recertification of Providers.

(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 shall detail requirements the provider shall meet to be recertified.

(b) After the initial year certification, the Division shall recertify an agency annually. This certification will include an on-site visit at least once every three (3) years.

(c) Recertification for providers 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 services in a facility they control, own or lease, the Division shall also review the provider's self-inspection of facilities and a current inspection report from an outside entity.

(d) For a scheduled on-site recertification, the Division will notify the provider of the visit sixty (60) days prior to the evaluation.

(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 agency is not complying with state or federal rules and regulation, or at the Division's discretion.

(f) Non-accredited providers may sign a form verifying that they do not provide services in their home or a provider-owned, leased, or controlled facility. 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.

(g) The Division does not require an on-site recertification for a case manager or providers of specialized equipment or environmental modifications.

(h) Providers shall submit verification that they have met all applicable recertification requirements to the Division at least forty-five (45) calendar days prior to their certification expiration date.

(i) If a provider fails to submit the applicable recertification requirements to the Division as described above, the Division shall notify the provider in writing of the expiration of the certification and may grant the provider fifteen (15) calendar days to meet the recertification requirements.

(ii) If the provider does not meet the recertification requirements within fifteen (15) business days after the date of the Division's letter, the Division shall decertify the provider.

(A) The provider may not apply to become a certified provider for a period of two (2) years from the date the provider was decertified.

(B) The provider shall be notified in writing through certified mail that their certification has expired.

(i) During any on-site recertification, 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 must be addressed within thirty (30) calendar days in order to maintain certification.

(i) The Division may approve a certification period for up to one year depending on deficiencies noted during the recertification 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.

Section 29, Corrective action plan requirements.

(a) The Division will, 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 chapter through a corrective action plan.

(c) Corrective action plans must 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 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 implemented to address all areas of suspected non-compliance, the Division may impose sanctions as warranted.

(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 disapproval of the plan.

(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 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.

(i) The Division may complete follow-up investigations or review additional items during the provider's recertification process to assure the provider has fully implemented and evaluated and that participants remain safe during the corrective action plan implementation.

Section 30, Sanctions.

(a) Sanctions may be imposed in accordance with the provisions of Chapter 16, Medicaid Program Integrity.

(b) Notwithstanding the provisions of Section 29 of this Chapter, the Division may impose sanctions for any violation of these rules.

(c) If the Division revokes a provider's certification or suspends a national provider identification number,

(i) The provider shall submit transition plans to the Division detailing the transition of each participant to other settings within thirty (30) calendar days of the date that the sanction is deemed final.

(ii) The transition plans may not be implemented until approval by the Division.

(iii) 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.

(iv) Transition plans must adhere to the requirements in Section 22 of this Chapter.

Section 31, Relative Providers.

(a) The Division shall allow a participant's relative to become a certified waiver provider and receive reimbursement for services provided to the related participant.

(b) A relative is defined as a participant's biological or adoptive parent(s) and stepparent(s).

(c) A participant's spouse or legally authorized representative may not directly or indirectly receive reimbursement for providing waiver services for their ward unless the guardian presents the Division with a certified copy of a court order establishing guardianship under the terms described by Wyo. Stat. Ann. § 3-2-107(b). Direct or indirect reimbursement shall include, but is not limited to, providing direct services at or serving as the owner or officer of a provider organization serving the ward, residing in a provider owned facility serving the ward, or being married to a person providing waiver services to the ward.

(d) To provide waiver services to a related participant, the relative 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, or legally authorized representative may be hired to provide services through self-direction.

(f) Services that 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, the parent or stepparent cannot live in same residence as the participant.

(ii) Personal care and supported living services reimbursed to a relative provider cannot exceed four (4) hours per day 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 may 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 must align with the needs and supports specified in the plan of care which demonstrate the need for extraordinary care; and

(B) The participant's Adaptive Behavior Quotient must 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 physician and the Behavioral Health Division.

(g) If a parent, stepparent, or legally authorized representative is providing personal care to his or her ward, the plan of care must 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 and appropriate team members, and the Division as needed, to choose other providers as appropriate and modify the plan of care to better suit the needs of the participant.

(i) Payment to any relative specified in subsections (f) and (g) 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) Any relative who provides services either as an owner, employee, 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, how the conflict of interest is mitigated, and the policy is shared with the participant and legally authorized representative(s).

Section 32, Interpretation of Chapter. 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. 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.

CHAPTER 46

MEDICAID SUPPORTS AND COMPREHENSIVE WAIVERS

Section 1, Authority.

This Chapter is promulgated by the Department of Health pursuant to Wyo. Stat. Ann. § 9-2-102, the Medical Assistance and Services Act at Wyo. Stat. Ann. §§ 42-4-104 through -120, 2013 Wyo. Sess. Laws 322-25, and the Wyoming Administrative Procedure Act at Wyo. Stat. Ann. §§ 16-3-101 through -115.

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) The Behavioral Health Division, hereafter referred to as the "Division", may issue manuals, bulletins, or both, 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 or bulletins shall be subordinate to the provisions of this Chapter.

Section 3, General Provisions.

(a) Terminology. Unless otherwise specified, the terminology used in this Chapter is standard terminology and has the standard meaning used in accounting, health care, Medicaid, and Medicare.

(b) Incorporation by reference:

(i) Any code, standard, rule or regulation incorporated by reference does not include any later amendments or editions of the incorporated matter beyond the effective date of this Chapter. These materials may be obtained at cost from the Department.

(ii) The following items are incorporated by reference:

(A) Title XIX of the Social Security Act. 42 C.F.R. Part 441, Subpart G, found at http://www/ecfr/gov/cgi-bin/ECFR.

(B) Wyoming's Medicaid State Plan found at http://health.wyo.gov/healthcarefin/medicaid/spa.html.

(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, objectives of the Supports and Comprehensive Waivers include:

(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, 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, Assessment and Eligibility.

(a) Eligibility under this Chapter is limited to persons who complete the application process and who meet the following requirements for clinical eligibility and financial eligibility. In order to be eligible for the Wyoming Medicaid Supports Waiver or Wyoming Medicaid Comprehensive Waiver, an individual must:

(i) Meet all citizenship, residency, and financial eligibility requirements established in Chapter 18 of Wyoming Medicaid Rules;

(ii) Meet ICF/ID level of care; and

(iii) Meet one of the following clinical eligibility diagnoses:

(A) A diagnosis of an intellectual disability with an Intelligence Quotient (IQ) score two standard deviations or more below the population mean, including a margin of measurement error within + 5 points, with a max score of 65–75 (70 ± 5). The diagnosis must:

(I) Be as determined by Medicaid enrolled clinical psychologist who is independent from the provider of waiver services, and currently licensed in Wyoming and

(II) Be verified in a written psychological evaluation.

(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 must 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 major life activity areas: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and

(VI) Has qualifying adaptive behavior scores as determined through standard measurement of adaptive behavior, using the most current forms of the Vineland or Adaptive Behavior Assessment System. For those with a diagnosis along the Autism Spectrum Disorder, a current autism evaluation must be completed.

(C) Has 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)

(II) Meets at least one of the following evaluations to confirm the diagnosis:

a. A score of 42 or more on the Mayo Portland Adaptability Inventory (MPAI), or

b. A score of 40 or less on the California Verbal Learning Test II Trials 1-5 T, or

c. A score of 4 or more on the Supervision Rating Scale.

(III) A completed LT-ABI-105 verifies that the individual meets ICF/MR level of care.

(D) A child applicant who is old enough to take 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 defined 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.

(iv) Qualify on the Inventory for Client and Agency Planning (ICAP) assessment with one of the following:

(A) If age twenty-one (21) or older,

(I) A service score of 70 or less; and

(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 seventeen (17) 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 must 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;

(II) For individuals age six (6) through twenty (20), an adaptive behavior quotient of .70 or below.

(b) Diagnoses and assessments used to meet initial clinical eligibility must be accurate and no more than five (5) years old. Any assessments or reassessment for eligibility are subject to review by the Division before acceptance and may require additional evidence or verification.

(c) For participation in the Comprehensive Waiver, an individual shall meet the clinical eligibility specified in this section and have assessed service needs in excess of the established cost limit on the Supports Waiver and meet the emergency criteria as approved by the Extraordinary Care Committee (ECC), or meet the criteria for reserved capacity. Transition to the Comprehensive Waiver shall only occur as funding and a slot on the Comprehensive Waiver becomes available.

(d) Loss of eligibility.

(i) A participant shall be determined to have lost eligibility when the participant:

(A) Does not meet clinical eligibility when re-assessed; or

(B) Does not meet financial eligibility; or

(C) Changes residence to another state.

(ii) Services to a participant determined not to meet eligibility requirements shall be terminated no more than forty-five (45) days after the determination is made. If an applicant is determined not to meet eligibility criteria, the applicant or the applicant's legal representative shall be notified in writing within fifteen (15) business days.

(iii) A participant may be denied waiver eligibility and may be required to reapply when the participant:

(A) Voluntarily does not receive any waiver services for three (3) consecutive months;

(B) Is in a nursing home, hospital, or residential treatment facility, institution, or ICF/ID for thirty (30) consecutive days; or

(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.

(iv) Upon written notification of the denial of waiver eligibility:

(A) The participant or legally authorized representative may submit, in writing, a request for reconsideration within thirty (30) days of the notice of loss of eligibility, which shall include the reasons why the participant should still be considered eligible for the services.

(B) The Division Administrator or Designee shall review this written request and make a final determination in writing within thirty (30) days of the request.

(v) If the participant is determined not to be eligible for services due to one of the criteria in (iii) of this Section, the participant or the participant's legally authorized representative shall be notified in writing within fifteen (15) business days.

(e) Reassessments.

(i) A participant shall be reassessed for level of care and clinical eligibility at least annually or more frequently at the option of the Division.

(ii) The psychological evaluation shall be completed before waiver eligibility is determined, then as necessary by the participant's change in condition with prior approval by the Division.

(iii) 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.

(iv) The Division may require other assessments to determine budget amounts or service authorization.

(v) Psychological reassessments must be conducted by an entity without a conflict of interest to the providers chosen by the participant or legally authorized representative.

Section 6, 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 data on programs, participant outcomes, costs, and other information as required by the Division.

Section 7, Waiver Services, Service Requirements, and Restrictions.

(a) All waiver services specified in the plan of care must 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 budget.

(b) Services must be prior authorized before they may be provided to a participant.

(c) The individualized plan of care must be developed using person-centered practices and planning, including the preferences and outcomes desired by the participant, and address the assessed needs, potential risks and plans to mitigate risks. The plan must describe the type, scope, frequency, amount and duration of services to be provided to the participant. The plan must also identify the provider, or provider types, that furnish the described services, regardless of the funding source.

(d) Waiver services must be intended to assist the participant in acquiring, retaining, and improving the skills necessary so the individual can function with as much independence as possible, exercise choice and self-management, and participate in the rights and responsibilities of community membership.

(e) The approved plan of care shall reflect the services, and actual units that providers agree to provide over the plan year. The approved plan of care shall also include details regarding the specific support to be provided in various settings, times of day, and for specific activities that require more support than others.

(f) Services available on the Supports and Comprehensive Waiver are approved by the Centers for Medicaid and Medicare Services in the waiver application.

(g) Providers cannot serve children under age 18 and adults at the same time unless prior authorized in writing by the Division.

(h) Waiver services shall not be used to duplicate a 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.);

(iv) Medicaid State Plan; or

(v) Local communities or school districts.

(i) Participants may request an exemption from subsection (h) by submitting a third payer liability form as part of the participant's annual plan of care. This form must 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.

(j) Routine transportation for activities provided during the service are included in the reimbursement rate for the service regardless of the number of trips. The provider may 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.

(k) Participants receiving residential habilitation services may receive up to an average of thirty-five (35) hours of day services per week of day service which includes: Adult Day, Community Integration, Companion, and Prevocational services.

(l) Waiver services include:

(i) Adult Day Services:

(A) Adult Day Services are structured services, for participants' ages twenty-one (21) and over, which are meant to supplement community based activities. The services should consist of meaningful day activities that maximize or maintain skills and abilities; keep participants engaged in their environment and community through optimal care and support; actively stimulate, encourage, develop, and maintain, personal skills; introduce new leisure pursuits; establish new relationships; improve or maintain flexibility, mobility, and strength; or build on previously learned skills. Services are billed by fifteen (15) minute units.

(B) Adult Day Services must provide active supports which foster independence, and be person-centered to the maximum extent possible, as identified in the participant's plan of care. Adult Day Services also include personal care, protective oversight, and health maintenance activities such as medication assistance and routine activities that may be provided by direct support professionals identified in the plan of care.

(C) Transportation into the community to shop, attend recreational and civic events, and to access community activities and resources, is a component of Adult Day Services. Transportation is included in the Adult Day Services rate.

(D) Adult Day Services may be provided in the participant's home if the team decides the home is a more appropriate place to receive the service and the approved plan of care supports the medical, behavioral, or other reason for the service to be provided in the person's home. If this option will be utilized during the provision of this service, the case manager must document it in the "objective" portion in the IPC for this service.

(E) Adult Day Service providers shall be reimbursed using a tiered service rate, which is based on the individual participant's level of service need. Budgets for participants who also receive residential habilitation services shall be based on an estimate of the participant specific day service need, and multiplied by the 15 minute Community Integration rate for each Level.

(I) Basic Level of Care: Levels 1 and 2 on the Level of Service Need score. Providers serving participants at this level must provide intermittent staff support and personal attention to provide assistance as needed due to the participant's moderately high levels of independence and functioning. Behavioral needs, if any, may be met with medication or informal direction by staff. The participant may have periods of time with indirect staff supervision where staff are onsite and available through hearing distance of a request. Participants are estimated to need between fifteen (15) and twenty (20) hours of services per week at this level.

(II) Intermediate Level of Care: Levels 3, 4, and 5 on the Level of Service Need score. Providers serving participants at this level must provide full-time supervision for the participant with staff available on-site, within line of sight, to meet the participant's functional limitations, medical, or behavioral needs. Behavioral and medical supports are not generally intense and may be provided in a shared staffing setting. Regular personal attention must be provided throughout the day for personal care, reinforcement, community or social activities. Participants are estimated to need between twenty (20) and thirty (30) hours of services per week at this level.

(III) High Level of Care: Levels 5 and 6 on the Level of Service Need score. Providers serving participants at this level must provide full-time supervision with staff available on-site within absolute line of sight and frequent staff interaction and personal attention to these participants due to significant functional limitations, medical, or behavioral needs. Support and supervision needs are moderately intense, but can still generally be provided in a shared setting unless otherwise specified in the plan of care. Frequent personal attention must be given to the participant throughout the day for reinforcement, positive behavior support, personal care, community or social activities. Participants are estimated to need between twenty-five (25) and thirty-five (35) hours of services per week at this level.

(ii) Behavioral Support Services:

(A) Behavioral Support Services include training, supervision, or assistance in appropriate expression of emotions and desires, cooperation, assertiveness, acquisition of socially appropriate behaviors, and the reduction of inappropriate behaviors through the implementation of positive behavior support and interventions. Behavioral Support services may be accessed for the purpose of reducing the use of restrictions and restraints within a participant's current plan of care or service environment.

(B) Behavioral Support services provided must not be covered under any billable service through the Medicaid State Plan.

(C) Activities conducted through this service may not include restrictive interventions described in Chapter 45, section 18, of the Wyoming Medicaid Rules.

(iii) Case management services:

(A) Case management is a required service for all waiver participants.

(B) Case managers may bill twelve (12) monthly units or up to two-hundred ninety-six (296) fifteen minute units per year. The number of 15 minute units used must be based upon the needs of the participant or guardian up to the approved amount authorized on the plan of care.

(C) Case managers must assist participants in gaining access to needed waiver and other Medicaid State Plan services. Case managers must also identify and assist participants with accessing additional medical, social, educational and other services, regardless of the funding source for the additional services.

(D) Billable case management activities include: plan of care development, service coordination, monitoring of the plan of care, second-line medication monitoring, following up on concerns, service observation, team meetings, conducting participant specific training, service documentation review, face to face meeting with participants, guardians or family member relating to the plan of care or service delivery, advocacy and referral activities, crisis intervention coordination, coordination of natural supports and non-waiver resources, and home visits.

(E) To bill for a monthly unit of case management, a case manager shall:

(I) Document all billable activities provided during the month; and

(II) Provide at least two hours minimum of documented service, with at least one hour of person-to-person contact with the participant or guardian per calendar month and a home visit.

(III) The direct contact must include either face-to-face meetings or phone conversations with the participant and guardian.

(IV) The direct monthly contact shall be used to discuss waiver services, health, and safety topics with the participant to ensure the participant is satisfied with services and has no unmet needs.

(F) To bill using fifteen (15) minute units, a case manager shall:

(I) Provide at least one (1) unit of service per month for each waiver participant on his or her caseload;

(II) Complete monthly in-home visits, with the participant present, for participants receiving residential habilitation, special family habilitation, and supported living services.

(III) Complete quarterly in-home visits, with the participant present, for participants residing in any other residential setting.

(IV) Complete additional in-home visits during times of crisis, when requested by the participant, or when otherwise required by these rules.

(G) The case manager shall schedule and facilitate annual and semi-annual individual plan of care team meetings, and other team meetings when requested by the participant, guardian, a member of the team, or the Division, and when concerns arise with incidents, restrictive interventions, or when service over- or under-utilization occurs.

(H) The case manager shall give at least thirty (30) days advance written notice to team members and the Division for a plan of care meeting unless a shorter notification time is approved by the Division.

(I) The case manager shall monitor the plan of care in accordance with Chapter 45 of the Wyoming Medicaid Rules.

(iv) Child Habilitation Services:

(A) Child Habilitation Services provide participants ages zero (0) through seventeen (17) with regularly scheduled activities and supervision for part of a day, where services include formal and informal training, the coordination and intervention directed at skill development and maintenance, physical health promotion and maintenance, language development, cognitive development, socialization, social and community integration, and domestic and economic management.

(B) Services may provide supplementary staffing necessary to meet the child's exceptional care needs in a daycare setting, and do not include the basic cost of child care for ages birth through age twelve (12). Basic cost of child care means the rate charged by and paid to a childcare center or worker for children who do not have special needs.

(C) Services are billed by fifteen (15) minute units. Services may not be approved on the Comprehensive waiver in excess of 9400 units per year. Services approved must be based on assessed need and fit within the person’s assigned budget.

(D) A provider may receive reimbursement for up to two (2) participants at one time. A Child Habilitation provider employee may not supervise more than three (3) persons regardless of funding source during the provision of this service.

(v) Cognitive Retraining Services: provide training to the person served or family members that will assist in compensating for the loss of or restoring cognitive function (e.g. ability/skills for learning, analysis, memory, attention, concentration, orientation, and information processing) in accordance with the Plan of Care. They are billed as a 15 (fifteen) minute unit.

(vi) Community Integration Services:

(A) Community Integration Services offer assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that takes place in a non-residential setting, separate from the participant's private residence or other residential living arrangement. Services are billed by fifteen (15) minute units.

(B) Services must be furnished in any of a variety of settings in the community and may not be limited to fixed-site facilities. Activities and environments must be designed to foster the acquisition of skills, appropriate behavior, greater independence, community networking, and personal choice. Making connections with community members is a strong component of this service provision.

(C) Community Integration services must focus on enabling the participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the service plan. Services may serve to reinforce skills or lessons taught in other settings.

(D) Community Integration Services are habilitative services that provide assistance and training with the acquisition and retention of skills. Twenty-five percent of services must address planning and participating in community integrated activities increasing annually with an ultimate goal of fifty percent. Community integration services should be meaningful to the participant and minimize time spent in a congregate facility.

(E) Tiered service rates must be provided based upon level of service need, according to the following tier descriptions:

(I) Basic Level of Care: Levels 1 and 2 on the Level of Service Need score. Providers serving participants at this level must provide intermittent staff supports and personal attention to the participant daily to provide assistance as needed due to the participant's moderately high level of independence and functioning. Behavioral needs, if any, may be met with medication or informal direction by staff. The participant may have periods of time with indirect staff supervision where staff are onsite and available within hearing distance to assist with a participant's request.

(II) Intermediate Level of Care: Levels 3 and 4 on the Level of Service Need score. Service tier requires full-time supervision for the participant with staff available on-site within line of sight to meet the participant's functional limitations, medical, or behavioral

needs. Behavioral and medical supports are not generally intense and can be provided in a shared staffing setting. Regular personal attention must be provided throughout the day for personal care, reinforcement, community, or social activities.

(III) High Level of Care: Levels 5 and 6 on the Level of Service Need score. Providers serving participants at this level must provide full-time supervision with staff available on-site within absolute line of sight, and frequent staff interaction and personal attention to meet the participant's functional limitations, medical, or behavioral needs. Support and supervision needs are moderately intense, but can still generally be provided in a shared setting unless otherwise specified in the plan of care. Frequent personal attention must be given to the participant throughout the day for reinforcement, positive behavior support, personal care, community, or social activities.

(vii) Companion Services:

(A) Companion services include non-medical care, supervision, socialization and assisting a waiver participant in maintaining safety in the home and community and enhancing independence. Companions may assist or supervise the individual with such tasks as meal preparation, laundry, and shopping, but do not perform these activities as discrete services. Companions may also perform light housekeeping tasks that are incidental to the care and supervision of the participant. Companion services include informal training goals in areas specified in the individual plan of care. The provision of companion services does not entail hands-on nursing care, but does include personal care assistance with activities of daily living as needed during the provision of services. This service is billed as a fifteen (15) minute unit.

(B) Companion services units are available for individual services or in groups serving no more than three (3) participants total.

(C) Service may exceed a nine (9) hour cap only for special events or out of town trips.

(viii) Crisis Intervention Services:

(A) Crisis intervention services may be provided for the purpose of supporting a participant when the need arises. Crisis intervention services may include positive behavior supports or other non-violent, non-physical crisis intervention services to deescalate a situation, teach appropriate behaviors, and keep the participant safe until the participant is stable. Crisis intervention services may not be used to watch a participant in case a behavior occurs.

(B) Crisis intervention services are available to a participant age eighteen (18) years or older in Residential Habilitation, Community Integration services, Prevocational, or Supported Employment Services.

(C) Crisis intervention services may be added to a plan for situations where a participant's tier level of habilitation services may not provide sufficient support for specific activities, medical conditions, or occurrences of behaviors or crisis, but the extensive supervision is not needed at all times. Intervention for behavioral purposes is not intended for watching the

person should the behavior occur, but for the purpose of supporting the participant when the need arises, using positive behavior supports and non-violent, non-physical crisis intervention services to de-escalate a situation, teach appropriate behaviors and keep the participant safe until the participant is stable.

(D) Service is billed as a fifteen (15) minute unit and the quantity of service must be approved by the Division and be based on verified need, evidence of the diagnosis, or condition requiring this service.

(E) Documentation of progress and data on behaviors and the outcome of the intervention services must be submitted to the case manager and Division every six months or at the frequency specified in the approved plan of care.

(ix) Dietician:

(A) Dietician services shall be supported by a formal assessment completed by a registered dietician and must be prescribed by a physician.

(B) Providers must provide at least thirty (30) minutes of service to bill for Dietician services. This service is billed at a per session rate.

(C) The Dietician services must be for participants who show a pattern of chronic and unusual need requiring Dietician services. Chronic needs encompass conditions, such as severe obesity, poor food choices that compromise health, special diets approved by a physician for specific diagnoses, or severe allergies.

(x) Environmental modification. Environmental modifications shall be provided pursuant to Chapter 44.

(xi) Employment Discovery and Customization:

(A) Employment Discovery and Customization services are available to a participant age eighteen (18) or older to determine the strengths, needs, and interests of the participant relating to employment. Services include developing an employment opportunity through job carving, self-employment or entrepreneurial initiative, or other job development or restructuring strategies that result in job responsibilities being customized and individually negotiated to fit the needs of participants.

(B) Employment Discovery and Customization services may not duplicate reasonable accommodations and supports that may be necessary and expected of an employer for a participant to perform functions of a job that is individually negotiated and developed.

(C) Employment discovery and customization is a 1:1 support service and has a limited time frame of 12 months. This service is reimbursed at a fifteen (15) minute unit rate. An additional twelve (12) months may be approved by the Division upon review of the progress made the prior year.

(D) Employment Discovery and Customization services are capped at 400 units annually. When the service is approved, participants will receive 100 units to develop a strengths, needs, and interest assessment, and an employment plan. Once the employment plan is submitted to the Division, an additional 300 units may be approved to explore various types of job customization, self-employment, or entrepreneurial opportunities.

(xii) Homemaker:

(A) Homemaker services may consist of general household activities such as meal preparation and routine household care, and may be provided by a trained homemaker when the individual regularly responsible for these activities is unable to manage the home and care for oneself or others in the home, or when the person who usually does these things is temporarily unavailable or unable to perform the tasks.

(B) Homemaker services do not include any direct care or supervision of the waiver participant.

(C) Units of homemaker service must not exceed three (3) hours per week per household or 624 units annually. Homemaker services are not available to participants who receive residential habilitation or special family habilitation home services on the waiver. This service is billed at a fifteen (15) minute unit rate.

(xiii) Independent Support Broker:

(A) Independent Support Brokerage must include services to assist the participant or the legally authorized representative in arranging for, directing, and managing services that are being self-directed. The support broker shall assist in identifying immediate and long-term needs, budgeting, developing options to meet needs, teaching self-advocacy, assisting with employee grievances and complaints, and accessing identified supports and services. The Support Broker shall conduct practical skills training to enable participants and their legal representatives to independently direct and manage waiver services by providing information on how to recruit and hire direct care workers, manage workers, effectively communicate, and problem-solve.

(B) This service may not duplicate other waiver services, including case management.

(C) The service has a cap of 320 units annually based on a fifteen (15) minute unit rate.

(D) A Support Broker, when on a participant’s plan of care, has the responsibility for training all of the participant's employees on the policy for reportable incidents and ensuring that all incidents meeting the criteria of the Division’s Notification of Incident Process are reported.

(E) A Support Broker must review employee time sheets and the monthly Fiscal Management Service reports to ensure that the individual budget amount is being spent in accordance with the approved plan of care, and coordinate follow-up on concerns with the participant's case manager.

(F) Support Brokerage is an optional service for a participant or legally authorized representative who self-directs services. If an employer of record is struggling with self-directing responsibilities, the Division may require the participant to work with a Support Broker in order for the participant to continue to self-direct. After a year of required support brokerage, the participant or representative may opt out of support broker services if a formal request is submitted to the Division and one of the following criteria is met:

(I) The participant or guardian, who is the employer of record, demonstrates the ability to choose workers, coordinates the hiring of workers, and coordinates the delivery of services; or

(II) The employer of record self-directs services for one (1) year with no concerns, including hiring, firing, training, scheduling workers and reviewing timesheets in a timely manner.

(G) A Support Broker shall be free of any conflict of interest including employment with a certified waiver provider or provision of any other waiver service to the same participant.

(H) A Support Broker hired by the participant through self-direction shall only serve one (1) participant or two (2) participants who are siblings residing in the same household.

(I) If a participant hires a parent or stepparent as an employee of a direct care service, then the participant must have an actively involved, unrelated support broker to ensure there is a responsible person in addition to the participant to assume employer responsibilities.

(xiv) Individual Habilitation Training:

(A) Individual Habilitation Training is a specialized 1:1 intensive training service for a participant under age twenty-two (22) to assist with the acquisition or improvement in skills not yet mastered that will lead to more independence and a higher level of functioning. Individual Habilitation Training services are for participants who live with unpaid caregivers or who need less than twenty-four (24) hour paid supervision and support.

(B) Supports and training objectives must be part of the plan of care and may include: adaptive skill development; assistance and training on activities of daily living; transportation safety; navigation; building social capital and connections; and hobby skill development for work on fine or gross motor skills.

(C) Objectives must be specific and measureable, and data must be tracked and analyzed for trends. Summary reports on progress or lack of progress must be given to the

case manager and participant or guardian monthly. Objectives shall be re-written as needed when skills are learned or training is not yielding progress.

(D) Supports may include facilitation of inclusion of the individual within a community group or volunteer organization; opportunities for the participant to join associations or community groups; opportunities for inclusion in a broad range of community settings including opportunities to pursue social and cultural interests; choice making; and volunteer time.

(E) Individual Habilitation Training is an hourly unit, which can be provided in different increments throughout the calendar day, as long as the total units billed equals at least 60 minutes. Only hourly billing units are accepted.

(F) Individual Habilitation Training has a four (4) hour a day limit and units shall be approved based upon the participant's need and budget limit.

(xv) Occupational therapy:

(A) Reimbursement for occupational therapy services shall require both a prescription and a treatment letter or recommendation from a physician.

(B) Providers of occupational therapy group services may serve up to three (3) participants at a time.

(C) Occupational Therapy services consist of the full range of activities provided by a licensed occupational therapist and services may be used for maintenance and the prevention or regression of skills.

(D) Services are available for a participant age twenty-one (21) and older.

(E) Service is available as a fifteen (15) minute unit for an individual session or as a group session unit, which requires a minimum of thirty (30) minutes in service in order to bill.

(xvi) Personal care:

(A) Personal care services shall be provided on a 1:1 basis and include assistance to a participant to accomplish tasks ranging from hands-on assistance and performing a task for the participant to cuing the participant to perform a personal care task.

(B) Health-related personal care services may be provided for care relating to medical or health protocols, medication assistance or administration, and range of motion exercises. Health related services may be provided after staff are trained by the appropriate trainer or medical professional, and the provider must maintain documentation of training.

(C) Services may include: (I) assistance in performing activities of daily living, such as: bathing, dressing, toileting, transferring, or maintaining continence, and (II) instrumental activities of daily living on the person's property, such as: personal hygiene, light housework, laundry, meal preparation (exclusive of the cost of the meal), using the telephone, medication, or money management. Personal Care Services must be essential to the health and welfare of the participant, rather than that participant's family.

(D) A participant living in a non-residential service setting may receive up to 6000 units per year based upon the participant's assessed need and availability of funds within the participant's assigned budget. This service is billed as a fifteen (15) minute unit.

(E) A participant living in a residential service setting on the Comprehensive Waiver, who needs ongoing supervision and cannot attend a day service due to medical or health conditions limit attendance in these programs, may receive up to 7280 units of personal care services per year based upon the participant's need and availability of funds within the participant's assigned budget.

(F) The amount of personal care services for a minor child provided by the child's legally authorized representative, parent or stepparent must be based upon individual extraordinary care needs as specified in the approved individualized plan of care and other assessments.

(G) For relative providers residing in the same household as the waiver participant, personal care provided by the relative provider in the home shall be for extraordinary care only and cannot exceed four (4) hours per day per participant unless approved by the Division's Extraordinary Care Committee.

(xvii) Physical therapy:

(A) Reimbursement for physical therapy services shall require both a prescription and a treatment letter or recommendation from a physician.

(B) Providers of physical therapy group services may serve up to three (3) participants at a time.

(C) Physical Therapy services may be used for maintenance and the prevention or regression of skills and assist participants to preserve and improve their abilities for independent functioning, such as range of motion, strength, tolerance, and coordination.

(D) Physical Therapy services are available for a participant age twenty-one (21) and older.

(E) Physical Therapy services are available as a fifteen (15) minute unit for an individual session or thirty (30) minute unit as a group session.

(xviii) Prevocational:

(A) Prevocational services are available to a participant age twenty-one (21) or older and must be designed to create a path to integrated community-based employment in a job matched to the individual's interests, strengths, priorities, abilities, and capabilities.

(B) Services must provide learning and work experiences, including volunteer work, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services may include teaching concepts such as compliance, attendance, task completion, problem solving, interpersonal relationships, and safety.

(C) Services may be furnished in a variety of locations in the community and are not limited to provider facilities. Prevocational services may be provided at a volunteer worksite or mentorship locations for the purpose of teaching job preparedness for a specific type of work.

(D) Participation in prevocational services may not be required as a pre-requisite for individual or small group supported employment services furnished under the waiver.

(E) Participants receiving paychecks in prevocational services must be compensated by the participant's employer in accordance with applicable state and federal laws.

(F) Waiver reimbursement is not available for the provision of vocational services delivered in facility-based or sheltered work settings, where individuals are supervised for the primary purpose of producing goods or performing services.

(G) Prevocational services are time-limited and should not exceed twelve (12) consecutive months. Units cannot exceed 7280 units per plan year either as a stand-alone service or in combination with Companion and Adult Day Services when a person is living in a residential habilitation setting. This service is billed as a fifteen (15) minute unit.

(H) An additional twelve (12) months may be approved by the Division in subsequent years with submission of an approved employment plan (through vocational rehabilitation, school district, or the waiver) and upon review of active progress made the prior year on finding employment opportunities, increasing work skills, time on tasks, or other job preparedness objectives.

(I) A monthly objective must be included in the provision of services relating to work readiness skills. These skills and objectives may include volunteering, mentoring, increasing involvement with community members, improving communication with community members, and accessing other resources to further employment development and potentially prepare the participant for work in the community. Progress on objectives must be reported monthly to the case manager, participant, and legally authorized representative.

(J) If there is no progress on prevocational training objectives or the employment pathway planning, a participant may not receive prevocational services in subsequent years and other waiver services may be accessed to meet the supervision and support needs of the participant.

(K) Tiered service rates must be based upon level of service need:

(I) Basic Level of Care for participants between a level 1 and 2.9 Level of Service Need score require limited staff supports and personal attention to a participant daily due to a moderately high level of independence and functioning. Behavioral needs, if any, can be met with medication or informal direction by staff. The participant may have periods of time with indirect staff supervision where staff are onsite and available through hearing distance of a request.

(II) Intermediate Level of Care for participants between a level 3 and 4.9 Level of Service Need score require full-time supervision with staff available on-site within line of sight due to significant functional limitations, medical or behavioral needs. Behavioral and medical supports are not generally intense and can be provided in a shared staffing setting. Regular personal attention is given throughout the day for personal care, reinforcement, community or social activities.

(III) High Level of Care for participants between a level 5 and 6 Level of Service Need score require full-time supervision with staff available on-site within absolute line of sight and frequent staff interaction and personal attention for significant functional limitations, medical or behavioral needs. Support and supervision needs are moderately intense, but can still generally be provided in a shared setting unless otherwise specified in the plan of care. Frequent personal attention given throughout the day for reinforcement, positive behavior support, personal care, community or social activities.

(L) For each participant receiving this service, documentation must be maintained in the provider and case manager's file that demonstrates prevocational services or a similar service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

(xix) Remote Monitoring:

(A) Remote Monitoring services provides extra monitoring of an individual in his or her residence by remote staff using one of more of the following electronic systems: live video feed, live audio feed, motion sensors, radio frequency identification, web-based monitoring system, or other devices. This service will be billed at an hourly rate and cover the required staff time.

(B) Waiver funds shall not be used for video monitoring in participant's bedrooms or bathrooms.

(C) The provider of remote monitoring must have a system for notifying emergency personnel such as police, fire, or additional support staff.

(xx) Remote Monitoring Equipment Installation: Remote Monitoring Equipment Installation is a one-time service per client for the initial set-up and installation of remote monitoring equipment. This service must follow the rules applying to specialized equipment in Wyoming Medicaid Chapter 44.

(xxi) Remote Monitoring Equipment: Remote Monitoring Equipment is a monthly service to cover the lease and maintenance costs of equipment.

(xxii) Residential Habilitation:

(A) Residential habilitation services shall consist of individually-tailored supports for a waiver participant age eighteen (18) or older on the Comprehensive Waiver to assist with the acquisition, retention, or improvement in skills related to living in the community. Services shall be provided appropriate to the level of supervision identified in the plan of care and include regular adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development. Services must assist the participant to be as independent as possible and reside in the most integrated setting appropriate to his or her needs.

(B) Participants receiving residential habilitation shall have one primary residence and bedroom that is uniquely assigned to him or her, stipulated in a lease or residency agreement, which is homelike in nature and decorated according to the participant's preferences.

(C) The participant must have immediate, on-site access to the provider of services inside the residence on a twenty-four (24) hour basis.

(D) Services shall not include payments for the cost of room and board, including the cost of building maintenance, upkeep and improvement.

(E) Residential Habilitation services are reimbursed using a daily unit based upon the level of service need of the participant, where the participant needs some level of ongoing twenty-four (24) hour support by a provider on site.

(F) Residential Habilitation may be delivered through self-direction as Shared Living, where the participant and other housemates own or lease the residence from an entity that is not a certified waiver provider. The employee hired through self-direction may serve up to three (3) people in shared living, but can serve no other participants in a residential habilitation service.

(G) For a participant receiving this service, the participant will be assigned a tiered level of reimbursement as specified in an approved plan of care. Tier levels for this service align with the assessed Level of Service Need for the participant and the expectations of the service as specified in the definition. All supervision and supports delivered must align with the participant's plan of care.

(H) Tiered Level descriptions. Residential Habilitation participants must receive services in accordance with the written plan of care, and the following tiers descriptions.

(I) Level 1–Level 1 participants exhibit a high level of independence and functioning without significant behavioral or medical issues. Provider staff serving Level 1 participants shall meet with participants on a periodic basis each day for the purpose of providing general supervision, support, monitoring, and training. Staff shall be available on-call for twenty-four (24) hour support.

(II) Level 2- Level 2 participants exhibit a moderately high level of independence and functioning with few or no behavioral or medical issues. Level 2 participants may require minimal staff support, monitoring, or personal care. Provider staff serving Level 2 participants shall meet periodically with the participant during awake hours on each day billed to provide general supervision, support, monitoring, training, and personal care. Staff shall be available on-call for twenty-four (24) hour support.

(III) Level 3- Due to moderate functional limitations in activities of daily living and possible behavioral support needs, this tier requires staff available to meet periodically with the participant on each day billed for general supervision, support, personal care, positive behavior support, monitoring, training and staff support through the night in the residence or in a nearby office.

(IV) Level 4- Level 4 participants exhibit significant functional limitations, and medical or behavioral support needs that can be met in a shared staff setting. Provider staff serving Level 4 participants shall be on-site, full-time, and regularly provide personal attention throughout the day for training, personal care, reinforcement, positive behavior support, community, and social activities. Staff shall be available for support in the residence through the night.

(V) Level 5- Level 5 participant's exhibit significant and somewhat intensive functional limitations, as well as medical or behavioral support needs that require a limited shared staff setting. Provider staff serving participants serving Level 5 participants shall be on-site and in line-of-sight during most awake hours when the participant is in this service, with frequent personal attention given throughout the day for training, personal care, reinforcement, community or social activities. Staff shall be available for support in the residence through the night, with additional expectations stipulated in the plan of care.

(VI) Level 6- Level 6 participants exhibit high medical, behavioral or personal care needs, which require frequent personal support and supervision. Level 6 participants shall be served by one (1) staff person who is on-site and in line-of-sight during all awake hours, while the participant is in this service. The expectation is that the participant shall receive the attention of at least one to two caregiver(s) as specified in the plan of care. Staffing ratios during the day and night must be kept as approved by BHD in the plan of care.

(I) Residential habilitation services and respite services may not appear on the same individual plan of care except when:

(I) The participant is transitioning into a residential setting such as a group home; or

(II) Unpaid caregivers need respite when the participant spends time at home visiting on weekends or vacations.

(III) The residential provider provides a host-home environment and the provider is not accredited by a national organization

(J) The provider shall provide residential habilitation services directly to the participant in the community or in the residence during both awake and sleeping time for a minimum of eight (8) hours in a twenty-four (24) hour period (from 12:00am-11:59pm) for the provider to be reimbursed.

(K) Participants shall be free to voluntarily leave their residential habilitation home, with the intent to return, for events such as vacations, family visits, or sleepovers. Providers shall not receive reimbursement while the participant is outside the residential habilitation home for these or other similar purposes, except that the provider may receive full reimbursement for the day that the participant returns to the residential habilitation provider home.

(L) A participant not yet receiving twenty-four (24) hour residential services who may be at significant risk due to extraordinary needs that cannot be met in their current living arrangement and require twenty-four (24) hour care may request Residential Habilitation services if the participant meets one of the following targeting criteria:

(I) A substantial threat to a person's life or health due to the abrupt absence of a residence or caregivers who can provide the necessary support needed to keep the person safe. The emergency requires verification of need by Department of Family Services, the Behavioral Health Division or Protection & Advocacy System, Inc.

(II) The person's condition poses a substantial threat to a person's life or health, and is documented in writing by a physician.

(III) The person has caused serious physical harm to him or herself or someone else in the home, or the person's condition presents a substantial risk of physical threat to him or herself or others in the home.

(IV) There are significant and frequently occurring behavior challenges resulting in danger to the person's health and safety, or the health and safety of others in the home.

(V) The person's critical medical condition requires ongoing twenty-four (24) hour support and supervision to maintain the person's health and safety.

(VI) Loss of primary caregiver due to caregiver's death, incapacitation, critical medical condition, or inability to provide continuous care.

(M) Any new residential habilitation placement must be approved by the Extraordinary Care Committee.

(xxiii) Respite:

(A) Respite is a short-term service that allows an unpaid caregiver, a Residential Habilitation provider who is not nationally certified or accredited, or a Special Family Habilitation Home provider to receive limited relief from the daily care of a participant. Services may include assistance with activities of daily living, medication assistance, and general supervision provided in the caregiver's home, the provider's home, or in community settings.

(B) Services must be primarily episodic in nature, and may not be used when parents or primary caregivers are working.

(C) A respite provider may serve up to two (2) unrelated participants at the same time or up to three (3) participants in the same family who live in the same household. A participant requiring 1:1 care must receive 1:1 respite services.

(D) Respite is reimbursed as a fifteen (15) minute unit or a daily rate.

(E) On the Comprehensive Waiver, the total number of fifteen (15) minute units available for respite per plan year is 5000. When respite services exceed nine (9) hours a day, the provider must bill as a daily unit. There is no unit cap on the Supports Waiver.

(F) A provider may provide supervision to other non-waiver participants requiring support and supervision, and must limit the total combined number of persons they are providing supervision to at a given time to no more three (3) persons unless approved by the Division.

(xxiv) Self-Directed Goods and Services. Self-Directed Goods and Services shall be provided pursuant to Chapter 44.

(xxv) Skilled nursing:

(A) Skilled Nursing services are medical care services delivered to individuals with complex chronic or acute medical conditions and performed within the Nurse's scope of practice as defined by Wyoming's Nurse Practice Act. Skilled Nursing services include the application of the nursing process including assessment, diagnosis, planning, intervention and evaluation, and the administration, teaching, counseling, supervision, delegation, and evaluation of nursing practice and the execution of the medical regimen.

(B) Services needed must be specifically prescribed by a physician on a form specified by the Division and require a level of expertise that is undeliverable by non-medical trained individuals.

(C) The delivery of Skilled Nursing services is limited to those individuals who possess an unencumbered license issued by the Wyoming State Board of Nursing.

(D) Skilled Nursing services may be used when the Medicaid State Plan Services have been exhausted, are not available in the person's area, are not available due to services denied by the home health provider, or the hours of need for the service are not available by the home health provider. The form showing evidence of no other skilled nursing services available will be reviewed annually and may be subject to an annual update as service providers or state plan service coverage in regions becomes available.

(E) A billable skilled nursing service unit is considered to be a service that is provided up to fifteen (15) minutes and that involves one-on-one direct patient care. Skilled nursing units may be rounded up to the nearest fifteen (15) minute unit. Units billed for rounded up services may not exceed eight (8) units within a one hour timeframe for multiple participants in a single location by one provider nurse.

(F) Skilled nursing services must address the ongoing chronic or acute medical issues for which the service is needed and must include direct patient care or services. Skilled Nursing providers cannot be reimbursed for watching television with a participant, transportation to and from doctor appointments, time spent charting, time spent in waiting room with participant, or time spent completing paperwork, or similar non-nursing activities.

(xxvi) Special Family Habilitation Home:

(A) Special Family Habilitation Home services must include participant specific, individually-designed and coordinated training within a family host home environment that does not include the participant's biological, step, or adoptive parents.

(B) This service is only available to participants under the age of twenty (20) years old on the Comprehensive waiver who are receiving this service before the effective date of this rule. The service is not open to newly enrolled participants.

(C) The Special Family Habilitation Home provider shall be the primary caregiver and assume twenty-four (24) hour care of the individual.

(D) This service may not be used in conjunction with Individual Habilitation Training services.

(E) The provision of Special Family Habilitation Home services includes personal care needs. Plans of care may not include the personal care service.

(F) This service pays for support to an individual who needs support twenty-four (24) hours a day. The provider shall be in the residence of the participant providing service during both awake and sleeping time for a minimum of (8) hours in a twenty-four (24) hour period (from 12:00am-11:59pm) for the provider to be reimbursed.

(G) Family visits and trips are encouraged. The provider shall not be reimbursed for days that the participant is absent, but may request reimbursement for the day the participant returns home from a trip.

(H) The Special Family Habilitation Home provider shall provide both formal and informal training opportunities to participants served. The schedule must be individualized and the training objective must be meaningful. Progress on objectives shall be reported to the case manager monthly.

(xxvii) Specialized equipment. Specialized equipment shall be provided pursuant to Chapter 44.

(xxviii) Speech, hearing, and language services:

(A) Reimbursement for speech, hearing, and language services requires both a prescription and a treatment letter or recommendation from a physician.

(B) Speech, hearing, and language services are available for a participant age twenty-one (21) and older and must consist of the full range of activities provided by a licensed speech therapist. Services may include screening and evaluation of participants with respect to speech function; development of therapeutic treatment plans; direct therapeutic intervention; selection, assistance, or training with augmentative communication devices; and the provision of ongoing therapy.

(C) Services through the waiver can be used for maintenance and the prevention of regression of skills.

(D) A minimum of forty-five (45) minutes of service per session must be provided in order to bill for one session

(E) Providers of speech, hearing, and language group services may seek reimbursement for providing such services to a group of up to three (3) participants at one time.

(xxix) Subsequent Assessment:

(A) Subsequent assessments may be provided as part of ongoing case management and will include the necessary collaboration of professionals to assess the needs, characteristics, preferences and desires of the waiver participant.

(B) Case managers shall initiate and oversee subsequent assessments, regardless of payment source, including the psychological assessment or neuropsychological

assessment needed for continued eligibility, and any other approved assessments necessary to determine the participant's needs and not available through the Medicaid State plan.

(C) A subsequent assessment must be prior authorized by the Division.

(xxx) Supported Employment:

(A) Supported employment services must provide support and assistance to a participant age eighteen (18) or older who needs intensive support to find and maintain a job in a competitive, integrated work setting because of his or her disability. Services must assist the participant with sustaining paid work. Services may include supervision and training. Services are billed as a fifteen (15) minute unit.

(B) Supported employment services must be provided at a work site where persons without disabilities are employed. Services may provide reimbursement for the adaptations, supervision and training required to assist a participant with sustaining paid work. Reimbursement shall not include payment for supervisory activities rendered in the normal course of business.

(C) Objectives must be identified in the participant's plan that support the need for job coaching and a plan to lessen the job coaching over time, if possible. The job coach must be in the immediate vicinity of the participant during services and available for immediate intervention and support.

(D) Documentation shall be maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

(E) Services shall be provided as either in an individual 1:1 setting or as part of a group.

(I) Group supported employment services may be provided to a group ranging from two (2) to nine (9) persons. Group employment for groups larger than nine (9) people will not be reimbursed by the waiver. Group Supported Employment services consist of intensive, ongoing support that enables a participant to perform in a regular work setting, including mobile work crews or enclaves.

(II) Individual Supported Employment services are 1:1 supports provided to a participant to obtain and maintain employment.

(1.) Services may assist a participant to work in a competitive or customized job, be self-employed, or work in an integrated work setting in the general workforce where the participant is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by an individual without a disability.

(2.) Individual Supported Employment must be provided in a community-integrated employment setting, unless the support is to develop customized employment, self-employment, or home-based employment, subject to prior approval of the Division.

(xxxi) Supported Employment Follow Along:

(A) Supported Employment Follow Along services enable a participant, who is paid at or above the federal minimum wage, to maintain employment in an integrated community employment setting.

(B) Service is provided for or on behalf of a participant through intermittent and occasional job support, communicating with the participant's supervisor or manager, whether in the presence of the participant or not. A provider may use this service for regular contact and follow-up with the employer and participant in order to reinforce and stabilize the job placement, facilitate natural supports at the work site, provide individual program development, write tasks analyses, or conduct monthly reviews, termination reviews, and behavioral intervention.

(C) This service may cover support through phone calls between support staff and the participant's managerial staff.

(D) A provider shall be reimbursed at a fifteen (15) minute rate for up to 100 units annually based upon individual need in order to maintain employment.

(E) This service does not reimburse for transportation, work crews, public relations, community education, in service meetings, or individual staff development.

(xxxii) Supported Living:

(A) Supported Living Services assist participants who do not require ongoing twenty-four (24) hour supervision but do require a range of community-based supports and habilitation training to be able to live in their own home, family home, or rental unit.

(B) Services must be based upon need and may include assisting with activities of daily living, performing routine household activities to maintain a clean and safe home, assistance with health issues, medications and medical services, teaching the participant to access the community, and building personal relationships with others. In some cases, the service may require twenty-four (24) hour emergency assistance if specified in the plan of care.

(C) The supported living service daily rate is based on seven (7) hours of service a day and a provider shall provide a minimum of four (4) hours of documented service per calendar day for reimbursement. One (1) staff or provider can be reimbursed for up to three (3) participants during a daily unit of service provided.

(D) Supported living services can be billed at a fifteen (15) minute unit rate for a maximum of 5,400 units per plan year for services provided to a group up to two (2) or three (3) participants, or 3,900 fifteen (15) minute units per plan year provided to an individual participant.

(E) Supported living is a habilitation service, which means training on objectives is required as part of the provision of services and objective progress must be reported to the participant, guardian, and case manager monthly.

(F) Supported living may not be provided on the same day as residential habilitation.

(G) The plan of care must identify either the daily unit or the individual or group 15-minute unit, based on the participant's need. Both the daily unit and the fifteen (15) minute unit may be on the participant's plan of care but cannot be used on the same day.

(xxxiii)Transportation:

(A) Transportation service on the waiver is a gap service to enable participants to gain access to an employment location, community services, activities, and resources as specified by the plan of care when a service provider is not needed at the event.

(B) Transportation services are not intended to replace formal or informal transportation options, like the use of natural supports, city transportation services, and travel vouchers. Whenever possible, family, neighbors, friends, or community agencies, that can provide this service without charge or with other resources, must be utilized.

(C) This service does not include transportation to medical appointments required under 42 CFR 431.53 or other transportation services available under the Medicaid state plan.

(D) Transportation services will be reimbursed based on mileage used. This service is capped at $2,000 per year.

(E) Transportation services cannot be utilized in conjunction with or to access other waiver services that specify in the service scope that transportation is covered in the rate for that service.

Section 8, Waiver Cost Limits and Individual Budget Amounts.

(a) The allocation of Medicaid waiver funds that may be available to a participant to purchase services is based on his or her assessed needs.

(b) Eligibility shall be determined pursuant to Section 5 of this Chapter before an individual budget amount is determined.

(c) The Supports Waiver.

(i) 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 to the participant 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;

(E) A temporary funding increase when needed for an emergency situation, which is approved by the Extraordinary Care Committee, not to exceed the established cost limit for the Supports Waiver.

(ii) Any participant eligible for the Supports Waiver shall also be given a Level of Service Need score in order to determine eligibility and priority order for Comprehensive Waiver funding.

(d) The Comprehensive Waiver.

(i) The Comprehensive Waiver shall fund services for participants whose needs are in excess of the Supports Waiver cap, meet the emergency criteria as specified by the ECC, or are transitioning from a state-funded institution that meets reserved capacity criteria as specified in Section 11 (g) of this Chapter.

(ii) Waiver recipients active on the Adult or Child DD Waivers before April 1, 2014 will automatically be placed on the Comprehensive Waiver unless they choose otherwise.

(iii) 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 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.

(F) A temporary or permanent increase or decrease as determined by the Clinical Review Team or Extraordinary Care Committee.

(iv) The factors in subsection (d) (iii) determine the participant's Level of Service Need score in order to plan for appropriate services and supports.

(v) Supports to the participant through waiver services must align with the Level of Service need scoring rubric associated with the person's Level of Service score. Standards of care for each level include:

(A) Level 1, which means the participant requires few supports weekly due to a high level of independence and functioning compared to one's peers. This participant is independent with ADLs but may follow checklists as reminders. No significant behavioral or medical issues that cannot be controlled with medication and routine medical care. Participant requires minimal support services that can be provided within a few hours per week, and can be left alone in the home or community for extended periods of time.

(B) Level 2, which means the participant requires infrequent care and limited supports daily due to a moderately high level of independence and functioning. Some days may not require any support. Behavioral needs, if any, can be met with medication or informal or infrequent verbal redirection by caregivers, which may or may not require a PBSP. There may be a need for day services and intermittent residential support services to assist with certain tasks, and the participant can be unsupervised for several hours at time during the day and night.

(C) Level 3, which means the participant requires limited personal care or regular supervision due to a moderate level of functional limitations in activities of daily living, requiring staff presence and some physical assistance. Behavioral needs, if any, are met through medication, informal direction by caregivers, or occasional therapy (every one to two weeks). Participant does not require 24-hour supervision – generally able to sleep unsupervised – but needs structure and routine throughout the day. Intermittent personal attention should be given daily for training, personal care, community or social activities.

(D) Level 4, which means the participant requires regular personal care or close supervision due to significant functional limitations, medical or behavioral conditions. Therapy and medical care may be needed monthly in addition to support from staff. Behavioral and medical supports are not generally staff-intensive and may be provided in a shared staffing setting. Regular attention is needed throughout the day for training, personal care, reinforcement, community or social activities.

(E) Level 5, which means the participant requires extensive personal care or constant supervision due to behavioral or medical concerns or due to significant functional limitations concerns, including frequent and regular on-site staff interaction and support. Therapy and medical care may be needed bi-monthly in addition to support from staff. Behavioral and medical concerns must be addressed with written behavioral or medical plans

and protocols. Support needs are highly intense, but can still generally be provided in a shared staff setting. Staff must provide line of sight supervision and frequent personal attention must be given throughout the day for training, reinforcement, positive behavior support, personal care, community or social activities.

(F) Level 6, which means the participant needs total personal care or intense supervision throughout the day and night. Supervision by a sole staff on-site (not shared) must be conducted by at least line of sight, with much of the staff's time within close proximity providing direct support during all waking hours. At times, the participant may require the full attention of two staff for certain activities of daily living and in response to certain behavioral events. Therapy and medical care may be needed weekly in addition to support from staff. Typically, this level of service is only needed by someone with intense behaviors, not just medical needs alone. There is no ratio flexibility from the amount approved in the plan of care. Behavioral and medical supports require written plans or protocols to address support needs.

(vi) A participant's individual budget amount on the Comprehensive Waiver may not exceed the current annual average cost of a resident at the Wyoming Life Resource Center. A participant who needs services in excess of this amount must have the plan of care and budget approved by the Division's Extraordinary Care Committee, 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.

Section 9, Clinical Review Team.

(a) The Division's Clinical Review Team (CRT) shall be comprised of the Division's licensed Psychologist, the Medicaid Medical Director, a Division manager, and the assigned Participant Support Specialist. When appropriate, the CRT may also include the Division's Registered Nurse, a behavioral specialist, or the Division's Psychiatrist. The CRT may consult with other specialists in the field.

(b) The CRT shall review submitted requests involving:

(i) Concerns about a Level of Service Need score; or

(ii) Requests for extraordinary service or support needs.

(c) A request may be made by the participant through the participant's Plan of Care team, if they can demonstrate that a participant's level of service need score does not reflect the participant's assessed needs.

(d) A request must 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 Inventory for Client and Agency Planning (ICAP) or in the information stored electronically by the Division for the case.

(e) The CRT has the authority to request additional assessments, including a new ICAP, a Supports Intensity Scale, or another appropriate and standardized assessment targeted for a specific diagnosis or condition, or refer the case to the Extraordinary Care Committee.

(i) The additional assessment in these cases may provide more detailed information about the person's support needs and assist the CRT in evaluating the need for a different Level of Service Need 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.

(f) The additional assessments and information CRT reviews may result in a Level of Service Need increase, decrease, or no change.

(g) Any eligible individual denied the requested level of service need score or a requested extraordinary support or service under this section may request administrative review of that decision pursuant to Chapter 4, Administrative Hearings.

Section 10, Self-Directed Service Delivery.

(a) The services that may be self-directed include Child Habilitation, Companion, Homemaker, Individual Supported Employment, Independent Support Brokerage, Individual Habilitation Training, Personal Care, Residential Habilitation Shared Living, Respite, Self-Directed Goods and Services, and Supported Living.

(b) Each participant's case manager shall provide the participant or guardian information regarding the option to self-direct waiver services at least once a year.

(c) Self-Direction opportunities are available to participants who:

(i) Live in his or her own private residence or the home of a family member; or

(ii) Reside 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 may 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.

(j) Consistent with the service definitions in this Chapter, 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 to be provided, 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 must maintain documentation in accordance with the Wyoming Medicaid Rules.

(m) The Employer of Record, with assistance from the case manager as needed, is responsible for reviewing 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 plan of care.

(n) A participant 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 services or providers. The case manager must disenroll the participant from the Financial Management Service within thirty (30) days.

(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 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

(iv) The participant chooses not to receive self-directed services for ninety (90) days after active enrollment begins.

Section 11, Wait List Process.

(a) The Division shall maintain a wait list for each waiver when there is insufficient funding to add additional participants to that waiver or no open slots in the waiver as approved by the Centers for Medicare and Medicaid Services.

(b) Participants who qualify for the Comprehensive Waiver may receive Supports Waiver funding and services and also apply to and be on the wait list for the Comprehensive Waiver.

(c) The Division shall prioritize eligible individuals on the wait lists on a first come, first serve basis. Funding opportunities will be given to the person who spent the longest time waiting for services starting from the date that the individual was determined eligible.

(d) Before being added to a Waiver wait list, the individual must be determined eligible as specified in Section 5 of this Chapter.

(e) For people with the same date of eligibility on the wait list, the Division will use the date that the "Selection of Case Manager" form was received by the Division to determine which individual's name goes first.

(f) The level of service need score and individual budget amount shall be determined for each individual on the wait lists. An eligible individual who needs services in excess of the Supports Waiver and has a level of service need score of 4 or higher may apply for the Comprehensive Waiver and may also be placed on the Comprehensive Waiver wait list, if funding or slots are not available.

(g) The Comprehensive Waiver shall reserve capacity each year for individuals who have resided in a Wyoming institution, such as an ICF/ID, nursing home, Psychiatric 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 BHD wait list for at least two (2) years; or

(iii) Previously on a BHD 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.

Section 12, Emergency Services.

(a) An emergency case involves an eligible person that calls for immediate action or an urgent need for waiver services, including physical care and supervision 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 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. A person residing in a homeless shelter is not a cause for an ECC consideration by itself.

(iv) A case involving a person removed from the home due to abuse, neglect, abandonment, exploitation, or self-neglect substantiated by the Department of Family Services (DFS), Protection & Advocacy Systems, 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 caused by a situation listed in (c)(i)(D) of this section that is either corroborated by the Department of Family Services, Protection & Advocacy Systems, Inc., or law enforcement;

(B) A situation where the person's health condition or significant and frequently occurring behavioral challenges poses 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;

(D) The loss of the eligible person's primary caregiver due to death, incapacitation, critical medical condition, or inability to provide continuous care.

(vi) 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 shall assist the person in reviewing options to choose a case manager and complete eligibility determination requirements as quickly as possible.

(vii) Emergency cases shall be referred to the Division's Extraordinary Care Committee pursuant to section 13 of this chapter.

(viii) 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.

Section 13, Extraordinary Care Committee.

(a) The Extraordinary Care Committee (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. Members may consult other specialists in the field as appropriate.

(b) The ECC may 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 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;

(iii) Temporary or any funding increases under Section 8 (c) and 8 (d); or

(iv) Requests requiring ECC approval under these Rules.

(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 (a) of Section 12.

(e) The ECC shall have the authority to approve, modify, or deny a submitted funding request for any person deemed eligible for a waiver operated by the Division or refer the case to the Clinical Review Team.

(f) An ECC request or emergency services must contain verification of how the participant's situation meets emergency criteria. Evidence should 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 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:

(1.) Other community resources, such as a homeless shelter, victim's shelter, or other temporary residence are not available or appropriate; or

(2.) The temporary shelter is 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) Decisions of the ECC shall be by majority and rendered in writing.

(h) The Division Administrator or designee shall document a review of the decisions and may approve, deny or order more action in a case. In cases of a tie vote among members, the Administrator shall issue the final vote.

(i) Any eligible individual denied services under this section may request administrative review of that decision pursuant to Chapter 4, Administrative Hearings.

Section 14, 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/ID, or other institutional placement;

(ii) A spouse of the participant, a legally appointed guardian of a participant age 18 and over, or an owner or officer of a provider organization serving their ward cannot directly or indirectly receive reimbursement for providing waiver services for that ward;

(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 cost of services provided in an ICF/ID, calculated by using the current annual ICF/ID rate; or

(vi) Service settings reimbursed by another state agency, such as the Department of Family Services or Department of Education.

(b) No service that is the responsibility of the school system will be authorized as a waiver service. The Division will not authorize waiver services for the hours the child is attending school or in a vocational program. Regular school hours and days apply for a child who receives home schooling or an adjusted school day.

(c) Any individual eligible for funding for specialized services under the Developmental Disabilities Services Act must 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, Denial of Funding.

(a) The Division can deny or revoke authorization for waiver services for any of the following reasons:

(i) The individual fails to meet waiver clinical eligibility criteria;

(ii) The individual fails to meet financial eligibility criteria;

(iii) The eligible individual has not met emergency criteria and no other waiver funding opportunities are available;

(iv) A waiver funding opportunity is not available;

(v) The individual or legal representative has not consented to waiver services;

(vi) The individual or legal representative has chosen to receive ICF/ID services;

(vii) The individual, his or her legally authorized representative, or other person on his or her behalf has not supplied needed information;

(viii) Intensity of services does not reflect the need for ICF/ID level of care services;

(ix) The individual's needs are not being met through waiver services;

(x) The individualized plan of care has not been implemented;

(xi) A plan of services and supports to protect the individual's health and welfare cannot be developed or maintained;

(xii) The legislature has not appropriated sufficient fiscal resources to fund all services for all persons determined eligible for waiver services;

(xiii) Funding for requested waiver services is available as a similar service from other sources;

(xiv) The eligible individual or legal 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.

(xv) The eligible individual or legal representative has not signed documentation required by the Department;

(xvi) The eligible individual or legal representative has failed to cooperate with, or refused the services funded by the Division;

(xvii) The individual, under the age of twenty-two (22), could receive educational services during a normal, regular, or adjusted school day.

Section 16, 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, 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 18, Severability. If any portion of this Chapter is found to be invalid or unenforceable, the remainder shall continue in full force and effect.

CHAPTER 46

MEDICAID SUPPORTS AND COMPREHENSIVE WAIVERS

Section 1, Authority.

This Chapter is promulgated by the Department of Health pursuant to Wyo. Stat. Ann. § 9-2-102, the Medical Assistance and Services Act at Wyo. Stat. Ann. §§ 42-4-104 through -120, 2013 Wyo. Sess. Laws 322-25, and the Wyoming Administrative Procedure Act at Wyo. Stat. Ann. §§ 16-3-101 through -115.

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) The Behavioral Health Division, hereafter referred to as the "Division", may issue manuals, bulletins, or both, 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 or bulletins shall be subordinate to the provisions of this Chapter.

Section 3, General Provisions.

(a) Terminology. Unless otherwise specified, the terminology used in this Chapter is standard terminology and has the standard meaning used in accounting, health care, Medicaid, and Medicare.

(b) Incorporation by reference:

(i) Any code, standard, rule or regulation incorporated by reference does not include any later amendments or editions of the incorporated matter beyond the effective date of this Chapter. These materials may be obtained at cost from the Department.

(ii) The following items are incorporated by reference:

(A) Title XIX of the Social Security Act. 42 C.F.R. Part 441, Subpart G, found at http://www/ecfr/gov/cgi-bin/ECFR.

(B) Wyoming's Medicaid State Plan found at http://health.wyo.gov/healthcarefin/medicaid/spa.html.

(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, objectives of the Supports and Comprehensive Waivers include:

(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, 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, Assessment and Eligibility.

(a) Eligibility under this Chapter is limited to persons who complete the application process and who meet the following requirements for clinical eligibility and financial eligibility. In order to be eligible for the Wyoming Medicaid Supports Waiver or Wyoming Medicaid Comprehensive Waiver, an individual must:

(i) Meet all citizenship, residency, and financial eligibility requirements established in Chapter 18 of Wyoming Medicaid Rules;

(ii) Meet ICF/ID level of care; and

(iii) Meet one of the following clinical eligibility diagnoses:

(A) A diagnosis of an intellectual disability with an Intelligence Quotient (IQ) score two standard deviations or more below the population mean, including a margin of measurement error within + 5 points, with a max score of 65–75 (70 ± 5). The diagnosis must:

(I) Be as determined by Medicaid enrolled clinical psychologist who is independent from the provider of waiver services, and currently licensed in Wyoming and

(II) Be verified in a written psychological evaluation.

(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 must 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 major life activity areas: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and

(VI) Has qualifying adaptive behavior scores as determined through standard measurement of adaptive behavior, using the most current forms of the Vineland or Adaptive Behavior Assessment System. For those with a diagnosis along the Autism Spectrum Disorder, a current autism evaluation must be completed.

(C) Has 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)

(II) Meets at least one of the following evaluations to confirm the diagnosis:

a. A score of 42 or more on the Mayo Portland Adaptability Inventory (MPAI), or

b. A score of 40 or less on the California Verbal Learning Test II Trials 1-5 T, or

c. A score of 4 or more on the Supervision Rating Scale.

(III) A completed LT-ABI-105 verifies that the individual meets ICF/MR level of care.

(D) A child applicant who is old enough to take 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 defined 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.

(iv) Qualify on the Inventory for Client and Agency Planning (ICAP) assessment with one of the following:

(A) If age twenty-one (21) or older,

(I) A service score of 70 or less; and

(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 seventeen (17) 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 must 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;

(II) For individuals age six (6) through twenty (20), an adaptive behavior quotient of .70 or below.

(b) Diagnoses and assessments used to meet initial clinical eligibility must be accurate and no more than five (5) years old. Any assessments or reassessment for eligibility are subject to review by the Division before acceptance and may require additional evidence or verification.

(c) For participation in the Comprehensive Waiver, an individual shall meet the clinical eligibility specified in this section and have assessed service needs in excess of the established cost limit on the Supports Waiver and meet the emergency criteria as approved by the Extraordinary Care Committee (ECC), or meet the criteria for reserved capacity. Transition to the Comprehensive Waiver shall only occur as funding and a slot on the Comprehensive Waiver becomes available.

(d) Loss of eligibility.

(i) A participant shall be determined to have lost eligibility when the participant:

(A) Does not meet clinical eligibility when re-assessed; or

(B) Does not meet financial eligibility; or

(C) Changes residence to another state.

(ii) Services to a participant determined not to meet eligibility requirements shall be terminated no more than forty-five (45) days after the determination is made. If an applicant is determined not to meet eligibility criteria, the applicant or the applicant's legal representative shall be notified in writing within fifteen (15) business days.

(iii) A participant may be denied waiver eligibility and may be required to reapply when the participant:

(A) Voluntarily does not receive any waiver services for three (3) consecutive months;

(B) Is in a nursing home, hospital, or residential treatment facility, institution, or ICF/ID for thirty (30) consecutive days; or

(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.

(iv) Upon written notification of the denial of waiver eligibility:

(A) The participant or legally authorized representative may submit, in writing, a request for reconsideration within thirty (30) days of the notice of loss of eligibility, which shall include the reasons why the participant should still be considered eligible for the services.

(B) The Division Administrator or Designee shall review this written request and make a final determination in writing within thirty (30) days of the request.

(v) If the participant is determined not to be eligible for services due to one of the criteria in (iii) of this Section, the participant or the participant's legally authorized representative shall be notified in writing within fifteen (15) business days.

(e) Reassessments.

(i) A participant shall be reassessed for level of care and clinical eligibility at least annually or more frequently at the option of the Division.

(ii) The psychological evaluation shall be completed before waiver eligibility is determined, then as necessary by the participant's change in condition with prior approval by the Division.

(iii) 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.

(iv) The Division may require other assessments to determine budget amounts or service authorization.

(v) Psychological reassessments must be conducted by an entity without a conflict of interest to the providers chosen by the participant or legally authorized representative.

Section 6, 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 data on programs, participant outcomes, costs, and other information as required by the Division.

Section 7, Waiver Services, Service Requirements, and Restrictions.

(a) All waiver services specified in the plan of care must 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 budget.

(b) Services must be prior authorized before they may be provided to a participant.

(c) The individualized plan of care must be developed using person-centered practices and planning, including the preferences and outcomes desired by the participant, and address the assessed needs, potential risks and plans to mitigate risks. The plan must describe the type, scope, frequency, amount and duration of services to be provided to the participant. The plan must also identify the provider, or provider types, that furnish the described services, regardless of the funding source.

(d) Waiver services must be intended to assist the participant in acquiring, retaining, and improving the skills necessary so the individual can function with as much independence as possible, exercise choice and self-management, and participate in the rights and responsibilities of community membership.

(e) The approved plan of care shall reflect the services, and actual units that providers agree to provide over the plan year. The approved plan of care shall also include details regarding the specific support to be provided in various settings, times of day, and for specific activities that require more support than others.

(f) Services available on the Supports and Comprehensive Waiver are approved by the Centers for Medicaid and Medicare Services in the waiver application.

(g) Providers cannot serve children under age 18 and adults at the same time unless prior authorized in writing by the Division.

(h) Waiver services shall not be used to duplicate a 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.);

(iv) Medicaid State Plan; or

(v) Local communities or school districts.

(i) Participants may request an exemption from subsection (h) by submitting a third payer liability form as part of the participant's annual plan of care. This form must 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.

(j) Routine transportation for activities provided during the service are included in the reimbursement rate for the service regardless of the number of trips. The provider may 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.

(k) Participants receiving residential habilitation services may receive up to an average of thirty-five (35) hours of day services per week of day service which includes: Adult Day, Community Integration, Companion, and Prevocational services.

(l) Waiver services include:

(i) Adult Day Services:

(A) Adult Day Services are structured services, for participants' ages twenty-one (21) and over, which are meant to supplement community based activities. The services should consist of meaningful day activities that maximize or maintain skills and abilities; keep participants engaged in their environment and community through optimal care and support; actively stimulate, encourage, develop, and maintain, personal skills; introduce new leisure pursuits; establish new relationships; improve or maintain flexibility, mobility, and strength; or build on previously learned skills. Services are billed by fifteen (15) minute units.

(B) Adult Day Services must provide active supports which foster independence, and be person-centered to the maximum extent possible, as identified in the participant's plan of care. Adult Day Services also include personal care, protective oversight, and health maintenance activities such as medication assistance and routine activities that may be provided by direct support professionals identified in the plan of care.

(C) Transportation into the community to shop, attend recreational and civic events, and to access community activities and resources, is a component of Adult Day Services. Transportation is included in the Adult Day Services rate.

(D) Adult Day Services may be provided in the participant's home if the team decides the home is a more appropriate place to receive the service and the approved plan of care supports the medical, behavioral, or other reason for the service to be provided in the person's home. If this option will be utilized during the provision of this service, the case manager must document it in the "objective" portion in the IPC for this service.

(E) Adult Day Service providers shall be reimbursed using a tiered service rate, which is based on the individual participant's level of service need. Budgets for participants who also receive residential habilitation services shall be based on an estimate of the participant specific day service need, and multiplied by the 15 minute Community Integration rate for each Level.

(I) Basic Level of Care: Levels 1 and 2 on the Level of Service Need score. Providers serving participants at this level must provide intermittent staff support and personal attention to provide assistance as needed due to the participant's moderately high levels of independence and functioning. Behavioral needs, if any, may be met with medication or informal direction by staff. The participant may have periods of time with indirect staff supervision where staff are onsite and available through hearing distance of a request. Participants are estimated to need between fifteen (15) and twenty (20) hours of services per week at this level.

(II) Intermediate Level of Care: Levels 3, 4, and 5 on the Level of Service Need score. Providers serving participants at this level must provide full-time supervision for the participant with staff available on-site, within line of sight, to meet the participant's functional limitations, medical, or behavioral needs. Behavioral and medical supports are not generally intense and may be provided in a shared staffing setting. Regular personal attention must be provided throughout the day for personal care, reinforcement, community or social activities. Participants are estimated to need between twenty (20) and thirty (30) hours of services per week at this level.

(III) High Level of Care: Levels 5 and 6 on the Level of Service Need score. Providers serving participants at this level must provide full-time supervision with staff available on-site within absolute line of sight and frequent staff interaction and personal attention to these participants due to significant functional limitations, medical, or behavioral needs. Support and supervision needs are moderately intense, but can still generally be provided in a shared setting unless otherwise specified in the plan of care. Frequent personal attention must be given to the participant throughout the day for reinforcement, positive behavior support, personal care, community or social activities. Participants are estimated to need between twenty-five (25) and thirty-five (35) hours of services per week at this level.

(ii) Behavioral Support Services:

(A) Behavioral Support Services include training, supervision, or assistance in appropriate expression of emotions and desires, cooperation, assertiveness, acquisition of socially appropriate behaviors, and the reduction of inappropriate behaviors through the implementation of

positive behavior support and interventions. Behavioral Support services may be accessed for the purpose of reducing the use of restrictions and restraints within a participant's current plan of care or service environment.

(B) Behavioral Support services provided must not be covered under any billable service through the Medicaid State Plan.

(C) Activities conducted through this service may not include restrictive interventions described in Chapter 45, section 18, of the Wyoming Medicaid Rules.

(iii) Case management services:

(A) Case management is a required service for all waiver participants.

(B) Case managers may bill twelve (12) monthly units or up to two-hundred ninety-six (296) fifteen minute units per year. The number of 15 minute units used must be based upon the needs of the participant or guardian up to the approved amount authorized on the plan of care.

(C) Case managers must assist participants in gaining access to needed waiver and other Medicaid State Plan services. Case managers must also identify and assist participants with accessing additional medical, social, educational and other services, regardless of the funding source for the additional services.

(D) Billable case management activities include: plan of care development, service coordination, monitoring of the plan of care, second-line medication monitoring, following up on concerns, service observation, team meetings, conducting participant specific training, service documentation review, face to face meeting with participants, guardians or family member relating to the plan of care or service delivery, advocacy and referral activities, crisis intervention coordination, coordination of natural supports and non-waiver resources, and home visits.

(E) To bill for a monthly unit of case management, a case manager shall:

(I) Document all billable activities provided during the month; and

(II) Provide at least two hours minimum of documented service, with at least one hour of person-to-person contact with the participant or guardian per calendar month and a home visit.

(III) The direct contact must include either face-to-face meetings or phone conversations with the participant and guardian.

(IV) The direct monthly contact shall be used to discuss waiver services, health, and safety topics with the participant to ensure the participant is satisfied with services and has no unmet needs.

(F) To bill using fifteen (15) minute units, a case manager shall:

(I) Provide at least one (1) unit of service per month for each waiver participant on his or her caseload;

(II) Complete monthly in-home visits, with the participant present, for participants receiving residential habilitation, special family habilitation, and supported living services.

(III) Complete quarterly in-home visits, with the participant present, for participants residing in any other residential setting.

(IV) Complete additional in-home visits during times of crisis, when requested by the participant, or when otherwise required by these rules.

(G) The case manager shall schedule and facilitate annual and semi-annual individual plan of care team meetings, and other team meetings when requested by the participant, guardian, a member of the team, or the Division, and when concerns arise with incidents, restrictive interventions, or when service over- or under-utilization occurs.

(H) The case manager shall give at least thirty (30) days advance written notice to team members and the Division for a plan of care meeting unless a shorter notification time is approved by the Division.

(I) The case manager shall monitor the plan of care in accordance with Chapter 45 of the Wyoming Medicaid Rules.

(iv) Child Habilitation Services:

(A) Child Habilitation Services provide participants ages zero (0) through seventeen (17) with regularly scheduled activities and supervision for part of a day, where services include formal and informal training, the coordination and intervention directed at skill development and maintenance, physical health promotion and maintenance, language development, cognitive development, socialization, social and community integration, and domestic and economic management.

(B) Services may provide supplementary staffing necessary to meet the child's exceptional care needs in a daycare setting, and do not include the basic cost of child care for ages birth through age twelve (12). Basic cost of child care means the rate charged by and paid to a childcare center or worker for children who do not have special needs.

(C) Services are billed by fifteen (15) minute units. Services may not be approved on the Comprehensive waiver in excess of 9400 units per year. Services approved must be based on assessed need and fit within the person’s assigned budget.

(D) A provider may receive reimbursement for up to two (2) participants at one time. A Child Habilitation provider employee may not supervise more than three (3) persons regardless of funding source during the provision of this service.

(v) Cognitive Retraining Services: provide training to the person served or family members that will assist in compensating for the loss of or restoring cognitive function (e.g. ability/skills for learning, analysis, memory, attention, concentration, orientation, and information processing) in accordance with the Plan of Care. They are billed as a 15 (fifteen) minute unit.

(vi) Community Integration Services:

(A) Community Integration Services offer assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that takes place in a non-residential setting, separate from the participant's private residence or other residential living arrangement. Services are billed by fifteen (15) minute units.

(B) Services must be furnished in any of a variety of settings in the community and may not be limited to fixed-site facilities. Activities and environments must be designed to foster the acquisition of skills, appropriate behavior, greater independence, community networking, and personal choice. Making connections with community members is a strong component of this service provision.

(C) Community Integration services must focus on enabling the participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the service plan. Services may serve to reinforce skills or lessons taught in other settings.

(D) Community Integration Services are habilitative services that provide assistance and training with the acquisition and retention of skills. Twenty-five percent of services must address planning and participating in community integrated activities increasing annually with an ultimate goal of fifty percent. Community integration services should be meaningful to the participant and minimize time spent in a congregate facility.

(E) Tiered service rates must be provided based upon level of service need, according to the following tier descriptions:

(I) Basic Level of Care: Levels 1 and 2 on the Level of Service Need score. Providers serving participants at this level must provide intermittent staff supports and personal attention to the participant daily to provide assistance as needed due to the participant's moderately high level of independence and functioning. Behavioral needs, if any, may be met with medication or informal direction by staff. The participant may have periods of time with indirect staff supervision where staff are onsite and available within hearing distance to assist with a participant's request.

(II) Intermediate Level of Care: Levels 3 and 4 on the Level of Service Need score. Service tier requires full-time supervision for the participant with staff available on-site within line of sight to meet the participant's functional limitations, medical, or behavioral needs. Behavioral and medical supports are not generally intense and can be provided in a shared staffing setting. Regular personal attention must be provided throughout the day for personal care, reinforcement, community, or social activities.

(III) High Level of Care: Levels 5 and 6 on the Level of Service Need score. Providers serving participants at this level must provide full-time supervision with staff available on-site within absolute line of sight, and frequent staff interaction and personal attention to meet the participant's functional limitations, medical, or behavioral needs. Support and supervision needs are moderately intense, but can still generally be provided in a shared setting unless otherwise specified in the plan of care. Frequent personal attention must be given to the participant throughout the day for reinforcement, positive behavior support, personal care, community, or social activities.

(vii) Companion Services:

(A) Companion services include non-medical care, supervision, socialization and assisting a waiver participant in maintaining safety in the home and community and enhancing independence. Companions may assist or supervise the individual with such tasks as meal preparation, laundry, and shopping, but do not perform these activities as discrete services. Companions may also perform light housekeeping tasks that are incidental to the care and supervision of the participant. Companion services include informal training goals in areas specified in the individual plan of care. The provision of companion services does not entail hands-on nursing care, but does include personal care assistance with activities of daily living as needed during the provision of services. This service is billed as a fifteen (15) minute unit.

(B) Companion services units are available for individual services or in groups serving no more than three (3) participants total.

(C) Service may exceed a nine (9) hour cap only for special events or out of town trips.

(viii) Crisis Intervention Services:

(A) Crisis intervention services may be provided for the purpose of supporting a participant when the need arises. Crisis intervention services may include positive behavior supports or other non-violent, non-physical crisis intervention services to deescalate a situation, teach appropriate behaviors, and keep the participant safe until the participant is stable. Crisis intervention services may not be used to watch a participant in case a behavior occurs.

(B) Crisis intervention services are available to a participant age eighteen (18) years or older in Residential Habilitation, Community Integration services, Prevocational, or Supported Employment Services.

(C) Crisis intervention services may be added to a plan for situations where a participant's tier level of habilitation services may not provide sufficient support for specific activities, medical conditions, or occurrences of behaviors or crisis, but the extensive supervision is not needed at all times. Intervention for behavioral purposes is not intended for watching the person should the behavior occur, but for the purpose of supporting the participant when the need arises, using positive behavior supports and non-violent, non-physical crisis intervention services to de-escalate a situation, teach appropriate behaviors and keep the participant safe until the participant is stable.

(D) Service is billed as a fifteen (15) minute unit and the quantity of service must be approved by the Division and be based on verified need, evidence of the diagnosis, or condition requiring this service.

(E) Documentation of progress and data on behaviors and the outcome of the intervention services must be submitted to the case manager and Division every six months or at the frequency specified in the approved plan of care.

(ix) Dietician:

(A) Dietician services shall be supported by a formal assessment completed by a registered dietician and must be prescribed by a physician.

(B) Providers must provide at least thirty (30) minutes of service to bill for Dietician services. This service is billed at a per session rate.

(C) The Dietician services must be for participants who show a pattern of chronic and unusual need requiring Dietician services. Chronic needs encompass conditions, such as severe obesity, poor food choices that compromise health, special diets approved by a physician for specific diagnoses, or severe allergies.

(x) Environmental modification. Environmental modifications shall be provided pursuant to Chapter 44.

(xi) Employment Discovery and Customization:

(A) Employment Discovery and Customization services are available to a participant age eighteen (18) or older to determine the strengths, needs, and interests of the participant relating to employment. Services include developing an employment opportunity through job carving, self-employment or entrepreneurial initiative, or other job development or restructuring strategies that result in job responsibilities being customized and individually negotiated to fit the needs of participants.

(B) Employment Discovery and Customization services may not duplicate reasonable accommodations and supports that may be necessary and expected of an employer for a participant to perform functions of a job that is individually negotiated and developed.

(C) Employment discovery and customization is a 1:1 support service and has a limited time frame of 12 months. This service is reimbursed at a fifteen (15) minute unit rate. An additional twelve (12) months may be approved by the Division upon review of the progress made the prior year.

(D) Employment Discovery and Customization services are capped at 400 units annually. When the service is approved, participants will receive 100 units to develop a strengths, needs, and interest assessment, and an employment plan. Once the employment plan is submitted

to the Division, an additional 300 units may be approved to explore various types of job customization, self-employment, or entrepreneurial opportunities.

(xii) Homemaker:

(A) Homemaker services may consist of general household activities such as meal preparation and routine household care, and may be provided by a trained homemaker when the individual regularly responsible for these activities is unable to manage the home and care for oneself or others in the home, or when the person who usually does these things is temporarily unavailable or unable to perform the tasks.

(B) Homemaker services do not include any direct care or supervision of the waiver participant.

(C) Units of homemaker service must not exceed three (3) hours per week per household or 624 units annually. Homemaker services are not available to participants who receive residential habilitation or special family habilitation home services on the waiver. This service is billed at a fifteen (15) minute unit rate.

(xiii) Independent Support Broker:

(A) Independent Support Brokerage must include services to assist the participant or the legally authorized representative in arranging for, directing, and managing services that are being self-directed. The support broker shall assist in identifying immediate and long-term needs, budgeting, developing options to meet needs, teaching self-advocacy, assisting with employee grievances and complaints, and accessing identified supports and services. The Support Broker shall conduct practical skills training to enable participants and their legal representatives to independently direct and manage waiver services by providing information on how to recruit and hire direct care workers, manage workers, effectively communicate, and problem-solve.

(B) This service may not duplicate other waiver services, including case management.

(C) The service has a cap of 320 units annually based on a fifteen (15) minute unit rate.

(D) A Support Broker, when on a participant's plan of care, has the responsibility for training all of the participant's employees on the policy for reportable incidents and ensuring that all incidents meeting the criteria of the Division's Notification of Incident Process are reported.

(E) A Support Broker must review employee time sheets and the monthly Fiscal Management Service reports to ensure that the individual budget amount is being spent in accordance with the approved plan of care, and coordinate follow-up on concerns with the participant's case manager.

(F) Support Brokerage is an optional service for a participant or legally authorized representative who self-directs services. If an employer of record is struggling with self-directing responsibilities, the Division may require the participant to work with a Support Broker in order for the participant to continue to self-direct. After a year of required support brokerage, the participant or representative may opt out of support broker services if a formal request is submitted to the Division and one of the following criteria is met:

(I) The participant or guardian, who is the employer of record, demonstrates the ability to choose workers, coordinates the hiring of workers, and coordinates the delivery of services; or

(II) The employer of record self-directs services for one (1) year with no concerns, including hiring, firing, training, scheduling workers and reviewing timesheets in a timely manner.

(G) A Support Broker shall be free of any conflict of interest including employment with a certified waiver provider or provision of any other waiver service to the same participant.

(H) A Support Broker hired by the participant through self-direction shall only serve one (1) participant or two (2) participants who are siblings residing in the same household.

(I) If a participant hires a parent or stepparent as an employee of a direct care service, then the participant must have an actively involved, unrelated support broker to ensure there is a responsible person in addition to the participant to assume employer responsibilities.

(xiv) Individual Habilitation Training:

(A) Individual Habilitation Training is a specialized 1:1 intensive training service for a participant under age twenty-two (22) to assist with the acquisition or improvement in skills not yet mastered that will lead to more independence and a higher level of functioning. Individual Habilitation Training services are for participants who live with unpaid caregivers or who need less than twenty-four (24) hour paid supervision and support.

(B) Supports and training objectives must be part of the plan of care and may include: adaptive skill development; assistance and training on activities of daily living; transportation safety; navigation; building social capital and connections; and hobby skill development for work on fine or gross motor skills.

(C) Objectives must be specific and measureable, and data must be tracked and analyzed for trends. Summary reports on progress or lack of progress must be given to the case manager and participant or guardian monthly. Objectives shall be re-written as needed when skills are learned or training is not yielding progress.

(D) Supports may include facilitation of inclusion of the individual within a community group or volunteer organization; opportunities for the participant to join associations

or community groups; opportunities for inclusion in a broad range of community settings including opportunities to pursue social and cultural interests; choice making; and volunteer time.

(E) Individual Habilitation Training is an hourly unit, which can be provided in different increments throughout the calendar day, as long as the total units billed equals at least 60 minutes. Only hourly billing units are accepted.

(F) Individual Habilitation Training has a four (4) hour a day limit and units shall be approved based upon the participant's need and budget limit.

(xv) Occupational therapy:

(A) Reimbursement for occupational therapy services shall require both a prescription and a treatment letter or recommendation from a physician.

(B) Providers of occupational therapy group services may serve up to three (3) participants at a time.

(C) Occupational Therapy services consist of the full range of activities provided by a licensed occupational therapist and services may be used for maintenance and the prevention or regression of skills.

(D) Services are available for a participant age twenty-one (21) and older.

(E) Service is available as a fifteen (15) minute unit for an individual session or as a group session unit, which requires a minimum of thirty (30) minutes in service in order to bill.

(xvi) Personal care:

(A) Personal care services shall be provided on a 1:1 basis and include assistance to a participant to accomplish tasks ranging from hands-on assistance and performing a task for the participant to cuing the participant to perform a personal care task.

(B) Health-related personal care services may be provided for care relating to medical or health protocols, medication assistance or administration, and range of motion exercises. Health related services may be provided after staff are trained by the appropriate trainer or medical professional, and the provider must maintain documentation of training.

(C) Services may include: (I) assistance in performing activities of daily living, such as: bathing, dressing, toileting, transferring, or maintaining continence, and (II) instrumental activities of daily living on the person's property, such as: personal hygiene, light housework, laundry, meal preparation (exclusive of the cost of the meal), using the telephone, medication, or money management. Personal Care Services must be essential to the health and welfare of the participant, rather than that participant’s family.

(D) A participant living in a non-residential service setting may receive up to 6000 units per year based upon the participant's assessed need and availability of funds within the participant's assigned budget. This service is billed as a fifteen (15) minute unit.

(E) A participant living in a residential service setting on the Comprehensive Waiver, who needs ongoing supervision and cannot attend a day service due to medical or health conditions limit attendance in these programs, may receive up to 7280 units of personal care services per year based upon the participant's need and availability of funds within the participant's assigned budget.

(F) The amount of personal care services for a minor child provided by the child's legally authorized representative, parent or stepparent must be based upon individual extraordinary care needs as specified in the approved individualized plan of care and other assessments.

(G) For relative providers residing in the same household as the waiver participant, personal care provided by the relative provider in the home shall be for extraordinary care only and cannot exceed four (4) hours per day per participant unless approved by the Division's Extraordinary Care Committee.

(xvii) Physical therapy:

(A) Reimbursement for physical therapy services shall require both a prescription and a treatment letter or recommendation from a physician.

(B) Providers of physical therapy group services may serve up to three (3) participants at a time.

(C) Physical Therapy services may be used for maintenance and the prevention or regression of skills and assist participants to preserve and improve their abilities for independent functioning, such as range of motion, strength, tolerance, and coordination.

(D) Physical Therapy services are available for a participant age twenty-one (21) and older.

(E) Physical Therapy services are available as a fifteen (15) minute unit for an individual session or thirty (30) minute unit as a group session.

(xviii) Prevocational:

(A) Prevocational services are available to a participant age twenty-one (21) or older and must be designed to create a path to integrated community-based employment in a job matched to the individual's interests, strengths, priorities, abilities, and capabilities.

(B) Services must provide learning and work experiences, including volunteer work, where the individual can develop general, non-job-task-specific strengths and skills that

contribute to employability in paid employment in integrated community settings. Services may include teaching concepts such as compliance, attendance, task completion, problem solving, interpersonal relationships, and safety.

(C) Services may be furnished in a variety of locations in the community and are not limited to provider facilities. Prevocational services may be provided at a volunteer worksite or mentorship locations for the purpose of teaching job preparedness for a specific type of work.

(D) Participation in prevocational services may not be required as a pre-requisite for individual or small group supported employment services furnished under the waiver.

(E) Participants receiving paychecks in prevocational services must be compensated by the participant's employer in accordance with applicable state and federal laws.

(F) Waiver reimbursement is not available for the provision of vocational services delivered in facility-based or sheltered work settings, where individuals are supervised for the primary purpose of producing goods or performing services.

(G) Prevocational services are time-limited and should not exceed twelve (12) consecutive months. Units cannot exceed 7280 units per plan year either as a stand-alone service or in combination with Companion and Adult Day Services when a person is living in a residential habilitation setting. This service is billed as a fifteen (15) minute unit.

(H) An additional twelve (12) months may be approved by the Division in subsequent years with submission of an approved employment plan (through vocational rehabilitation, school district, or the waiver) and upon review of active progress made the prior year on finding employment opportunities, increasing work skills, time on tasks, or other job preparedness objectives.

(I) A monthly objective must be included in the provision of services relating to work readiness skills. These skills and objectives may include volunteering, mentoring, increasing involvement with community members, improving communication with community members, and accessing other resources to further employment development and potentially prepare the participant for work in the community. Progress on objectives must be reported monthly to the case manager, participant, and legally authorized representative.

(J) If there is no progress on prevocational training objectives or the employment pathway planning, a participant may not receive prevocational services in subsequent years and other waiver services may be accessed to meet the supervision and support needs of the participant.

(K) Tiered service rates must be based upon level of service need:

(I) Basic Level of Care for participants between a level 1 and 2.9 Level of Service Need score require limited staff supports and personal attention to a participant daily

due to a moderately high level of independence and functioning. Behavioral needs, if any, can be met with medication or informal direction by staff. The participant may have periods of time with indirect staff supervision where staff are onsite and available through hearing distance of a request.

(II) Intermediate Level of Care for participants between a level 3 and 4.9 Level of Service Need score require full-time supervision with staff available on-site within line of sight due to significant functional limitations, medical or behavioral needs. Behavioral and medical supports are not generally intense and can be provided in a shared staffing setting. Regular personal attention is given throughout the day for personal care, reinforcement, community or social activities.

(III) High Level of Care for participants between a level 5 and 6 Level of Service Need score require full-time supervision with staff available on-site within absolute line of sight and frequent staff interaction and personal attention for significant functional limitations, medical or behavioral needs. Support and supervision needs are moderately intense, but can still generally be provided in a shared setting unless otherwise specified in the plan of care. Frequent personal attention given throughout the day for reinforcement, positive behavior support, personal care, community or social activities.

(L) For each participant receiving this service, documentation must be maintained in the provider and case manager's file that demonstrates prevocational services or a similar service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

(xix) Remote Monitoring:

(A) Remote Monitoring services provides extra monitoring of an individual in his or her residence by remote staff using one of more of the following electronic systems: live video feed, live audio feed, motion sensors, radio frequency identification, web-based monitoring system, or other devices. This service will be billed at an hourly rate and cover the required staff time.

(B) Waiver funds shall not be used for video monitoring in participant's bedrooms or bathrooms.

(C) The provider of remote monitoring must have a system for notifying emergency personnel such as police, fire, or additional support staff.

(xx) Remote Monitoring Equipment Installation: Remote Monitoring Equipment Installation is a one-time service per client for the initial set-up and installation of remote monitoring equipment. This service must follow the rules applying to specialized equipment in Wyoming Medicaid Chapter 44.

(xxi) Remote Monitoring Equipment: Remote Monitoring Equipment is a monthly service to cover the lease and maintenance costs of equipment.

(xxii) Residential Habilitation:

(A) Residential habilitation services shall consist of individually-tailored supports for a waiver participant age eighteen (18) or older on the Comprehensive Waiver to assist with the acquisition, retention, or improvement in skills related to living in the community. Services shall be provided appropriate to the level of supervision identified in the plan of care and include regular adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development. Services must assist the participant to be as independent as possible and reside in the most integrated setting appropriate to his or her needs.

(B) Participants receiving residential habilitation shall have one primary residence and bedroom that is uniquely assigned to him or her, stipulated in a lease or residency agreement, which is homelike in nature and decorated according to the participant's preferences.

(C) The participant must have immediate, on-site access to the provider of services inside the residence on a twenty-four (24) hour basis.

(D) Services shall not include payments for the cost of room and board, including the cost of building maintenance, upkeep and improvement.

(E) Residential Habilitation services are reimbursed using a daily unit based upon the level of service need of the participant, where the participant needs some level of ongoing twenty-four (24) hour support by a provider on site.

(F) Residential Habilitation may be delivered through self-direction as Shared Living, where the participant and other housemates own or lease the residence from an entity that is not a certified waiver provider. The employee hired through self-direction may serve up to three (3) people in shared living, but can serve no other participants in a residential habilitation service.

(G) For a participant receiving this service, the participant will be assigned a tiered level of reimbursement as specified in an approved plan of care. Tier levels for this service align with the assessed Level of Service Need for the participant and the expectations of the service as specified in the definition. All supervision and supports delivered must align with the participant's plan of care.

(H) Tiered Level descriptions. Residential Habilitation participants must receive services in accordance with the written plan of care, and the following tiers descriptions.

(I) Level 1–Level 1 participants exhibit a high level of independence and functioning without significant behavioral or medical issues. Provider staff serving Level 1 participants shall meet with participants on a periodic basis each day for the purpose of providing general supervision, support, monitoring, and training. Staff shall be available on-call for twenty-four (24) hour support.

(II) Level 2- Level 2 participants exhibit a moderately high level of independence and functioning with few or no behavioral or medical issues. Level 2 participants

may require minimal staff support, monitoring, or personal care. Provider staff serving Level 2 participants shall meet periodically with the participant during awake hours on each day billed to provide general supervision, support, monitoring, training, and personal care. Staff shall be available on-call for twenty-four (24) hour support.

(III) Level 3- Due to moderate functional limitations in activities of daily living and possible behavioral support needs, this tier requires staff available to meet periodically with the participant on each day billed for general supervision, support, personal care, positive behavior support, monitoring, training and staff support through the night in the residence or in a nearby office.

(IV) Level 4- Level 4 participants exhibit significant functional limitations, and medical or behavioral support needs that can be met in a shared staff setting. Provider staff serving Level 4 participants shall be on-site, full-time, and regularly provide personal attention throughout the day for training, personal care, reinforcement, positive behavior support, community, and social activities. Staff shall be available for support in the residence through the night.

(V) Level 5- Level 5 participant's exhibit significant and somewhat intensive functional limitations, as well as medical or behavioral support needs that require a limited shared staff setting. Provider staff serving participants serving Level 5 participants shall be on-site and in line-of-sight during most awake hours when the participant is in this service, with frequent personal attention given throughout the day for training, personal care, reinforcement, community or social activities. Staff shall be available for support in the residence through the night, with additional expectations stipulated in the plan of care.

(VI) Level 6- Level 6 participants exhibit high medical, behavioral or personal care needs, which require frequent personal support and supervision. Level 6 participants shall be served by one (1) staff person who is on-site and in line-of-sight during all awake hours, while the participant is in this service. The expectation is that the participant shall receive the attention of at least one to two caregiver(s) as specified in the plan of care. Staffing ratios during the day and night must be kept as approved by BHD in the plan of care.

(I) Residential habilitation services and respite services may not appear on the same individual plan of care except when:

(I) The participant is transitioning into a residential setting such as a group home; or

(II) Unpaid caregivers need respite when the participant spends time at home visiting on weekends or vacations.

(III) The residential provider provides a host-home environment and the provider is not accredited by a national organization

(J) The provider shall provide residential habilitation services directly to the participant in the community or in the residence during both awake and sleeping time for a minimum of eight (8) hours in a twenty-four (24) hour period (from 12:00am-11:59pm) for the provider to be reimbursed.

(K) Participants shall be free to voluntarily leave their residential habilitation home, with the intent to return, for events such as vacations, family visits, or sleepovers. Providers shall not receive reimbursement while the participant is outside the residential habilitation home for these or other similar purposes, except that the provider may receive full reimbursement for the day that the participant returns to the residential habilitation provider home.

(L) A participant not yet receiving twenty-four (24) hour residential services who may be at significant risk due to extraordinary needs that cannot be met in their current living arrangement and require twenty-four (24) hour care may request Residential Habilitation services if the participant meets one of the following targeting criteria:

(I) A substantial threat to a person's life or health due to the abrupt absence of a residence or caregivers who can provide the necessary support needed to keep the person safe. The emergency requires verification of need by Department of Family Services, the Behavioral Health Division or Protection & Advocacy System, Inc.

(II) The person's condition poses a substantial threat to a person's life or health, and is documented in writing by a physician.

(III) The person has caused serious physical harm to him or herself or someone else in the home, or the person's condition presents a substantial risk of physical threat to him or herself or others in the home.

(IV) There are significant and frequently occurring behavior challenges resulting in danger to the person's health and safety, or the health and safety of others in the home.

(V) The person's critical medical condition requires ongoing twenty-four (24) hour support and supervision to maintain the person's health and safety.

(VI) Loss of primary caregiver due to caregiver's death, incapacitation, critical medical condition, or inability to provide continuous care.

(M) Any new residential habilitation placement must be approved by the Extraordinary Care Committee.

(xxiii) Respite:

(A) Respite is a short-term service that allows an unpaid caregiver, a Residential Habilitation provider who is not nationally certified or accredited, or a Special Family Habilitation Home provider to receive limited relief from the daily care of a participant. Services may include

assistance with activities of daily living, medication assistance, and general supervision provided in the caregiver's home, the provider's home, or in community settings.

(B) Services must be primarily episodic in nature, and may not be used when parents or primary caregivers are working.

(C) A respite provider may serve up to two (2) unrelated participants at the same time or up to three (3) participants in the same family who live in the same household. A participant requiring 1:1 care must receive 1:1 respite services.

(D) Respite is reimbursed as a fifteen (15) minute unit or a daily rate.

(E) On the Comprehensive Waiver, the total number of fifteen (15) minute units available for respite per plan year is 5000. When respite services exceed nine (9) hours a day, the provider must bill as a daily unit. There is no unit cap on the Supports Waiver.

(F) A provider may provide supervision to other non-waiver participants requiring support and supervision, and must limit the total combined number of persons they are providing supervision to at a given time to no more three (3) persons unless approved by the Division.

(xxiv) Self-Directed Goods and Services. Self-Directed Goods and Services shall be provided pursuant to Chapter 44.

(xxv) Skilled nursing:

(A) Skilled Nursing services are medical care services delivered to individuals with complex chronic or acute medical conditions and performed within the Nurse's scope of practice as defined by Wyoming's Nurse Practice Act. Skilled Nursing services include the application of the nursing process including assessment, diagnosis, planning, intervention and evaluation, and the administration, teaching, counseling, supervision, delegation, and evaluation of nursing practice and the execution of the medical regimen.

(B) Services needed must be specifically prescribed by a physician on a form specified by the Division and require a level of expertise that is undeliverable by non-medical trained individuals.

(C) The delivery of Skilled Nursing services is limited to those individuals who possess an unencumbered license issued by the Wyoming State Board of Nursing.

(D) Skilled Nursing services may be used when the Medicaid State Plan Services have been exhausted, are not available in the person's area, are not available due to services denied by the home health provider, or the hours of need for the service are not available by the home health provider. The form showing evidence of no other skilled nursing services available will be reviewed annually and may be subject to an annual update as service providers or state plan service coverage in regions becomes available.

(E) A billable skilled nursing service unit is considered to be a service that is provided up to fifteen (15) minutes and that involves one-on-one direct patient care. Skilled nursing units may be rounded up to the nearest fifteen (15) minute unit. Units billed for rounded up services may not exceed eight (8) units within a one hour timeframe for multiple participants in a single location by one provider nurse.

(F) Skilled nursing services must address the ongoing chronic or acute medical issues for which the service is needed and must include direct patient care or services. Skilled Nursing providers cannot be reimbursed for watching television with a participant, transportation to and from doctor appointments, time spent charting, time spent in waiting room with participant, or time spent completing paperwork, or similar non-nursing activities.

(xxvi) Special Family Habilitation Home:

(A) Special Family Habilitation Home services must include participant specific, individually-designed and coordinated training within a family host home environment that does not include the participant's biological, step, or adoptive parents.

(B) This service is only available to participants under the age of twenty (20) years old on the Comprehensive waiver who are receiving this service before the effective date of this rule. The service is not open to newly enrolled participants.

(C) The Special Family Habilitation Home provider shall be the primary caregiver and assume twenty-four (24) hour care of the individual.

(D) This service may not be used in conjunction with Individual Habilitation Training services.

(E) The provision of Special Family Habilitation Home services includes personal care needs. Plans of care may not include the personal care service.

(F) This service pays for support to an individual who needs support twenty-four (24) hours a day. The provider shall be in the residence of the participant providing service during both awake and sleeping time for a minimum of (8) hours in a twenty-four (24) hour period (from 12:00am-11:59pm) for the provider to be reimbursed.

(G) Family visits and trips are encouraged. The provider shall not be reimbursed for days that the participant is absent, but may request reimbursement for the day the participant returns home from a trip.

(H) The Special Family Habilitation Home provider shall provide both formal and informal training opportunities to participants served. The schedule must be individualized and the training objective must be meaningful. Progress on objectives shall be reported to the case manager monthly.

(xxvii) Specialized equipment. Specialized equipment shall be provided pursuant to Chapter 44.

(xxviii) Speech, hearing, and language services:

(A) Reimbursement for speech, hearing, and language services requires both a prescription and a treatment letter or recommendation from a physician.

(B) Speech, hearing, and language services are available for a participant age twenty-one (21) and older and must consist of the full range of activities provided by a licensed speech therapist. Services may include screening and evaluation of participants with respect to speech function; development of therapeutic treatment plans; direct therapeutic intervention; selection, assistance, or training with augmentative communication devices; and the provision of ongoing therapy.

(C) Services through the waiver can be used for maintenance and the prevention of regression of skills.

(D) A minimum of forty-five (45) minutes of service per session must be provided in order to bill for one session

(E) Providers of speech, hearing, and language group services may seek reimbursement for providing such services to a group of up to three (3) participants at one time.

(xxix) Subsequent Assessment:

(A) Subsequent assessments may be provided as part of ongoing case management and will include the necessary collaboration of professionals to assess the needs, characteristics, preferences and desires of the waiver participant.

(B) Case managers shall initiate and oversee subsequent assessments, regardless of payment source, including the psychological assessment or neuropsychological assessment needed for continued eligibility, and any other approved assessments necessary to determine the participant's needs and not available through the Medicaid State plan.

(C) A subsequent assessment must be prior authorized by the Division.

(xxx) Supported Employment:

(A) Supported employment services must provide support and assistance to a participant age eighteen (18) or older who needs intensive support to find and maintain a job in a competitive, integrated work setting because of his or her disability. Services must assist the participant with sustaining paid work. Services may include supervision and training. Services are billed as a fifteen (15) minute unit.

(B) Supported employment services must be provided at a work site where persons without disabilities are employed. Services may provide reimbursement for the adaptations, supervision and training required to assist a participant with sustaining paid work. Reimbursement shall not include payment for supervisory activities rendered in the normal course of business.

(C) Objectives must be identified in the participant's plan that support the need for job coaching and a plan to lessen the job coaching over time, if possible. The job coach must be in the immediate vicinity of the participant during services and available for immediate intervention and support.

(D) Documentation shall be maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

(E) Services shall be provided as either in an individual 1:1 setting or as part of a group.

(I) Group supported employment services may be provided to a group ranging from two (2) to nine (9) persons. Group employment for groups larger than nine (9) people will not be reimbursed by the waiver. Group Supported Employment services consist of intensive, ongoing support that enables a participant to perform in a regular work setting, including mobile work crews or enclaves.

(II) Individual Supported Employment services are 1:1 supports provided to a participant to obtain and maintain employment.

(1.) Services may assist a participant to work in a competitive or customized job, be self-employed, or work in an integrated work setting in the general workforce where the participant is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by an individual without a disability.

(2.) Individual Supported Employment must be provided in a community-integrated employment setting, unless the support is to develop customized employment, self-employment, or home-based employment, subject to prior approval of the Division.

(xxxi) Supported Employment Follow Along:

(A) Supported Employment Follow Along services enable a participant, who is paid at or above the federal minimum wage, to maintain employment in an integrated community employment setting.

(B) Service is provided for or on behalf of a participant through intermittent and occasional job support, communicating with the participant's supervisor or manager, whether in the presence of the participant or not. A provider may use this service for regular contact and follow-up with the employer and participant in order to reinforce and stabilize the job placement, facilitate natural supports at the work site, provide individual program development, write tasks analyses, or conduct monthly reviews, termination reviews, and behavioral intervention.

(C) This service may cover support through phone calls between support staff and the participant's managerial staff.

(D) A provider shall be reimbursed at a fifteen (15) minute rate for up to 100 units annually based upon individual need in order to maintain employment.

(E) This service does not reimburse for transportation, work crews, public relations, community education, in service meetings, or individual staff development.

(xxxii) Supported Living:

(A) Supported Living Services assist participants who do not require ongoing twenty-four (24) hour supervision but do require a range of community-based supports and habilitation training to be able to live in their own home, family home, or rental unit.

(B) Services must be based upon need and may include assisting with activities of daily living, performing routine household activities to maintain a clean and safe home, assistance with health issues, medications and medical services, teaching the participant to access the community, and building personal relationships with others. In some cases, the service may require twenty-four (24) hour emergency assistance if specified in the plan of care.

(C) The supported living service daily rate is based on seven (7) hours of service a day and a provider shall provide a minimum of four (4) hours of documented service per calendar day for reimbursement. One (1) staff or provider can be reimbursed for up to three (3) participants during a daily unit of service provided.

(D) Supported living services can be billed at a fifteen (15) minute unit rate for a maximum of 5,400 units per plan year for services provided to a group up to two (2) or three (3) participants, or 3,900 fifteen (15) minute units per plan year provided to an individual participant.

(E) Supported living is a habilitation service, which means training on objectives is required as part of the provision of services and objective progress must be reported to the participant, guardian, and case manager monthly.

(F) Supported living may not be provided on the same day as residential habilitation.

(G) The plan of care must identify either the daily unit or the individual or group 15-minute unit, based on the participant's need. Both the daily unit and the fifteen (15) minute unit may be on the participant's plan of care but cannot be used on the same day.

(xxxiii)Transportation:

(A) Transportation service on the waiver is a gap service to enable participants to gain access to an employment location, community services, activities, and resources as specified by the plan of care when a service provider is not needed at the event.

(B) Transportation services are not intended to replace formal or informal transportation options, like the use of natural supports, city transportation services, and travel vouchers. Whenever possible, family, neighbors, friends, or community agencies, that can provide this service without charge or with other resources, must be utilized.

(C) This service does not include transportation to medical appointments required under 42 CFR 431.53 or other transportation services available under the Medicaid state plan.

(D) Transportation services will be reimbursed based on mileage used. This service is capped at $2,000 per year.

(E) Transportation services cannot be utilized in conjunction with or to access other waiver services that specify in the service scope that transportation is covered in the rate for that service.

Section 8, Waiver Cost Limits and Individual Budget Amounts.

(a) The allocation of Medicaid waiver funds that may be available to a participant to purchase services is based on his or her assessed needs.

(b) Eligibility shall be determined pursuant to Section 5 of this Chapter before an individual budget amount is determined.

(c) The Supports Waiver.

(i) 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 to the participant 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;

(E) A temporary funding increase when needed for an emergency situation, which is approved by the Extraordinary Care Committee, not to exceed the established cost limit for the Supports Waiver.

(ii) Any participant eligible for the Supports Waiver shall also be given a Level of Service Need score in order to determine eligibility and priority order for Comprehensive Waiver funding.

(d) The Comprehensive Waiver.

(i) The Comprehensive Waiver shall fund services for participants whose needs are in excess of the Supports Waiver cap, meet the emergency criteria as specified by the ECC, or are transitioning from a state-funded institution that meets reserved capacity criteria as specified in Section 11 (g) of this Chapter.

(ii) Waiver recipients active on the Adult or Child DD Waivers before April 1, 2014 will automatically be placed on the Comprehensive Waiver unless they choose otherwise.

(iii) 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 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.

(F) A temporary or permanent increase or decrease as determined by the Clinical Review Team or Extraordinary Care Committee.

(iv) The factors in subsection (d) (iii) determine the participant's Level of Service Need score in order to plan for appropriate services and supports.

(v) Supports to the participant through waiver services must align with the Level of Service need scoring rubric associated with the person's Level of Service score. Standards of care for each level include:

(A) Level 1, which means the participant requires few supports weekly due to a high level of independence and functioning compared to one's peers. This participant is independent with ADLs but may follow checklists as reminders. No significant behavioral or medical issues that cannot be controlled with medication and routine medical care. Participant requires minimal support services that can be provided within a few hours per week, and can be left alone in the home or community for extended periods of time.

(B) Level 2, which means the participant requires infrequent care and limited supports daily due to a moderately high level of independence and functioning. Some days may not require any support. Behavioral needs, if any, can be met with medication or informal or infrequent verbal redirection by caregivers, which may or may not require a PBSP. There may be a need for day services and intermittent residential support services to assist with certain tasks, and the participant can be unsupervised for several hours at time during the day and night.

(C) Level 3, which means the participant requires limited personal care or regular supervision due to a moderate level of functional limitations in activities of daily living, requiring staff presence and some physical assistance. Behavioral needs, if any, are met through medication, informal direction by caregivers, or occasional therapy (every one to two weeks). Participant does not require 24-hour supervision – generally able to sleep unsupervised – but needs structure and routine throughout the day. Intermittent personal attention should be given daily for training, personal care, community or social activities.

(D) Level 4, which means the participant requires regular personal care or close supervision due to significant functional limitations, medical or behavioral conditions. Therapy and medical care may be needed monthly in addition to support from staff. Behavioral and medical supports are not generally staff-intensive and may be provided in a shared staffing setting. Regular attention is needed throughout the day for training, personal care, reinforcement, community or social activities.

(E) Level 5, which means the participant requires extensive personal care or constant supervision due to behavioral or medical concerns or due to significant functional limitations concerns, including frequent and regular on-site staff interaction and support. Therapy and medical care may be needed bi-monthly in addition to support from staff. Behavioral and medical concerns must be addressed with written behavioral or medical plans and protocols. Support needs are highly intense, but can still generally be provided in a shared staff setting. Staff must provide line of sight supervision and frequent personal attention must be given throughout the day for training, reinforcement, positive behavior support, personal care, community or social activities.

(F) Level 6, which means the participant needs total personal care or intense supervision throughout the day and night. Supervision by a sole staff on-site (not shared) must be conducted by at least line of sight, with much of the staff's time within close proximity providing direct support during all waking hours. At times, the participant may require the full attention of

two staff for certain activities of daily living and in response to certain behavioral events. Therapy and medical care may be needed weekly in addition to support from staff. Typically, this level of service is only needed by someone with intense behaviors, not just medical needs alone. There is no ratio flexibility from the amount approved in the plan of care. Behavioral and medical supports require written plans or protocols to address support needs.

(vi) A participant's individual budget amount on the Comprehensive Waiver may not exceed the current annual average cost of a resident at the Wyoming Life Resource Center. A participant who needs services in excess of this amount must have the plan of care and budget approved by the Division's Extraordinary Care Committee, 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.

Section 9, Clinical Review Team.

(a) The Division's Clinical Review Team (CRT) shall be comprised of the Division's licensed Psychologist, the Medicaid Medical Director, a Division manager, and the assigned Participant Support Specialist. When appropriate, the CRT may also include the Division's Registered Nurse, a behavioral specialist, or the Division's Psychiatrist. The CRT may consult with other specialists in the field.

(b) The CRT shall review submitted requests involving:

(i) Concerns about a Level of Service Need score; or

(ii) Requests for extraordinary service or support needs.

(c) A request may be made by the participant through the participant's Plan of Care team, if they can demonstrate that a participant's level of service need score does not reflect the participant's assessed needs.

(d) A request must 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 Inventory for Client and Agency Planning (ICAP) or in the information stored electronically by the Division for the case.

(e) The CRT has the authority to request additional assessments, including a new ICAP, a Supports Intensity Scale, or another appropriate and standardized assessment targeted for a specific diagnosis or condition, or refer the case to the Extraordinary Care Committee.

(i) The additional assessment in these cases may provide more detailed information about the person's support needs and assist the CRT in evaluating the need for a different Level of Service Need 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.

(f) The additional assessments and information CRT reviews may result in a Level of Service Need increase, decrease, or no change.

(g) Any eligible individual denied the requested level of service need score or a requested extraordinary support or service under this section may request administrative review of that decision pursuant to Chapter 4, Administrative Hearings.

Section 10, Self-Directed Service Delivery.

(a) The services that may be self-directed include Child Habilitation, Companion, Homemaker, Individual Supported Employment, Independent Support Brokerage, Individual Habilitation Training, Personal Care, Residential Habilitation Shared Living, Respite, Self-Directed Goods and Services, and Supported Living.

(b) Each participant's case manager shall provide the participant or guardian information regarding the option to self-direct waiver services at least once a year.

(c) Self-Direction opportunities are available to participants who:

(i) Live in his or her own private residence or the home of a family member; or

(ii) Reside 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 may 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.

(j) Consistent with the service definitions in this Chapter, 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 to be provided, 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 must maintain documentation in accordance with the Wyoming Medicaid Rules.

(m) The Employer of Record, with assistance from the case manager as needed, is responsible for reviewing 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 plan of care.

(n) A participant 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 services or providers. The case manager must disenroll the participant from the Financial Management Service within thirty (30) days.

(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 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

(iv) The participant chooses not to receive self-directed services for ninety (90) days after active enrollment begins.

Section 11, Wait List Process.

(a) The Division shall maintain a wait list for each waiver when there is insufficient funding to add additional participants to that waiver or no open slots in the waiver as approved by the Centers for Medicare and Medicaid Services.

(b) Participants who qualify for the Comprehensive Waiver may receive Supports Waiver funding and services and also apply to and be on the wait list for the Comprehensive Waiver.

(c) The Division shall prioritize eligible individuals on the wait lists on a first come, first serve basis. Funding opportunities will be given to the person who spent the longest time waiting for services starting from the date that the individual was determined eligible.

(d) Before being added to a Waiver wait list, the individual must be determined eligible as specified in Section 5 of this Chapter.

(e) For people with the same date of eligibility on the wait list, the Division will use the date that the "Selection of Case Manager" form was received by the Division to determine which individual's name goes first.

(f) The level of service need score and individual budget amount shall be determined for each individual on the wait lists. An eligible individual who needs services in excess of the Supports Waiver and has a level of service need score of 4 or higher may apply for the Comprehensive Waiver and may also be placed on the Comprehensive Waiver wait list, if funding or slots are not available.

(g) The Comprehensive Waiver shall reserve capacity each year for individuals who have resided in a Wyoming institution, such as an ICF/ID, nursing home, Psychiatric 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 BHD wait list for at least two (2) years; or

(iii) Previously on a BHD 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.

Section 12, Emergency Services.

(a) An emergency case involves an eligible person that calls for immediate action or an urgent need for waiver services, including physical care and supervision 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 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. A person residing in a homeless shelter is not a cause for an ECC consideration by itself.

(iv) A case involving a person removed from the home due to abuse, neglect, abandonment, exploitation, or self-neglect substantiated by the Department of Family Services (DFS), Protection & Advocacy Systems, 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 caused by a situation listed in (c)(i)(D) of this section that is either corroborated by the Department of Family Services, Protection & Advocacy Systems, Inc., or law enforcement;

(B) A situation where the person's health condition or significant and frequently occurring behavioral challenges poses 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;

(D) The loss of the eligible person's primary caregiver due to death, incapacitation, critical medical condition, or inability to provide continuous care.

(vi) 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 shall assist the person in reviewing options to choose a case manager and complete eligibility determination requirements as quickly as possible.

(vii) Emergency cases shall be referred to the Division's Extraordinary Care Committee pursuant to section 13 of this chapter.

(viii) 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.

Section 13, Extraordinary Care Committee.

(a) The Extraordinary Care Committee (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. Members may consult other specialists in the field as appropriate.

(b) The ECC may 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 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;

(iii) Temporary or any funding increases under Section 8 (c) and 8 (d); or

(iv) Requests requiring ECC approval under these Rules.

(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 (a) of Section 12.

(e) The ECC shall have the authority to approve, modify, or deny a submitted funding request for any person deemed eligible for a waiver operated by the Division or refer the case to the Clinical Review Team.

(f) An ECC request or emergency services must contain verification of how the participant's situation meets emergency criteria. Evidence should 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 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:

(1.) Other community resources, such as a homeless shelter, victim's shelter, or other temporary residence are not available or appropriate; or

(2.) The temporary shelter is 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) Decisions of the ECC shall be by majority and rendered in writing.

(h) The Division Administrator or designee shall document a review of the decisions and may approve, deny or order more action in a case. In cases of a tie vote among members, the Administrator shall issue the final vote.

(i) Any eligible individual denied services under this section may request administrative review of that decision pursuant to Chapter 4, Administrative Hearings.

Section 14, 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/ID, or other institutional placement;

(ii) A spouse of the participant, a legally appointed guardian of a participant age 18 and over, or an owner or officer of a provider organization serving their ward cannot directly or indirectly receive reimbursement for providing waiver services for that ward;

(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 cost of services provided in an ICF/ID, calculated by using the current annual ICF/ID rate; or

(vi) Service settings reimbursed by another state agency, such as the Department of Family Services or Department of Education.

(b) No service that is the responsibility of the school system will be authorized as a waiver service. The Division will not authorize waiver services for the hours the child is attending school or in a vocational program. Regular school hours and days apply for a child who receives home schooling or an adjusted school day.

(c) Any individual eligible for funding for specialized services under the Developmental Disabilities Services Act must 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, Denial of Funding.

(a) The Division can deny or revoke authorization for waiver services for any of the following reasons:

(i) The individual fails to meet waiver clinical eligibility criteria;

(ii) The individual fails to meet financial eligibility criteria;

(iii) The eligible individual has not met emergency criteria and no other waiver funding opportunities are available;

(iv) A waiver funding opportunity is not available;

(v) The individual or legal representative has not consented to waiver services;

(vi) The individual or legal representative has chosen to receive ICF/ID services;

(vii) The individual, his or her legally authorized representative, or other person on his or her behalf has not supplied needed information;

(viii) Intensity of services does not reflect the need for ICF/ID level of care services;

(ix) The individual's needs are not being met through waiver services;

(x) The individualized plan of care has not been implemented;

(xi) A plan of services and supports to protect the individual's health and welfare cannot be developed or maintained;

(xii) The legislature has not appropriated sufficient fiscal resources to fund all services for all persons determined eligible for waiver services;

(xiii) Funding for requested waiver services is available as a similar service from other sources;

(xiv) The eligible individual or legal 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.

(xv) The eligible individual or legal representative has not signed documentation required by the Department;

(xvi) The eligible individual or legal representative has failed to cooperate with, or refused the services funded by the Division;

(xvii) The individual, under the age of twenty-two (22), could receive educational services during a normal, regular, or adjusted school day.

Section 16, 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, 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 18, Severability. If any portion of this Chapter is found to be invalid or unenforceable, the remainder shall continue in full force and effect.