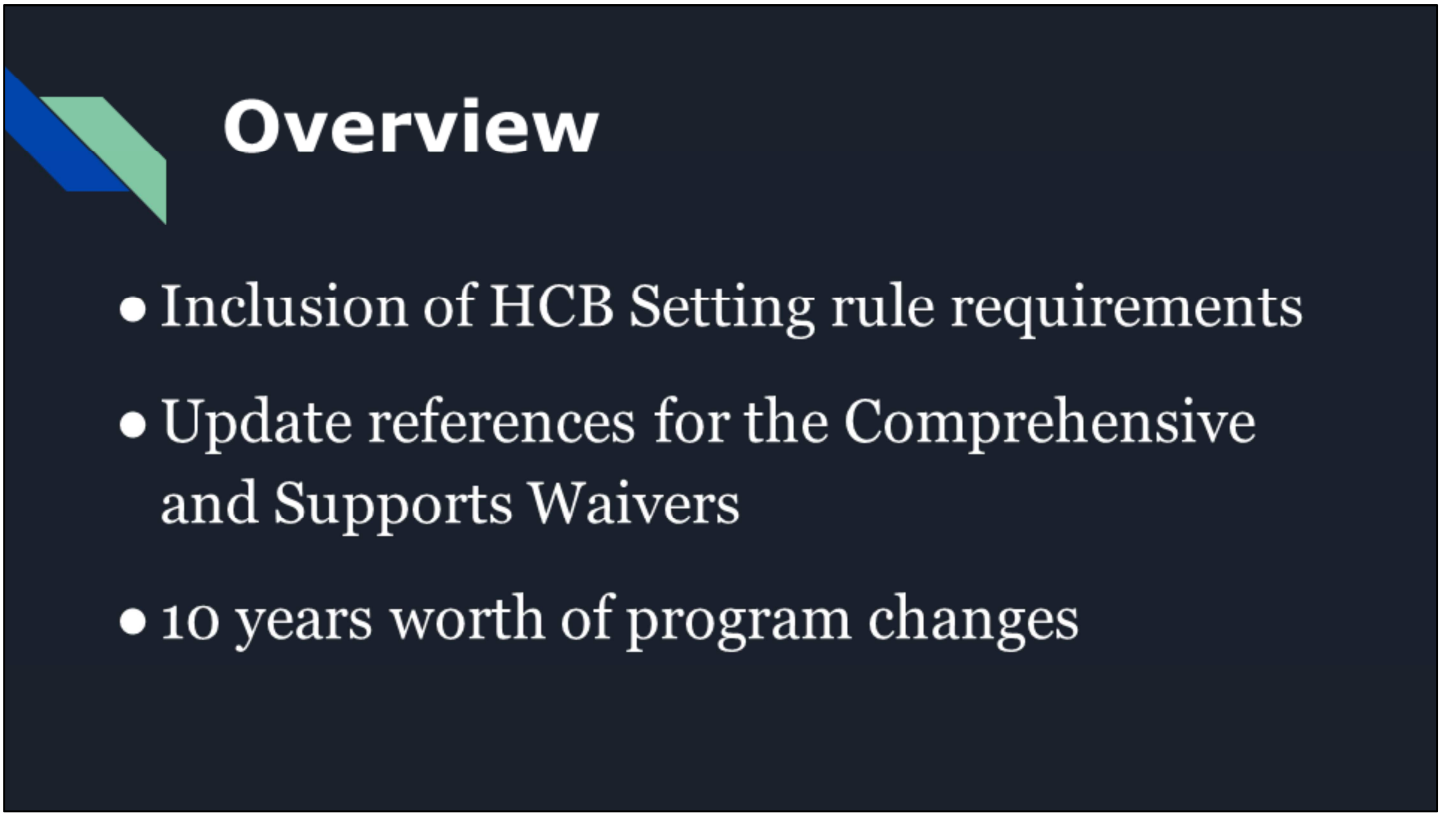
Hello! Welcome to the Medicaid Rules Chapter 45 Waiver Provider Standards, Certification and Sanction training presented by the Behavioral Health Division Developmental Disabilities Section. On June 21, 2017, new Medicaid Chapter 45 rules were promulgated by the Office of Governor. The Division is going to implement the rules starting January 1, 2018. During this training, there will be multiple modules that will take us through the rules. We encourage you to listen to each one of the modules to gain the best knowledge of the rules. This training is meant for anyone who works with the Developmental Disabilities Waivers from providers, case managers, legally authorized representaives, family members, and most importantly our participants!


Welcome!

Learning Objectives

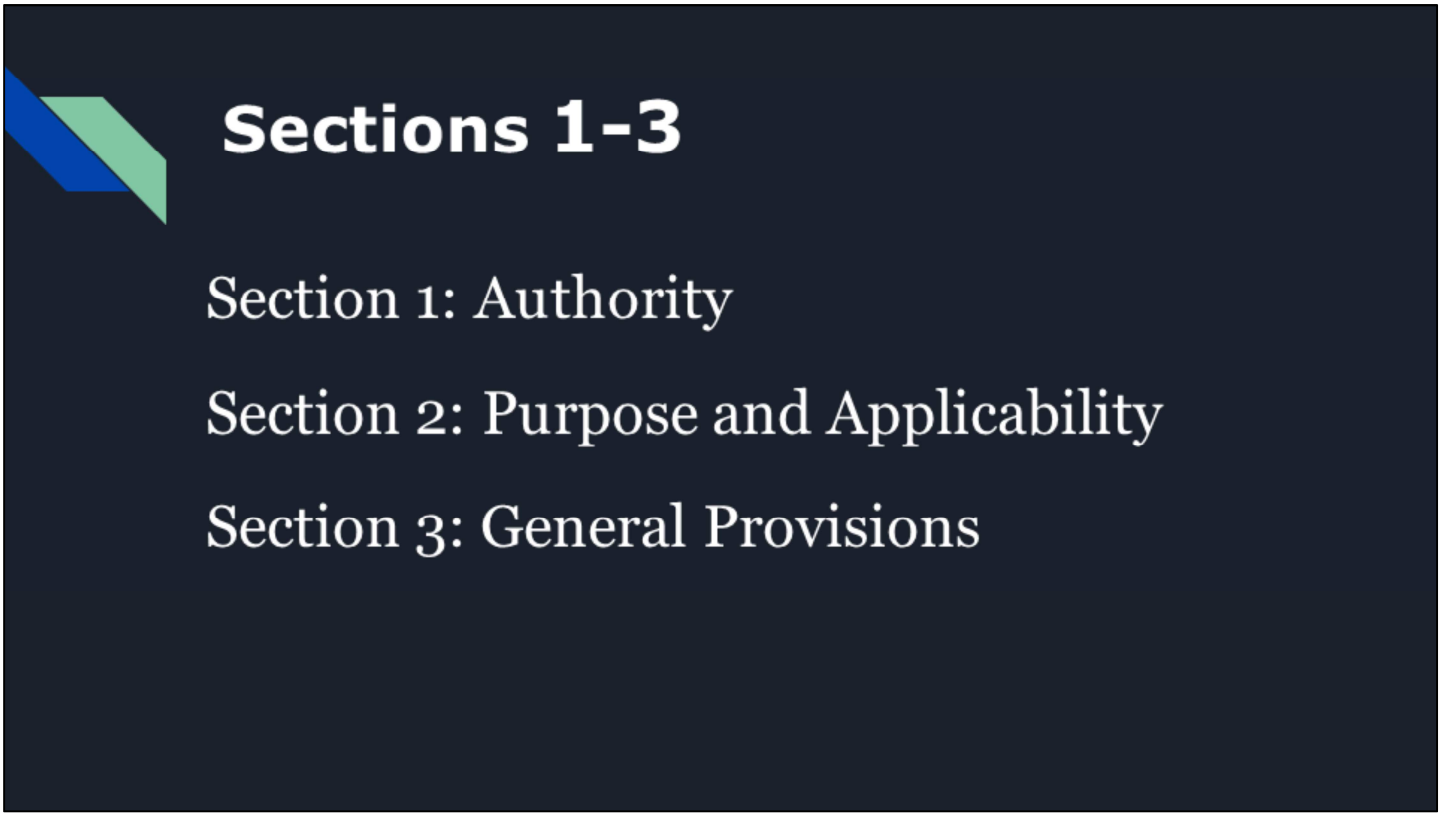
- Review the sections of Chapter 45
- Learn about the changes and/or additions to the rule
- Learn the Division's interpretation of the section and how it will be implemented and monitored
- Learn and understand the timelines for full implementation of the rules
- Learn what changes have been made as a result of the new rules



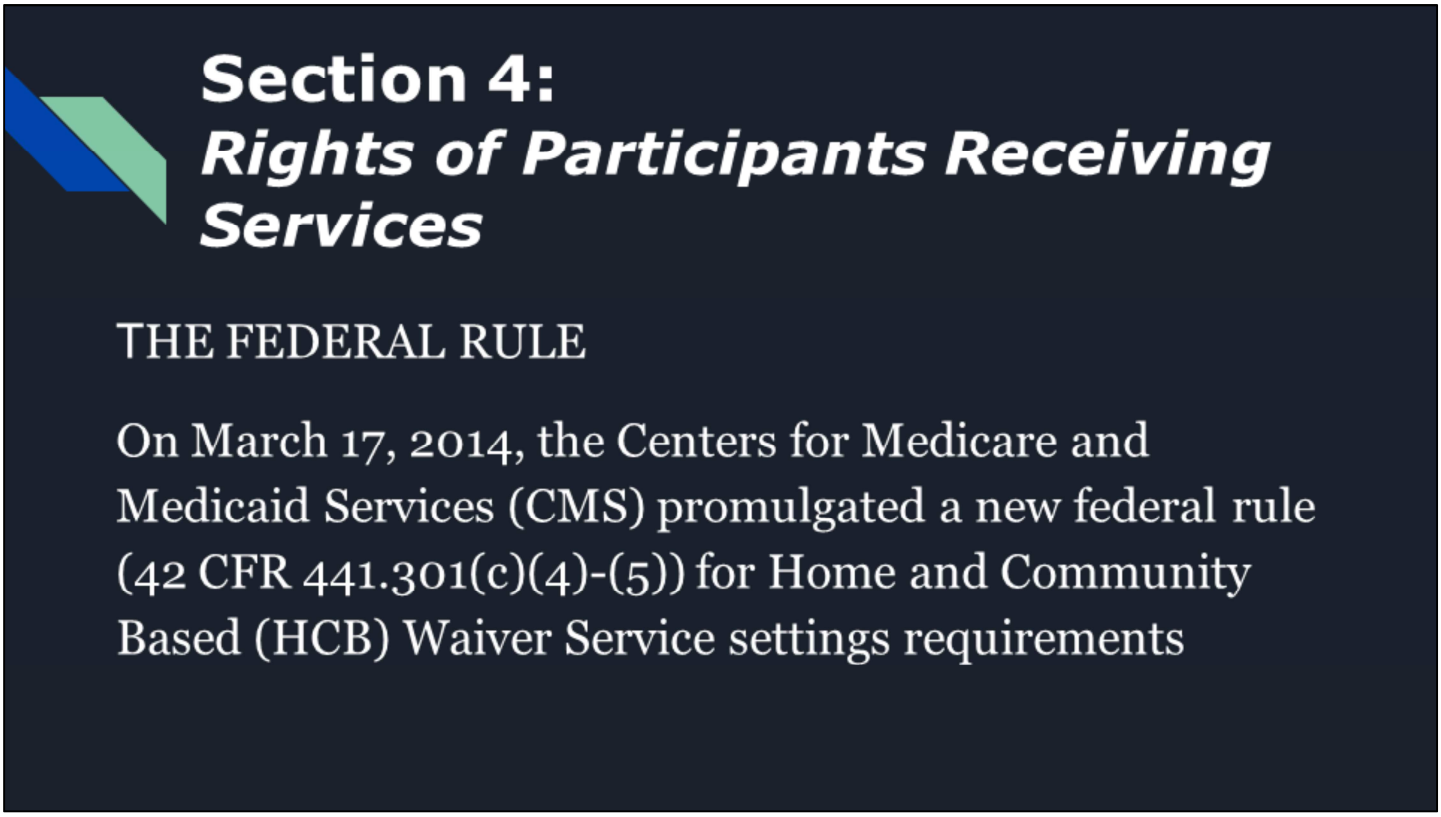
The Division updated these rules to incorporate the new Home and Community Based Setting rule that was passed in 2014 by the Centers for Medicare and Medicaid commonly referred to as CMS. CMS funds the Developmental Disabilities Waivers in conjunction with state general funds. Not only were these rules updated for the purpose of being in compliance with CMS rules, but also to update references to the Comprehensive and Supports Waivers as well as an update of 10 years worth of program changes!

So lets get started!! We have a lot to cover! This is Module 1 which will cover Sections 1-8

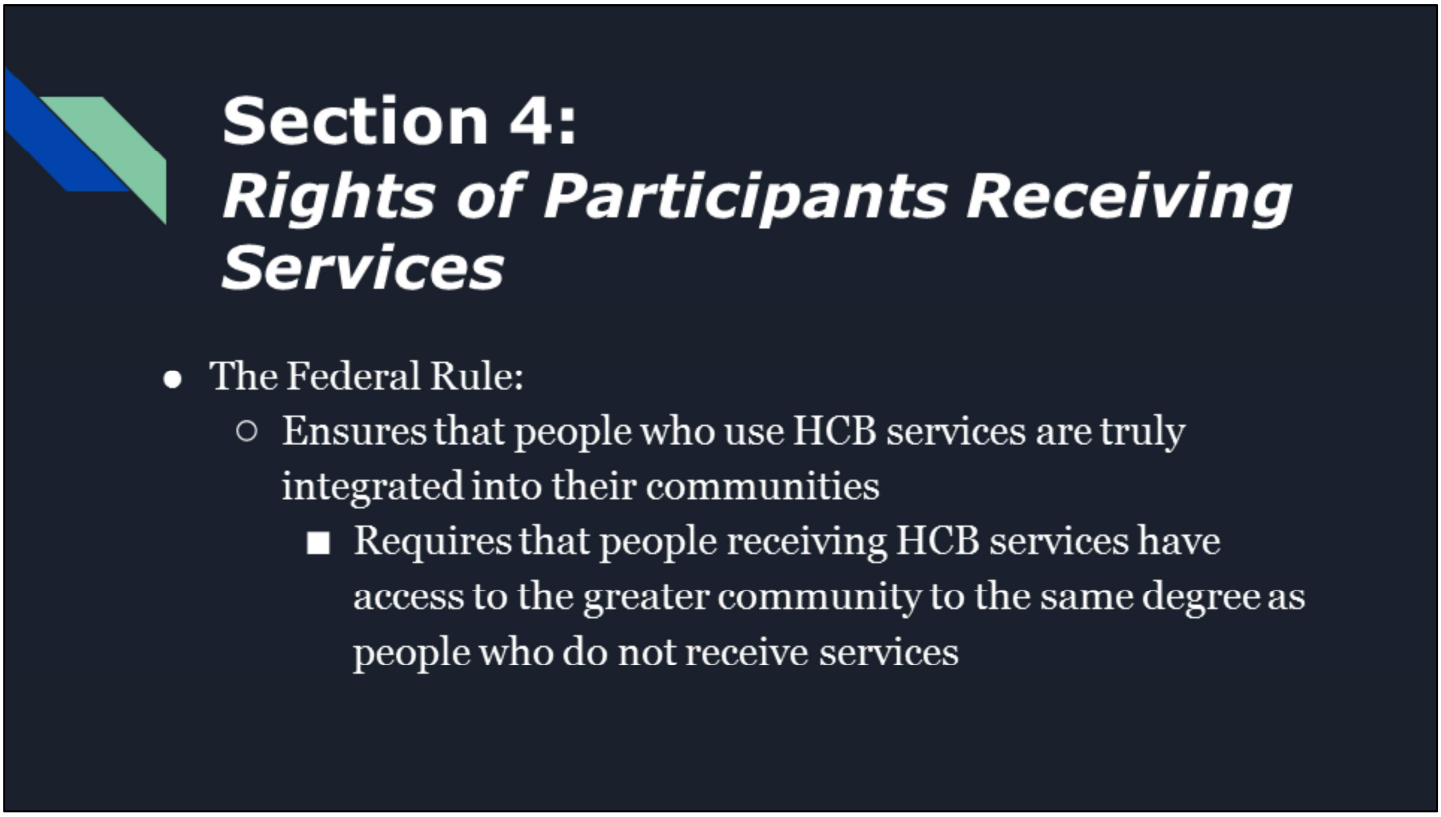
This module will cover sections 1-8, which will include:
Section 1: Authority
Section 2: Purpose and Applicability
Section 3: General Provisions
Section 4: Rights of Participants
Section 5: Provider Qualifications
Section 6: Standards for all Providers
Section 7: Provider Record Keeping and Data Collection
Section 8: Documentation Standards



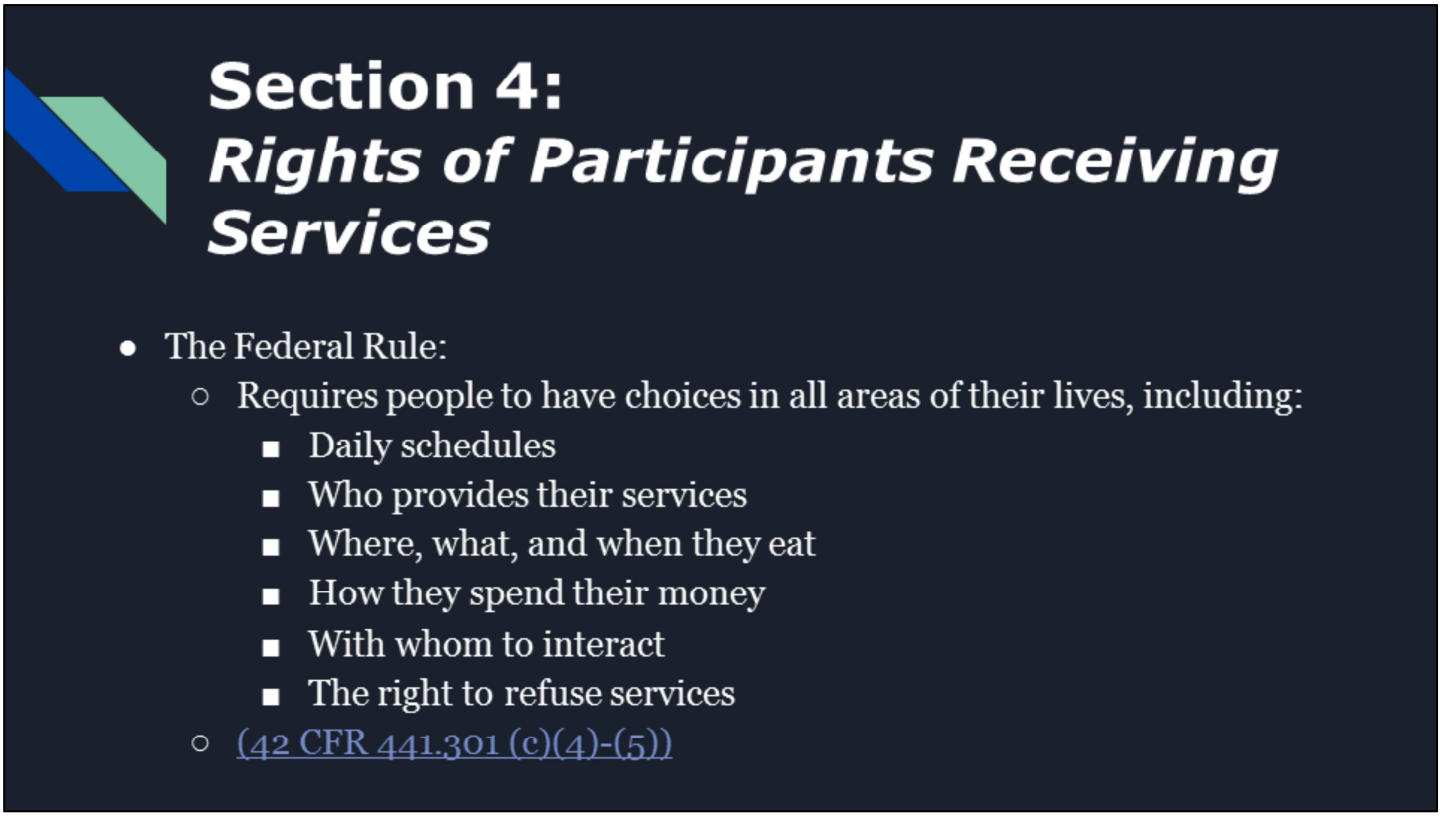
This is a brief overview of these sections. They are required to start any rule set. We will not be reviewing these, but please note that definitions for certain terms are located in these Sections.



On March 17, 2014, the Centers for Medicare and Medicaid Services (CMS) promulgated a new federal rule for Home and Community Based (HCB) Waiver Service settings requirements. This rule went into effect immediately, with a transition period to allow settings to come into compliance over a period of time. The final implementation date for settings is March 17, 2022. However, other components of this rule went into effect immediately.

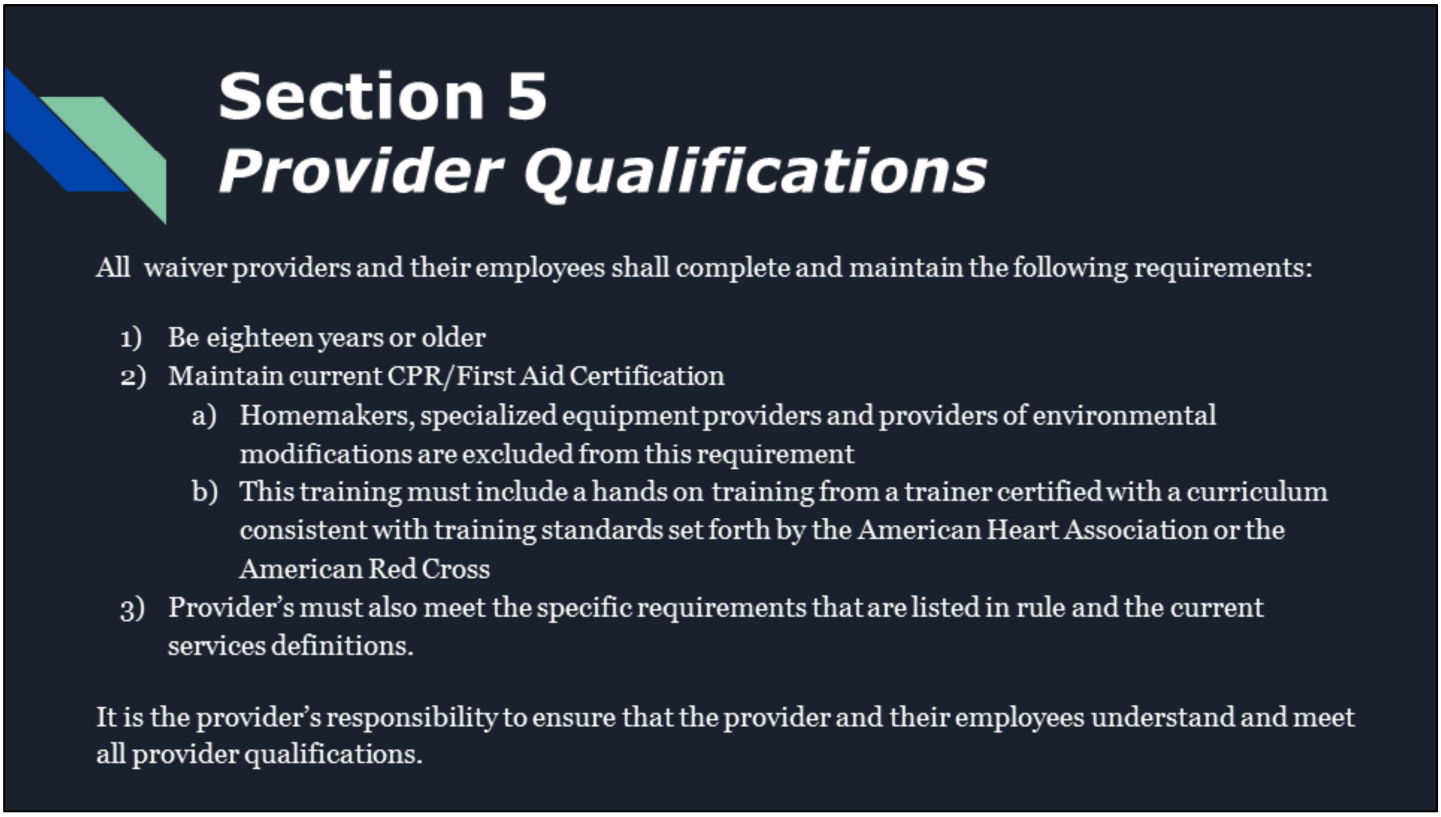


The intent behind the federal rule is simple. It is for people receiving home and community based services to have access to and be integrated into their community. To integrate means to bring people into equal participation or membership, which is the ultimate goal of this rule.



The rule also ensures that people receiving HCB services have choice in their lives. Having choice in issues related to what you do during the day, who you spend time with, what and when you eat, and how you spend your income is part of the human experience. Even a person with a legally authorized representative should have have as much control, power, and choice in their life as possible.

To review the Federal Code of Regulation citation, follow the link in the Powerpoint presentation or on the webpage.



Providers and their employees must meet the identified qualifications as outlined per service in Section 5. The Division considers subcontractors employees. Provider qualifications specific to each service at listed in Chapter 45, Sec. (b)i-xx. Each of the services that are offered on the Comprehensive and Support waiver lists the specific qualifications for that service in the rules. All services require that the employee be 18 years of age and have CPR and First Aid certification with the exception of homemakers, specialized equipment providers and environmental modification providers. Homemakers, specialized equipment providers and environmental modification providers do not have this requirement as they provide an indirect services and do not have supervision requirements for participants. Our rules do not allow for a lapse in CPR and First Aid certifications as it is a qualification. CPR and First Aid must have at the minimum a "hands on" component from a trainer certified with a curriculum consistent with training standards set forth by the American Heart Association of the American Red Cross. Should you have questions regarding the CPR and First Aid training curriculum you or your employees are certified under please contact your assigned Provider Support Specialist for further clarification. Current Service definitions can be found on the Division website under the Comprehensive and Supports Waiver section.

Policies and procedures should be:
(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.

Section 7
Provider Record Keeping and Data Collection

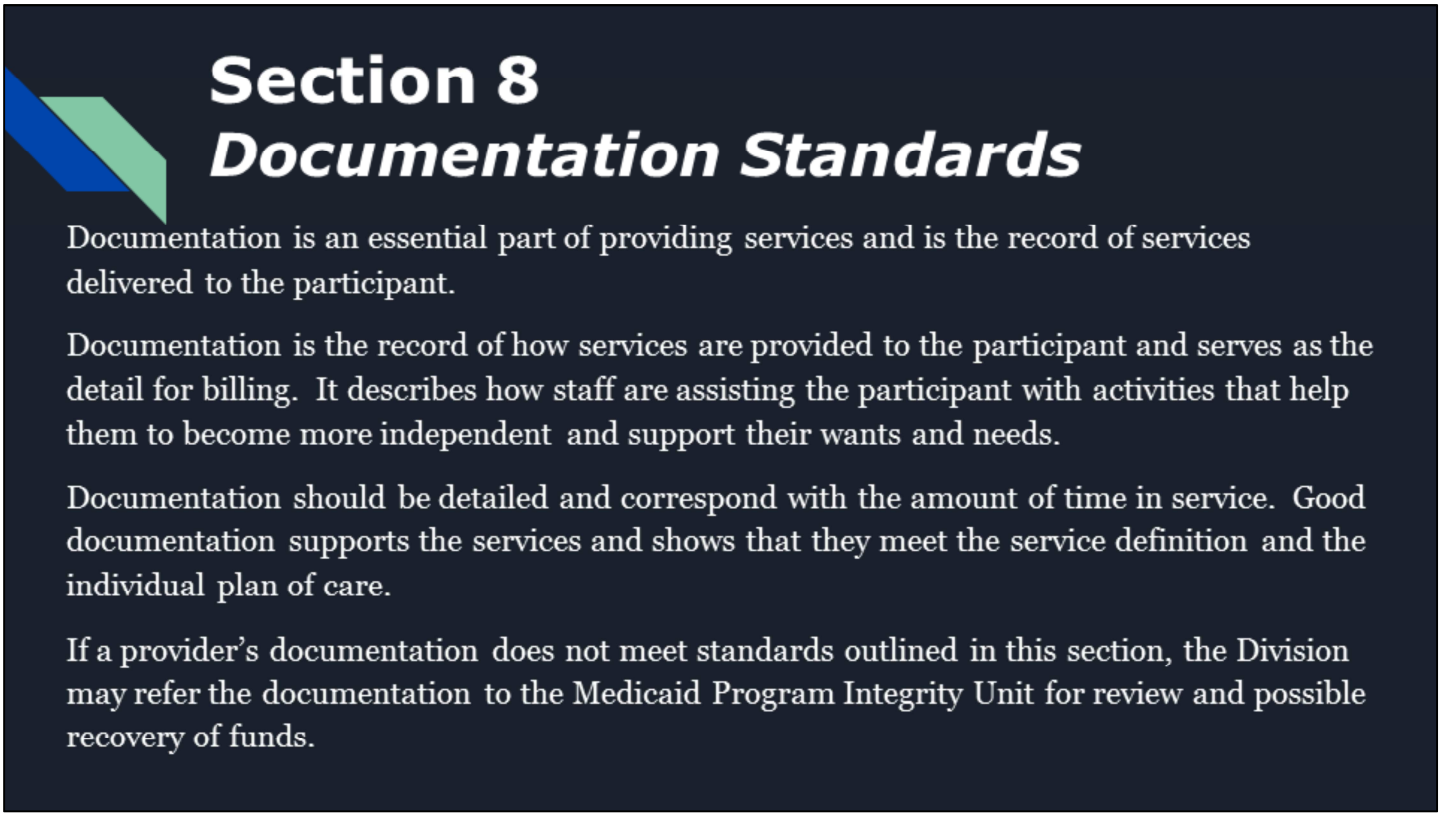
Provider shall:

- Collect and maintain data, records, and information
- Develop and maintain a record keeping system that includes separate participant files
- Develop a system of record keeping that ensures permanency, accuracy, completeness, and easy retrieval of information
- Develop a process for safe storage and destruction of information to protect confidentiality. (Maintain records for at least 6 years)
- Follow Medicaid disenrollment procedures before dissolution of a provider agency & transfer participant records when there is a change in ownership of a provider agency

Section 7
Provider Record Keeping and Data Collection

Provider shall:

- Establish and implement policies regarding access to, duplication, dissemination, and release of information from participant records
- Obtain a written authorization from the participant or the participant's legally authorized representative for the release of participant information
- Make all records available to Division staff, the Medicaid Fraud Control Unit and Medicaid representatives without prior written consent or releases
- Specify the method and frequency of obtaining authorizations for medical treatment and consents
- Ensure all record entries are dated, legible, and identify the person making the entry



Documentation standards is an area that all providers need to focus on to ensure they are in-compliance with Medicaid rules. This is your record of the services you provided to the participant and your way to show that you are assisting the participant with activities that are meaningful and help them become more independent.

Documentation should be detailed and match the amount of time the participant is in service. For example, if you are providing supported living services to a participant and are documenting for two hours of service, the documentation should include information about what was done during those two hours. It could be a narrative of activities or it could be a list of things that were done.

If the documentation does not meet standards during a provider recertification (or review due to an incident or complaint), the Division may refer the documentation to the Medicaid Program Integrity Unit, which is part of the Division of Healthcare Financing at the Department of Health. The Medicaid Program Integrity Unit is the post payment audit system for Wyoming Medicaid payments. They will review the information and make a determination on whether a recovery of funds is needed.

Section 8
Documentation Standards

Each page of documentation must include the following:

- Participant's full name
- Individualized plan of care start date
- Physical address of location of services
- Date of service (year, month, day)
- Type of service provided, service name, billing code
- Time services began
- Time services ended
- Printed name of person performing service
- At least one signature of each person performing a service

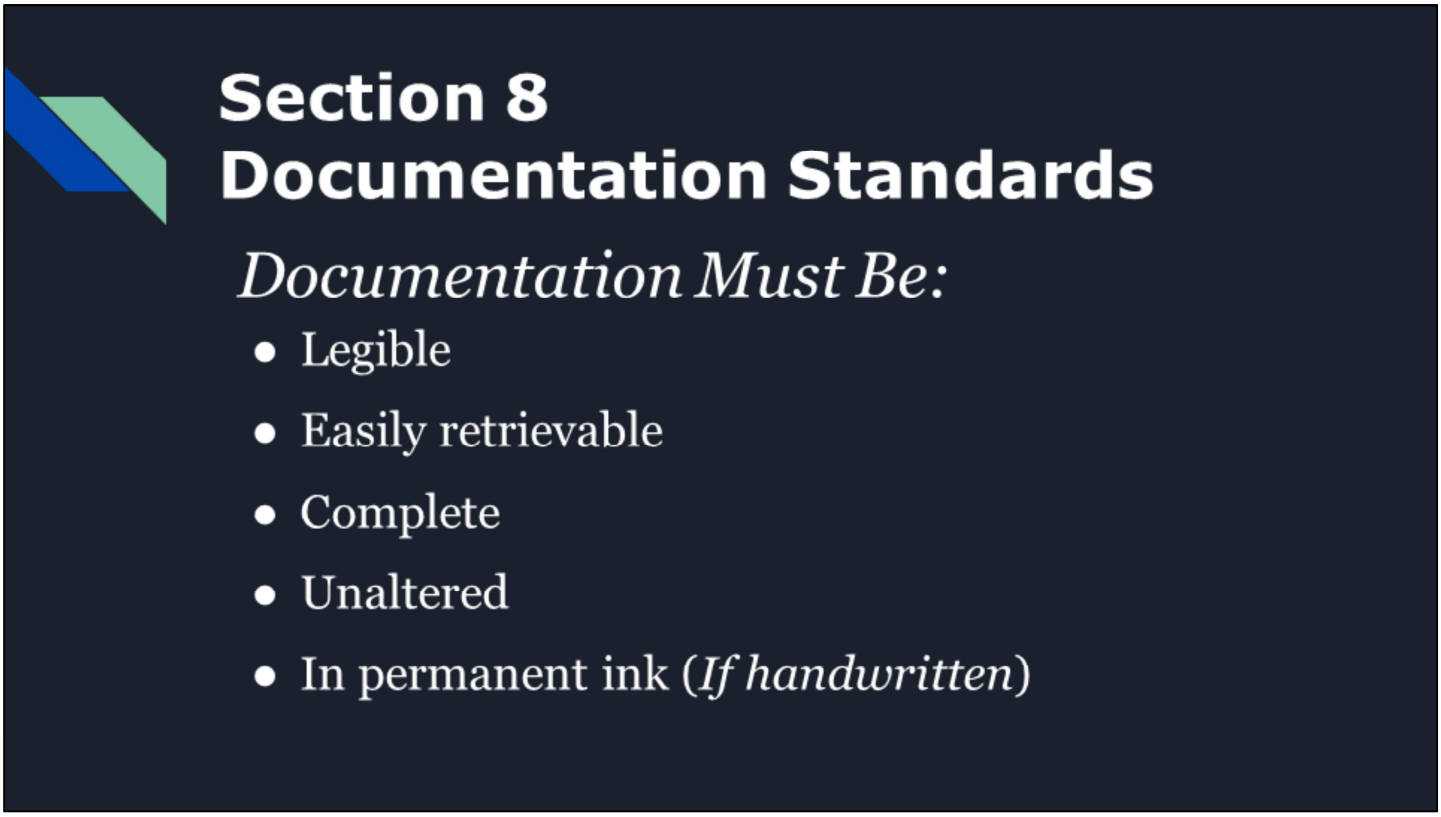
Please make sure the times in/out are clearly marked

Different services must be documented on separate forms

Section 8
Documentation Standards

A detailed description of services provided includes:

- A personalized list of tasks or activities that describe a typical day, week or month
- Includes specific objectives for habilitation services, support needs, health and safety needs, and approximate number of hours in service
    - Providers should document what staff is doing to assist the participant in obtaining the skills and not just provide prompts to the participant to complete the objective.
    - Goals and objective progress (*including percentages*) should be completed by the PROVIDER.
- Services MUST meet service definitions and be consistent to a participant's plan of care.
    - Please contact your Provider Support staff if you have questions

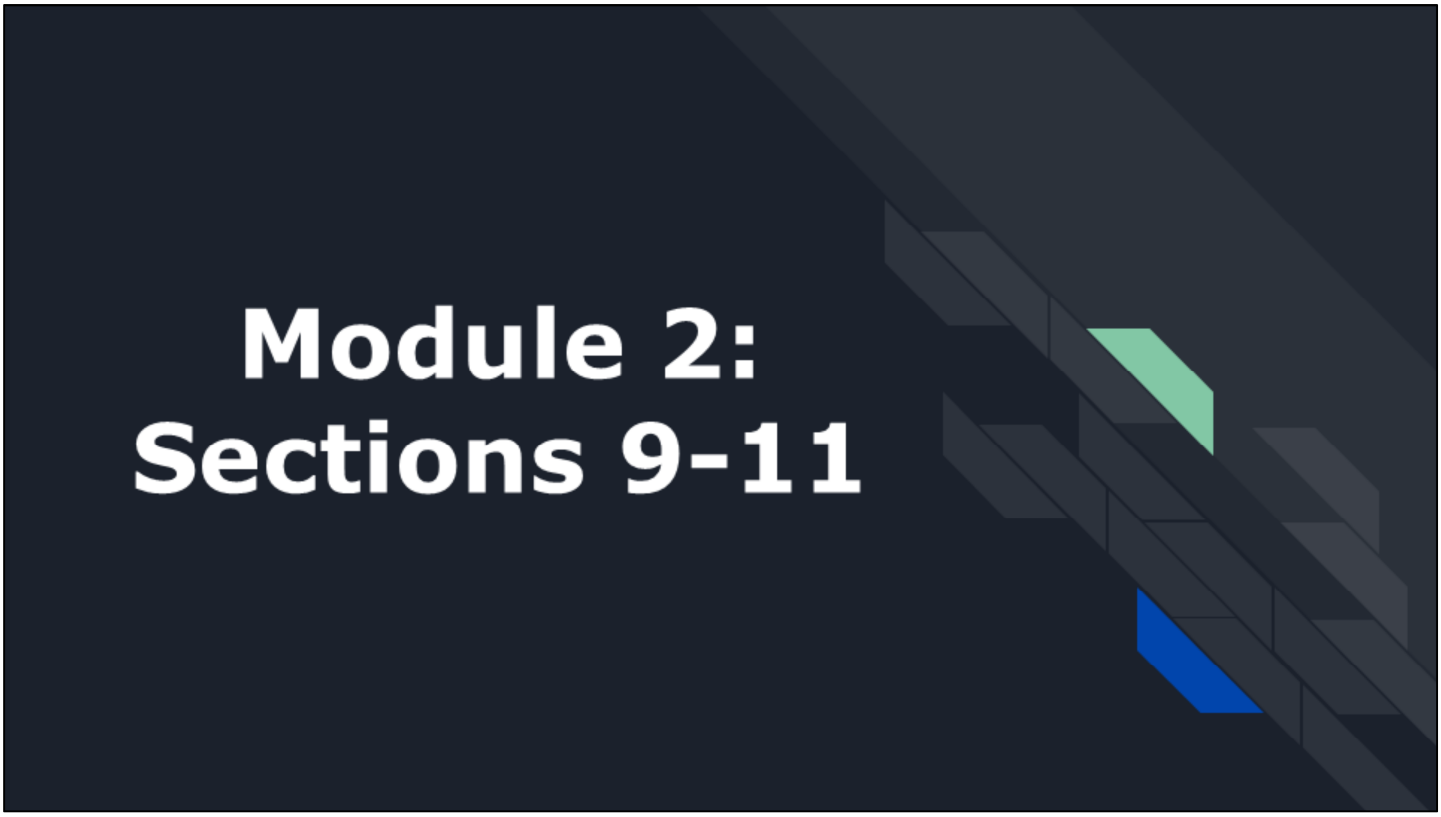


Documentation of services must meet the following requirements:

- Legible - anyone reviewing the documentation should be able to read the information easily
- Easily retrievable - The documentation, either paper or electronic format, must be easy to find and available upon request
- Complete - This is your record of what services were provided. If you didn't document something, it didn't happen
- Unaltered - Documentation cannot be changed in ANY way once billing is submitted unless the participant/legally appointed representative requests an amendment to the documentation allowed by the patient privacy rules in HIPAA of 1996.
- Permanent Ink - If a provider chooses to handwrite documentation, it MUST be in permanent ink. Blue is preferred by Wyoming Medicaid.

Section 8
Documentation Standards

- Providers may not bill for more than one direct service for the same participant at the same time
- Providers may not round up total service time to the next unit (except Skilled Nursing)
- A Participant must be present for all direct care services
- Providers must make service documentation and billing information available to case managers by the 10th business day of the month following the date that services were rendered
    - Documentation non-compliance should be submitted to the Division if case managers do not receive the documentation from the provider. The case managers have been encouraged to reach out to providers to obtain the information, but can file a documentation non-compliance form if they don't receive it on or before the 10th business day



This module includes:
Section 9: Case Management Services
Section 10: Individualized Plan of Care
Section 11: Rate Reimbursement Requirements

Section 9
Case Management Services

- Case Management rules moved from Chapter 1 in the previous Medicaid Rules to Chapter 45, Section 9 in the new rules.
- Case Management is the hub of all services provided to a participant.
- The Case Manager is the participant's advocate and is a mandatory service to all participants enrolled on the waivers.
- Case Managers are expected to use a person-centered planning approach to understand the needs, preferences, goals, and desired accomplishments of the participant.
    - The plan of care should be written to reflect the participant's desired goals and outcomes to assist them in achieving the above listed principles.
    - Provider's should determine the goals and objectives based on what is listed in the plan of care.
    - Participant's plans should be detailed enough to ensure that all providers on the plan can determine what the participant wants to achieve during the plan year
    - The plan of care is considered a living document.
- The Division may establish caseload limits to ensure the case manager effectively coordinates services with all participants on his and her caseload.

It is the case manager's responsibility to provide person-centered planning for each participant. The case manager must include enough detail to allow for providers to develop goals and objectives based on the information contained in the plan of care. The plan of care is considered a living document which includes regular updates when changes occurr. The Division offers Person-Centered Thinking training several times a year to assist case managers in understanding these principles.

It is important to note that due to the case manager's role being so important to the participant and their team's success, should the Division determine (after providing intensive technical assistance) the case manager cannot provide appropriate case management services to all participants on their caseload, the Division shall limit the amount of participants a case manager can serve.

Section 9
Case Management Services

Case Managers must ensure the following:

- All eligibility paperwork is completed within 30 calendar days
- Maintain current *physical and mailing* address of:
  - the Participant
  - Legally Authorized Representative(s)
- The Division and all providers on the plan must be updated as changes occur
- Maintain a participant's file and service documentation
  - Assure that information is disseminated to and received by:
    - The participant
    - Appropriate parties involved in the participant's care
    - As authorized by a signed release of information

All eligibility paperwork includes initial application, medical eligibility (ABI Waiver only) ICAP, psychological, LT 104, and financial eligibility.

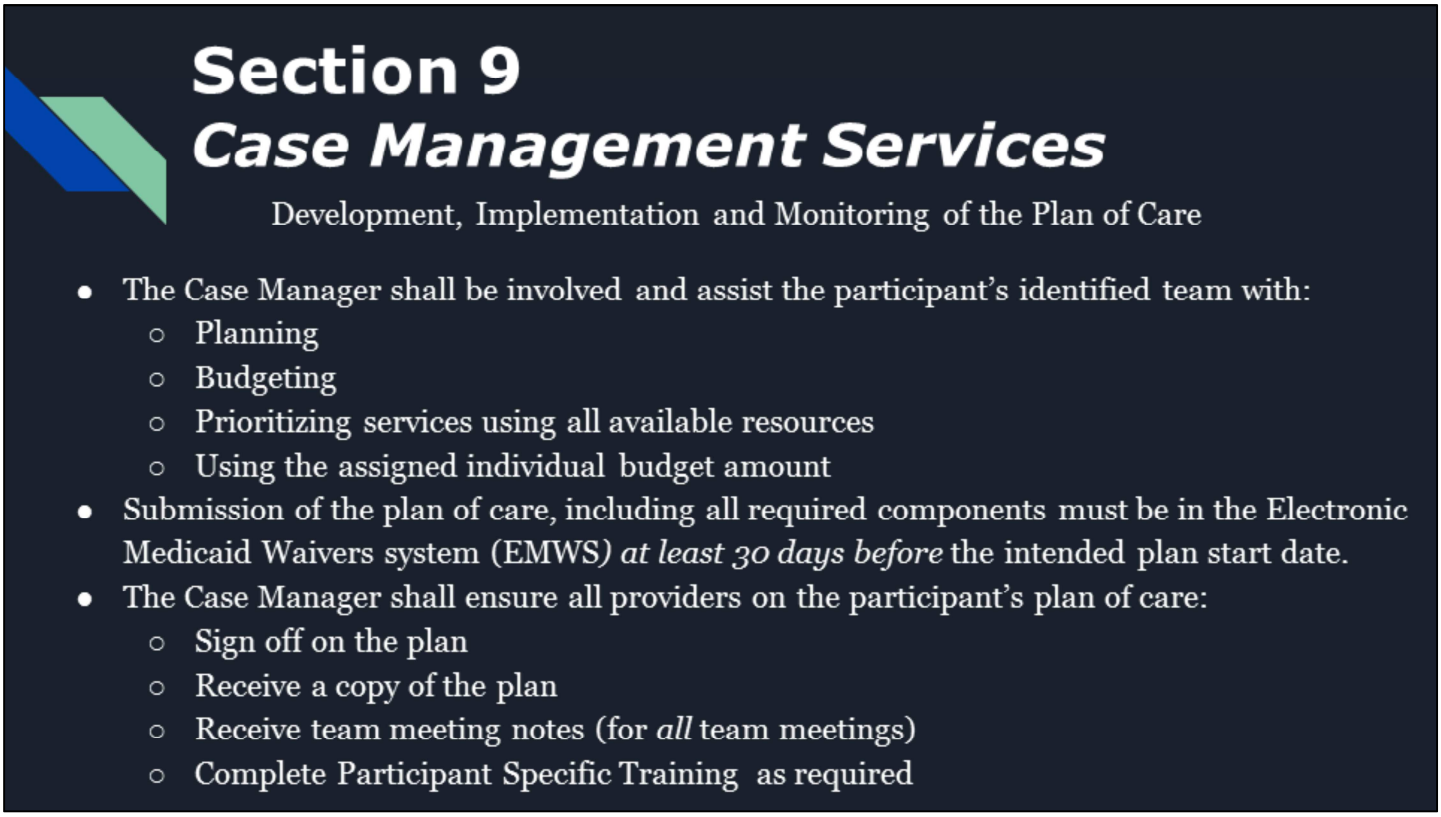
Section 9
Case Management Services

Transitions and Choice

- The Case Manager shall provide the participant and any legally authorized representative with a list of all providers to allow for choice of providers
  - This shall be done at least once every six (6) months or
  - More frequently as requested by the participant or legally authorized representative(s).
- The case manager shall coordinate transition plans when the participant chooses to change, stop, or add providers to his or her plan of care or exit the waiver.
- Should the case manager want to resign, 30 days written notice is required to the following:
  - The participant and their legally authorized representative (as applicable)
  - The Division - Your assigned Participant Support Specialist is who should receive this.
  - Case management services will need to continue for the 30 days or until a new case manager is approved, whichever is first.

The Wyoming Developmental Disability Waiver's system is based on participant choice. In order to assist participants with choice it is important that the case manager regularly review provider options with them. If a participant chooses to change providers, the case manager will schedule and facilitate a transition meeting to allow for an exchange of information between all parties involved (typically this includes the new provider, previous provider, legally authorized representative, participant, and case manager). The case manager also must complete participant specific training with any new providers on the plan prior to the provider working with the participant.

If a case manager wants to resign their duties as a case manager for a pariticipant, they are required to give at least 30 days notice in writing to the participant and legally authorized representative.

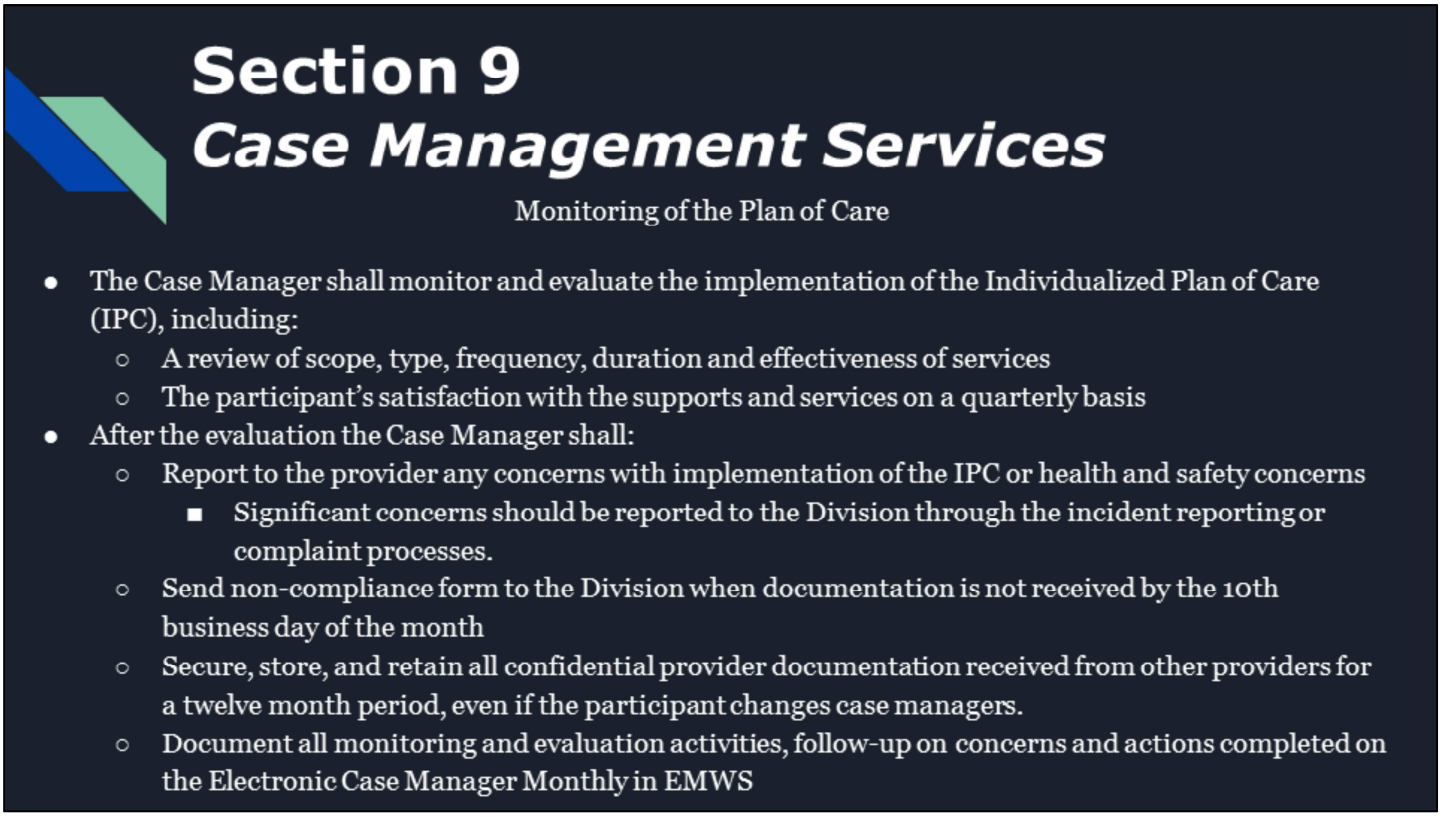


The plan of care should utilize the participant's budget as needed and should be based on the participant's needs and choices. The IBA must last the entire plan year and budgeting of units should reflect this.

Plans must be submitted 30 days in advance to the start of the plan- the only exceptions are those that are approved by the Division for extenuating circumstances. This is now a recertification point and will be looked at annually.

The Division's expectation is that case managers ensure that all providers have a copy of the plan, all team meeting notes (including 6 month reviews) and that participant specific training is completed as required. This should be reflected in case notes and indicate who was trained as well as the date, time, etc.

For The Plan of Care Team: The team should agree on the unit usage per month as well as how the budget will be used. The case manager is responsible for tracking the unit usage and will refer to the Division when units are being used too quickly during the agreed on plan year. Providers should work with case managers to discuss when more units possibly need to be used. The units are expected to last the full plan year.



One of the essential functions of the case manager's job is to monitor the plan of care.

There are many different ways to do this including completing service observations, which is required for Supported Living and all Habilitation services at least every 6 months and for all other services at least one time annually for each provider that does the service. Service observations must be noted in the Electronic Case Manager Monthly Form in EMWS review. The case manager is also required to complete a review of the provider's billing and documentation from the previous month and summarize this in the monthly review forms. Providers are required to submit documentation to the case manager by the 10th business day of the month. Providers who do not submit this documentation should understand that the Division requires case managers to complete a non-compliance form when they do not receive provider documentation so the Division can follow up with the provider.

Section 9
Case Management Services

Second Line Monitoring

- Case Managers are the second line monitor for participants receiving medications.
  - Second line monitoring is conducted to help:
    - Ensure a participant's medical needs are addressed
    - Medication regimens are delivered in a manner that promotes the health, safety, and well being of the participant
- The Case Manager shall provide monitoring on:
  - The delivery of the participant's medication through *monthly* review of the participant's Medication Assistance Records (MAR)
  - The usage of the participant's over the counter and prescription medications
  - The usage of the participant's psychotropic medications
    - The above should be done through monthly review of medication assistance records and PRN medication usage records

Case Managers are required to be the second line monitor for participant's and their medical needs. This requirement is in place to have another person ensure that a participant's medical needs are being met and they are receiving the care they require. Case Managers can monitor this through the participant's MAR's as well as the record of PRN medications that were accessed by the participant. Anytime the case manager identifies what they perceive to be an unmet medical need, it is important that the team discuss this and determine a way to assist the participant in getting what they need.

Section 10
Individualized Plan of Care

The Plan of Care:

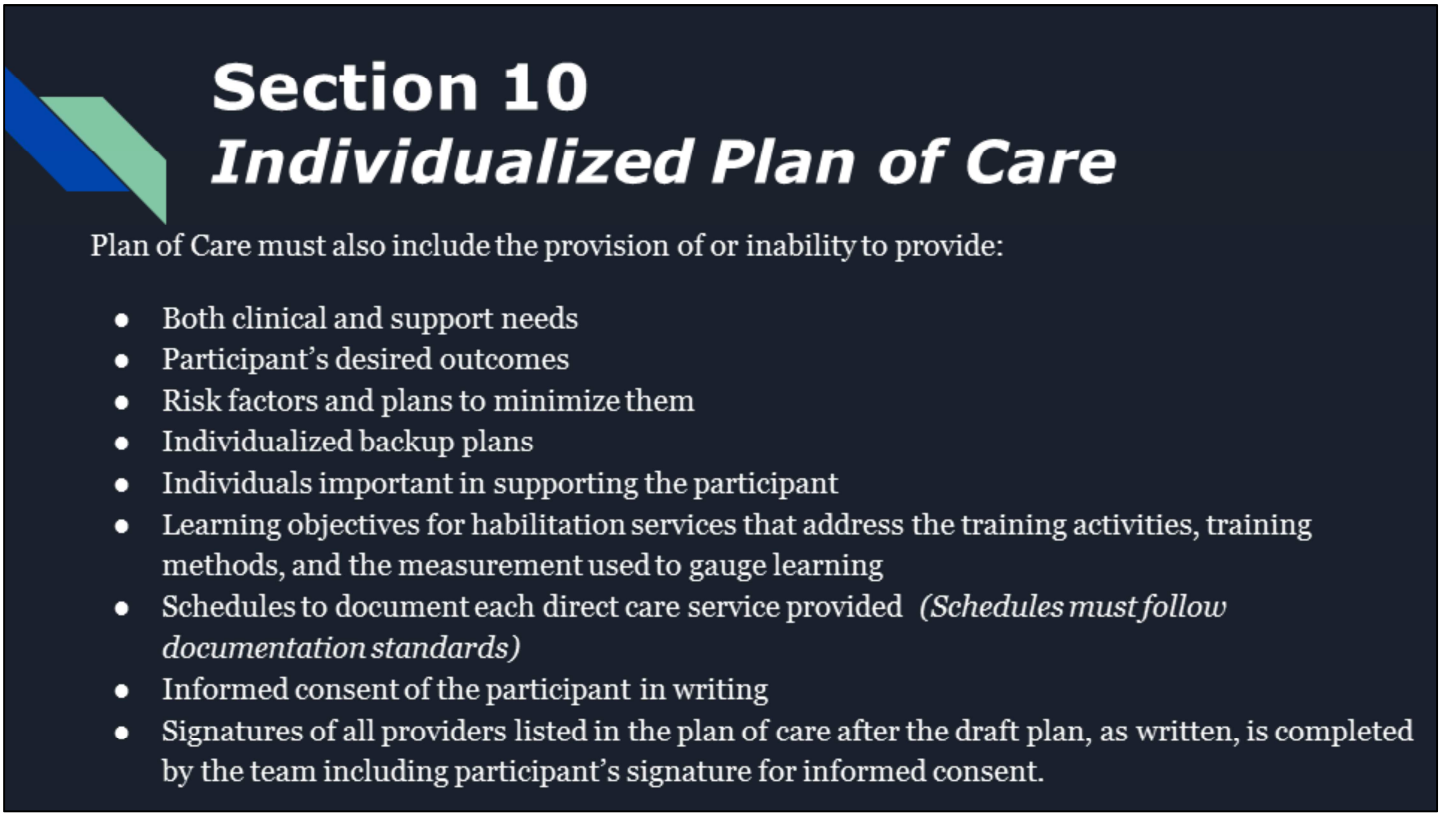
- Should be based on the comprehensive assessment(s) and the person-centered planning process.
- Meeting must be scheduled at times and location convenient for the participant
- Cannot not exceed 12 months, must be submitted to the Division 30 days prior to the plan start date
- Shall be reviewed at least semi-annually, when a participant's needs change significantly, or at the request of a team member
- Must be written in plain language that is understandable to the participant

Submitting the Plan of Care 30 Days prior to the plan start date is new to this rule set. This will be reviewed during recertification of case managers to ensure compliance.

Section 10
Individualized Plan of Care

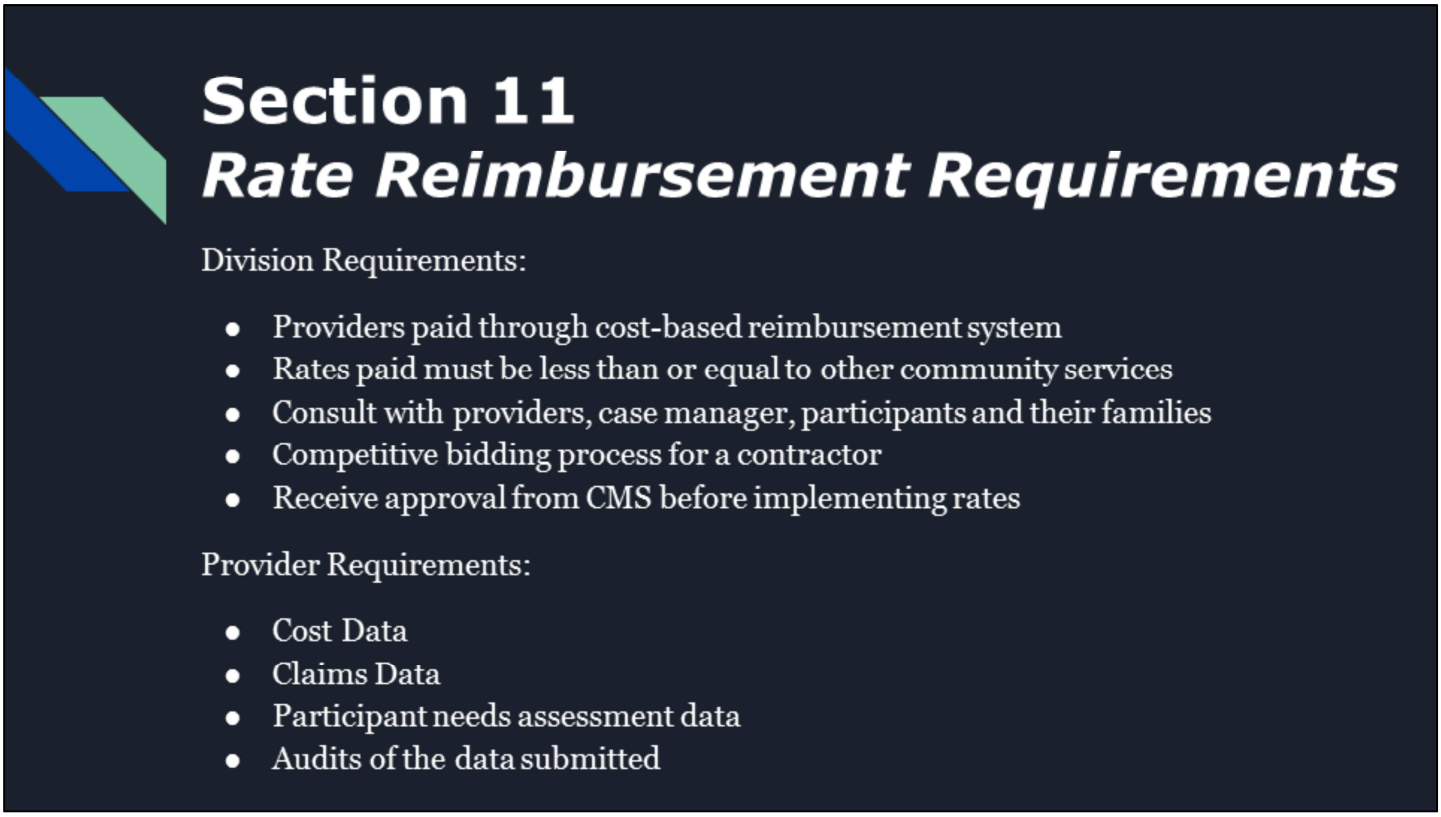
Plan of Care must include the provision of or inability to provide:

- Services in a setting chosen by the participant from all available service options
- Opportunities for the participant to seek employment and work in competitive integrated settings
- Opportunities for the participant to engage in community life, and control personal resources
- Cultural and religious considerations
- Services based on the choices made by the participant
- What is important to the participant and for the participant
- Services based on the participant's strengths and preferences
- Any rights or freedoms that are restricted and the plan to restore the right to fullest extent possible



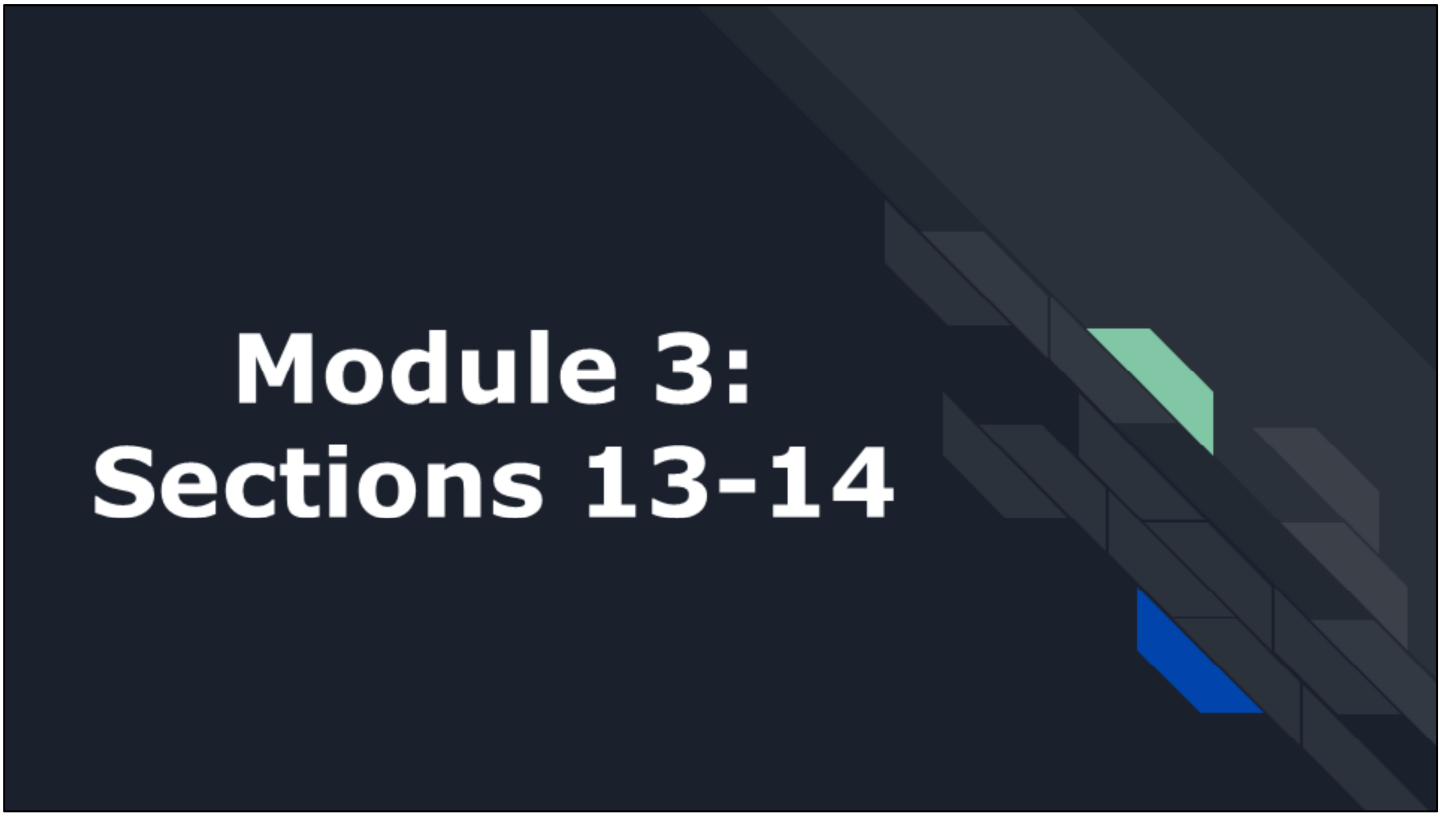
Goals and objectives must match those that are in a plan of care.

If you have questions about writing a plan of care, contact your Participant Support Specialist plan review staff.



The purpose of this section is to outline not only how the Division is required to conduct a Rate Rebasing Study but also what the provider responsibility in this study.

Provider Requested Information:
This data is an extremely important component to setting rate for the DD services. The more information we have to analyze, the more we can get an accurate picture of what it costs to fund the system and to set proper rates.



Welcome to Module 3. We will be reviewing:
Section 13: Home & Community Base Standards for all Providers
Section 14: Background Check Requirements

Section 13
Home & Community Based Services Standards for all Providers

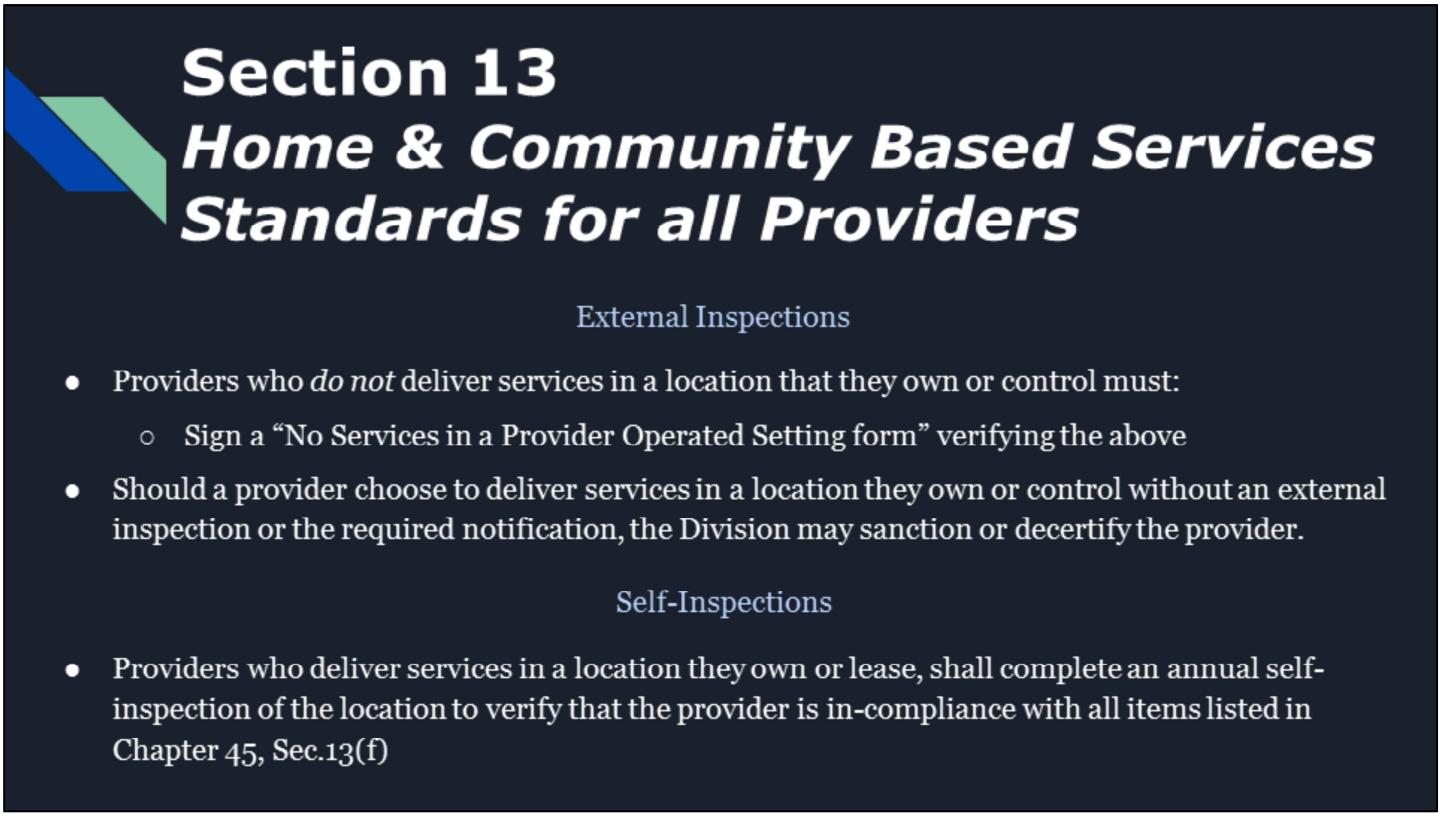
- All certified waiver providers that deliver direct care services to participants in a facility they own or control must meet all applicable federal and state, city, county and tribal health and safety code requirements. A facility does include the provider's home if services are delivered in that setting.
- All certified waiver providers shall provide services that are home and community-based in nature, which means the service setting:
  - Assists the participant to achieve success in the environment and supports full access to the greater community to the same degree as individuals not receiving Medicaid Home and Community Based Services.
  - Is selected by the individual from options including non-disability specific settings.
  - Assists the participant to self-advocate and participate in lifelong learning opportunities.
  - Ensures the individual's rights of privacy, dignity, and respect and freedom from coercion and restraint.
  - Optimizes independence in making life choices, including daily and recreational activities, physical environment and with whom to interact.
  - Facilitates individual choice regarding services and supports and who provides them.
  - Encourages individuals to have visitors of their choosing at any time.

Section 13
Home & Community Based Services Standards for all Providers

- **New** provider owned or operated residential settings, intending to serve 5 or more participants ***will not be certified.***

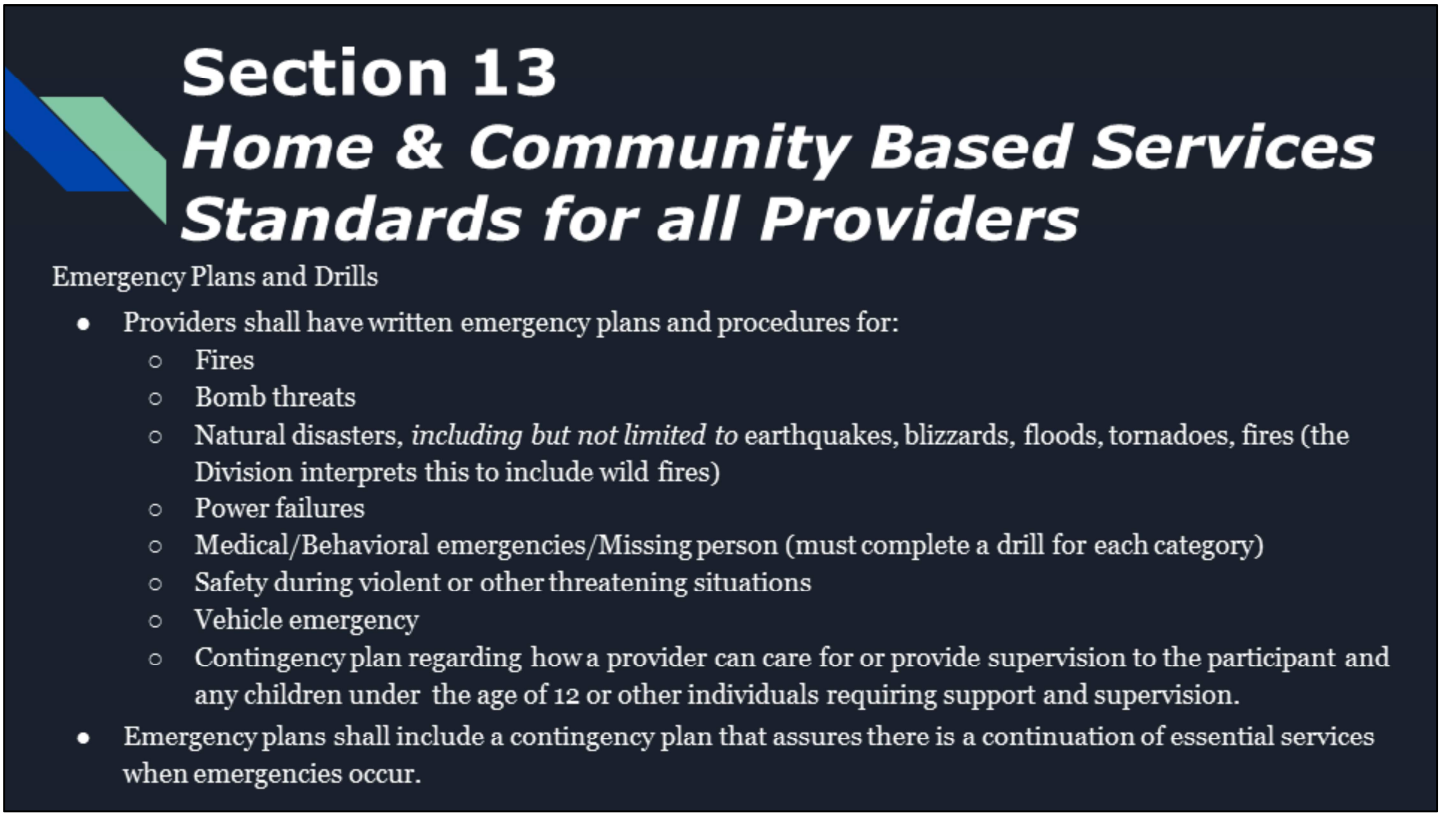
Provider Facility Inspections

- Provider owned or controlled service locations must have a facility inspection completed by an outside entity at least once every 36 months.
    - The facility inspection must be completed by a fire marshal or designee; a certified or licensed home or building inspector; or appropriate contractor inspecting a part of the facility within the scope of the contractor's license.
- Facilities that are found to have deficiencies must correct them within 30 days or have a plan on file regarding how the deficiency will be corrected with follow up indicated that includes the date.

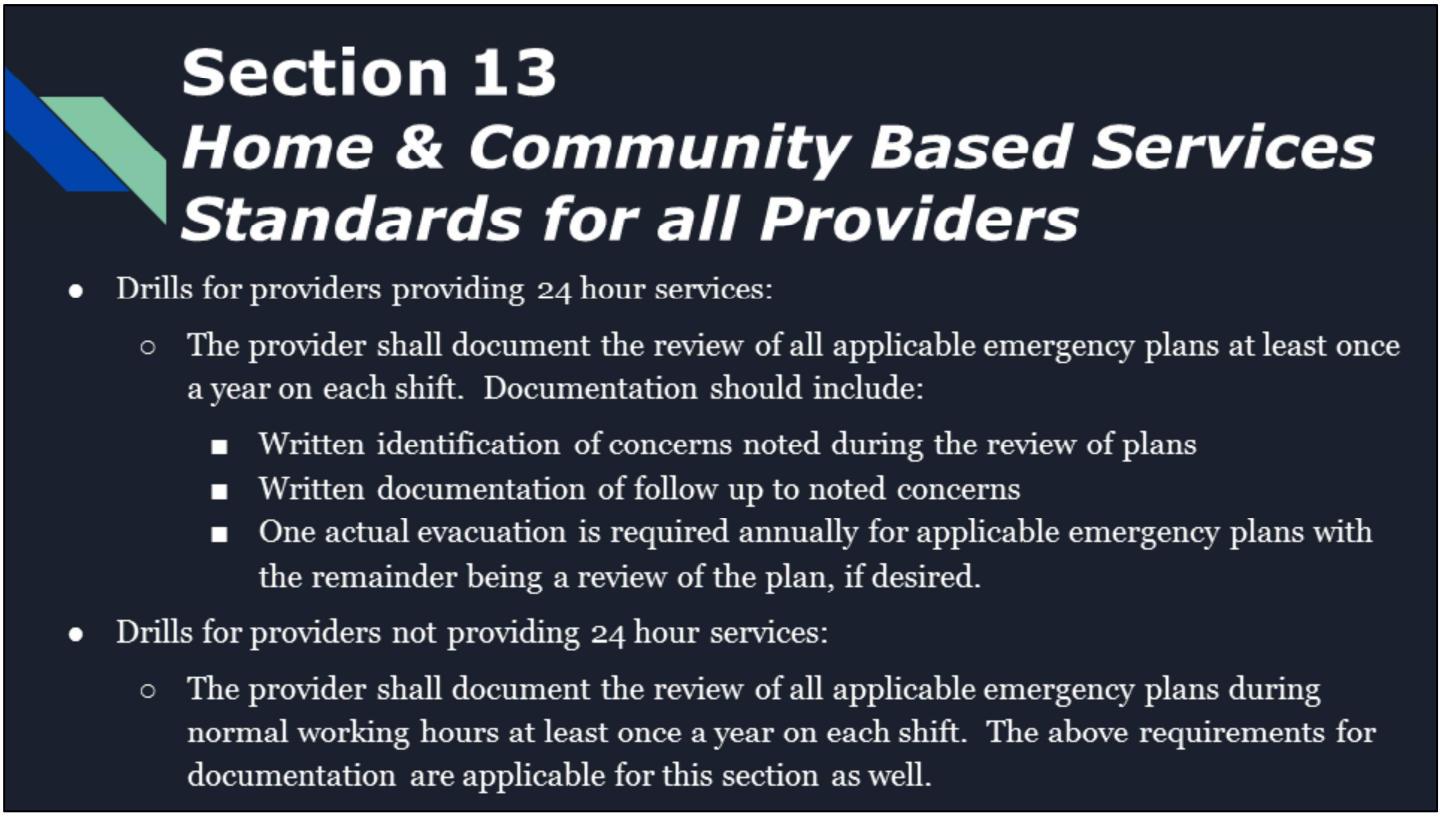


The rules have the same basic standards for all providers. A provider that is also nationally accredited, must also meet the requirements of the accediting agency.

For example, a provider is accredited by CARF, they may be required to conduct one internal inspection annually and one external inspection every 36 months. However, the Division will only review provider documentation for compliance with Chapter 45 rules, which is one internal inspection annually and an external inspection every 36 months.



The above listed categories are all that the Division is requiring per Chapter 45 rules to be completed. When a provider is being recertified, Division staff will be looking to ensure drills are completed in all categories for all provider locations.



The Division has a drill plan form that is available to providers to use that designates each required category. This is optional as providers are welcome to develop their own template as well.

Drills must be run in all identified categories as described above. All providers including Carf provider's must run all drills as identified by Chapter 45 rules. Providers who provide non 24 hour services are still required to show evidence of running applicable emergency drills with their participant's at least once annually.

Section 13
Home & Community Based Services Standards for all Providers

The following standards are additions or changes to from the previous rules and can be found Ch. 45, Sec 13(g)

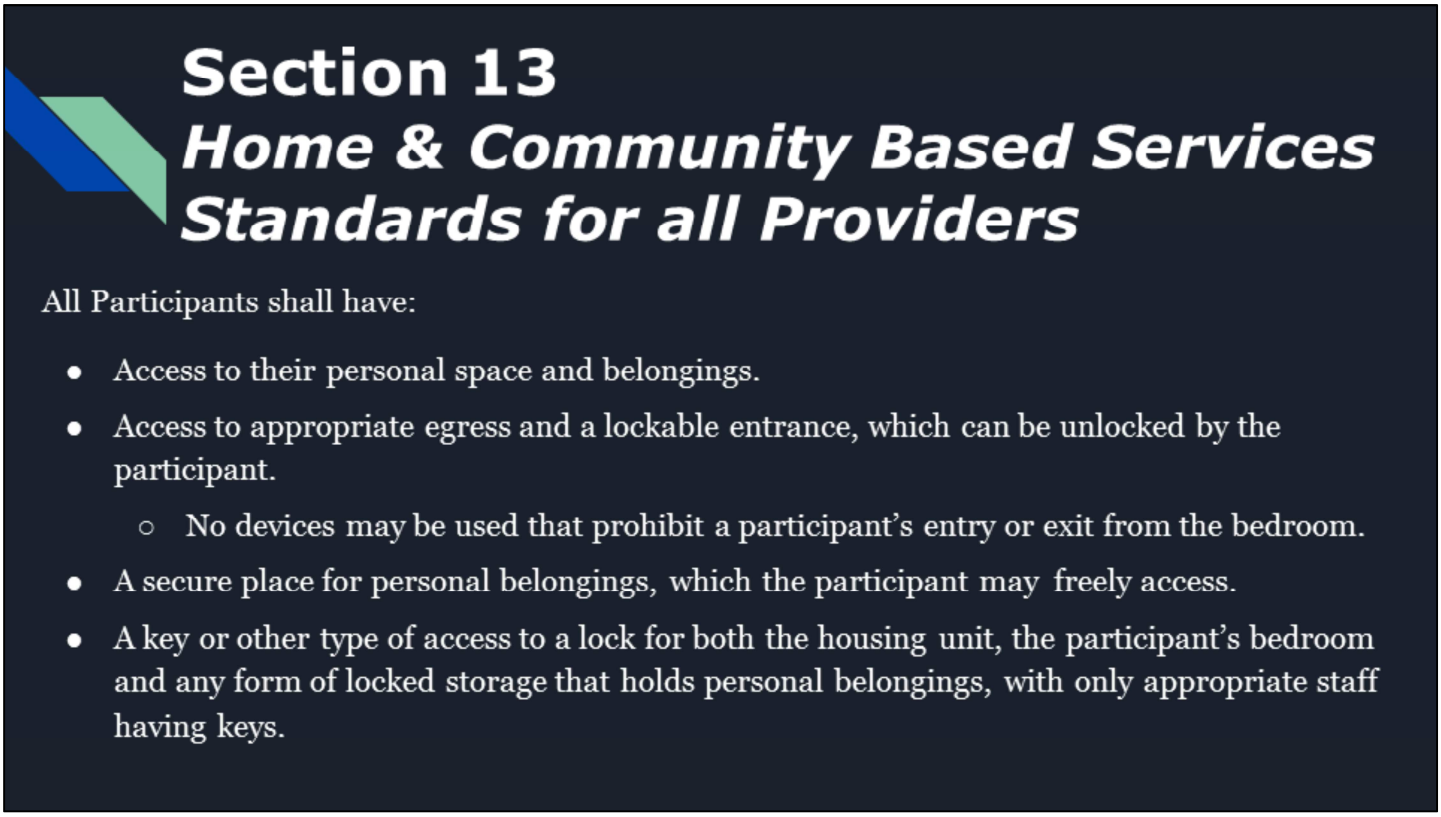
- Residential and Day service facilities must ensure that participants have access to food at all times and provide nutritious meals and snack options. A regimented meal schedule cannot be required.
- All chemicals, poisons, or household cleaners must be secured in a manner that prevents the risk of improper use or harm to individuals as outlined in the plan of care.
- 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.

Food restrictions such as locking up food, restricting access cannot occur for a congregate group based on one person's need.
Participants should have choice as to when and where they eat.
Chemicals- If a participant is safe to use cleaning chemicals that contain bleach or other caustic agents this should be outlined in the plan of care. The Division will consider the group in congregate settings so if one person is not safe to have access to chemicals that means that they need to be secured in a manner that does not allow for access for that person so if they are stored in common areas then they must be secured.

Section 13
Home & Community Based Services Standards for all Providers

- Providers shall ensure that all participants residing in an provider owned or leased facility have:
  - A lease or residency agreement for the location in which they are agreeing to reside, signed by the participant and/or their legally authorized representative
  - The lease must allow for the same responsibilities and protections from eviction as all tenants under landlord tenant law of the state of Wyoming, 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
  - Have freedom and support to control their schedules and activities
  - Freedom to furnish and decorate their sleeping and living unit with the lease or other agreement
  - Have a private bedroom with no more than 1 person to a bedroom except as stated in Ch. 45, Sec. 13(g)(xiv)D(I-IV)
  - An individual bed, unless the participants are legally related or joint sleep accommodations are specifically requested by the participant and specified in the plan of care.

All participants must has a lease. It is the provider's responsibility to determine what the local regulations regarding landlord tenant rules are for areas. It is important to note that if a participant lives in the provider's home such as Residential Habilitation or Special Family Habilitation Home, the provider cannot ask the participant to leave their residence to give the provider a break. The provider can bring another employee to the home or another provider could come in and care for the participant, but unless it is the participant's choice, they cannot be asked to stay elsewhere for the convenience of the provider.



Except for minors, providers must allow participants to have a locking door and they must be given a key to their bedroom. It is also expected that if a participant only wants certain people to have access to their bedroom they have this right.

Section 13
Home & Community Based Services Standards for all Providers

- Any provider that is transporting participants shall comply with all applicable federal, state, county and city laws, including but not limited to, vehicle and driver licensing and insurance and shall:
  - Maintain vehicles in good repair.
  - Keep current emergency information on each participant in the vehicle or demonstrate how emergency information is quickly accessible each time a participant is transported.
  - Keep and replenish first aid supplies in the vehicle.

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

Section 13
Home & Community Based Services Standards for all Providers

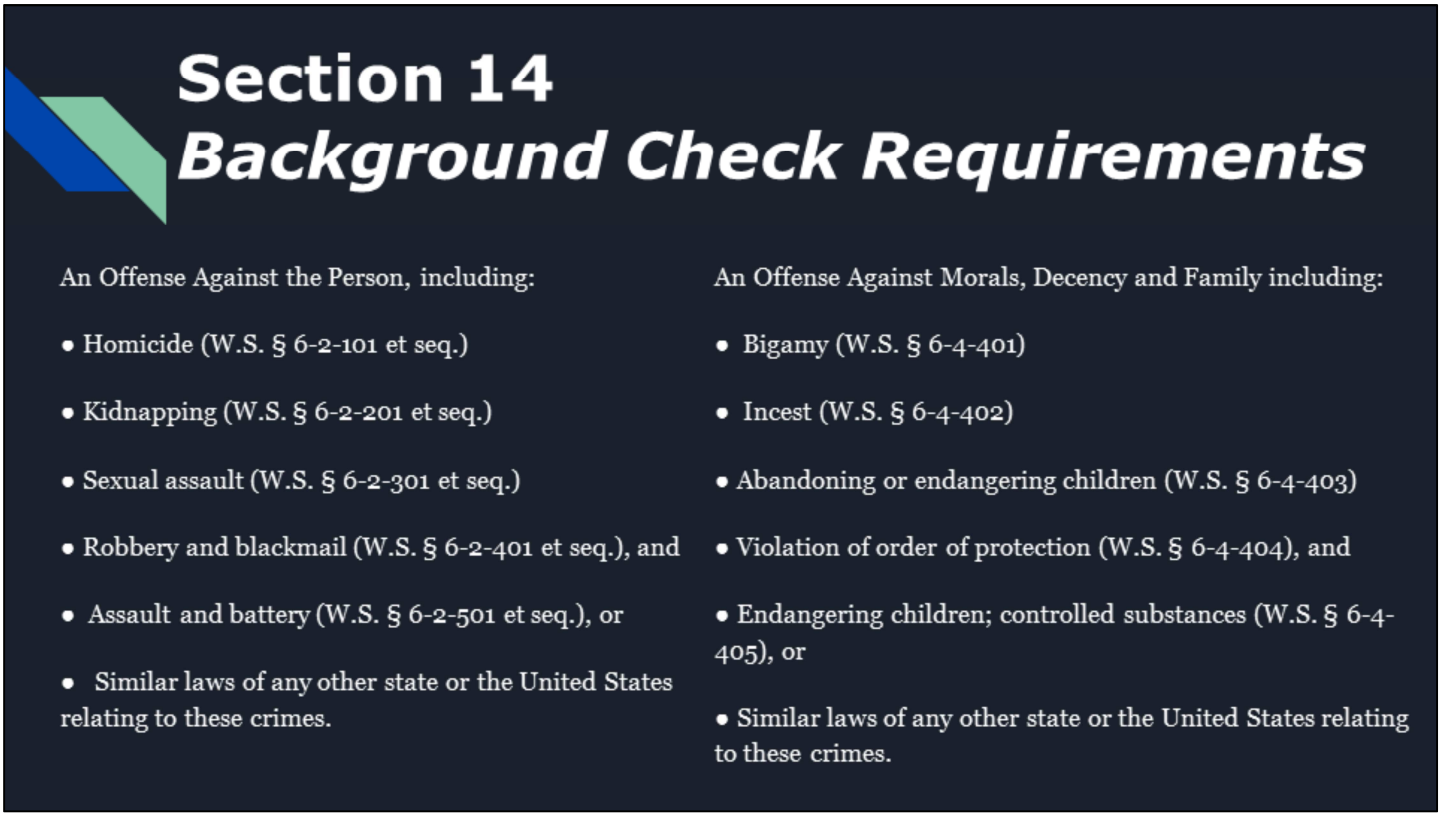
- Settings that include a modification to a participant's right to food or a non regimented meal schedule imposed by a provider must be ordered by the participant's attending physician and be present in the plan of care.
- Settings that include any restriction to a participant's right to visitors, communication, privacy or other standards 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.

For more information on how rights can be restricted or how restrictive interventions can be used, please refer to the Rights Restrictions Training available on the Division website.

Section 14
Background Check Requirements

- All providers, employees (including self-direction employees), anyone with unsupervised access to participants must complete and pass a background screening
  - Dept. of Family Services (DFS) Central Registry screening
  - Office of Inspector General (OIG) Exclusion Database screening
  - State and national fingerprint criminal history check
- Individual cannot deliver unsupervised services to a participant 18 year or older until the DFS Central Registry Screen and OIG Exclusion Database screen have been returned with no findings and the fingerprint criminal history check is in process.
- Individual cannot deliver unsupervised services to a participant 17 or younger until the DFS Central Registry Screen, OIG Exclusion Database screen and the fingerprint criminal history check have been returned with no findings.
- If a provider is delivering services in their own home, anyone living in the home ages 18 years or older must pass all components of the background screening.
  - If person is staying in the home longer than 1 month, they must complete a background screening of the DFS Central Registry screening and the state and national fingerprint criminal history check (this does not include the participant residing in the home).

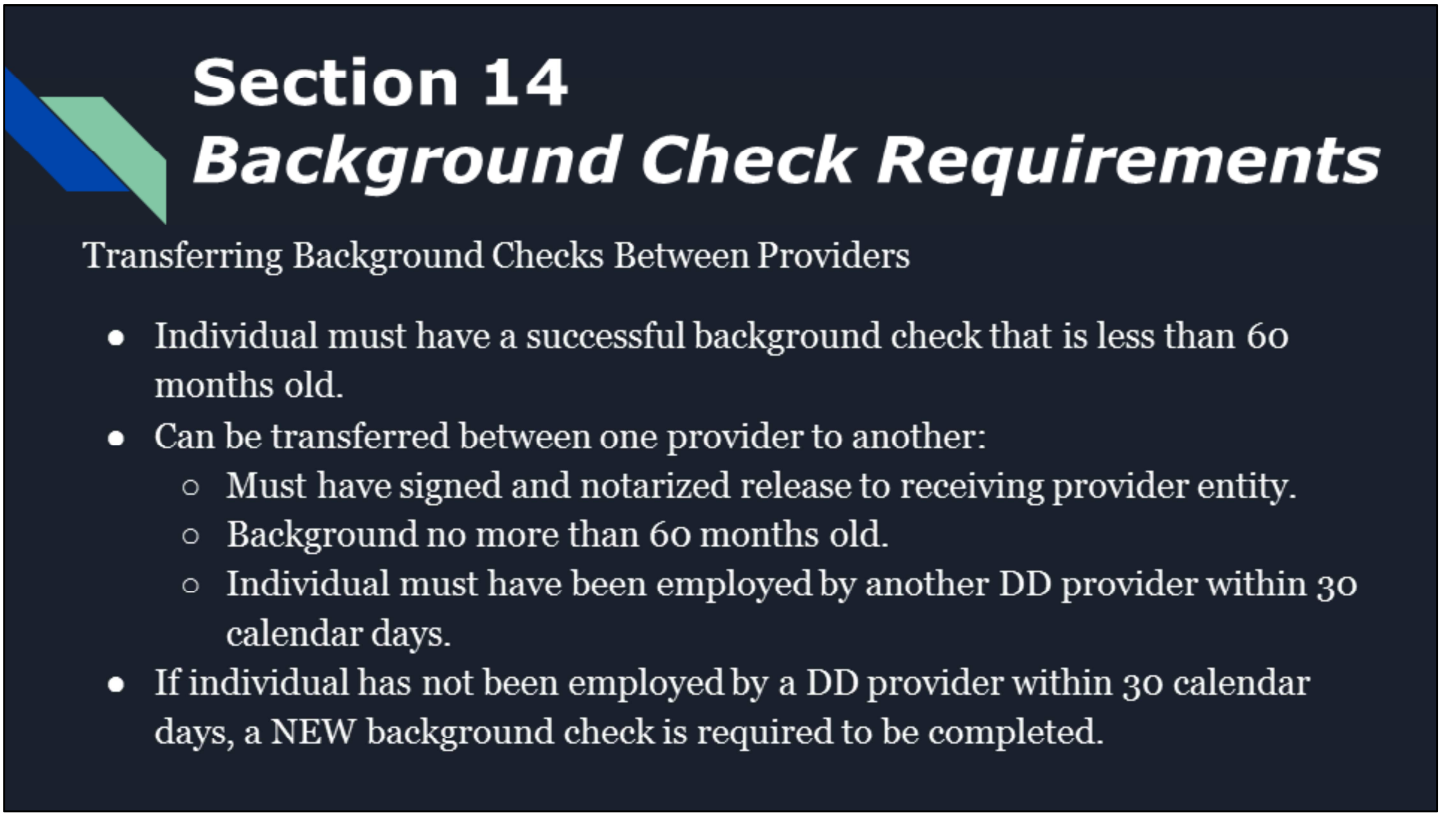
A successful background screening shall include:
(i) A Wyoming Department of Family Services Central Registry Screening, which shows that the individual is not listed on the Central Registry.
(ii) A United States Department of Health and Human Services, Office of Inspector General's Exclusions Database search result, which shows that the individual or entity is not currently excluded.
(iii) A state and national fingerprint 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



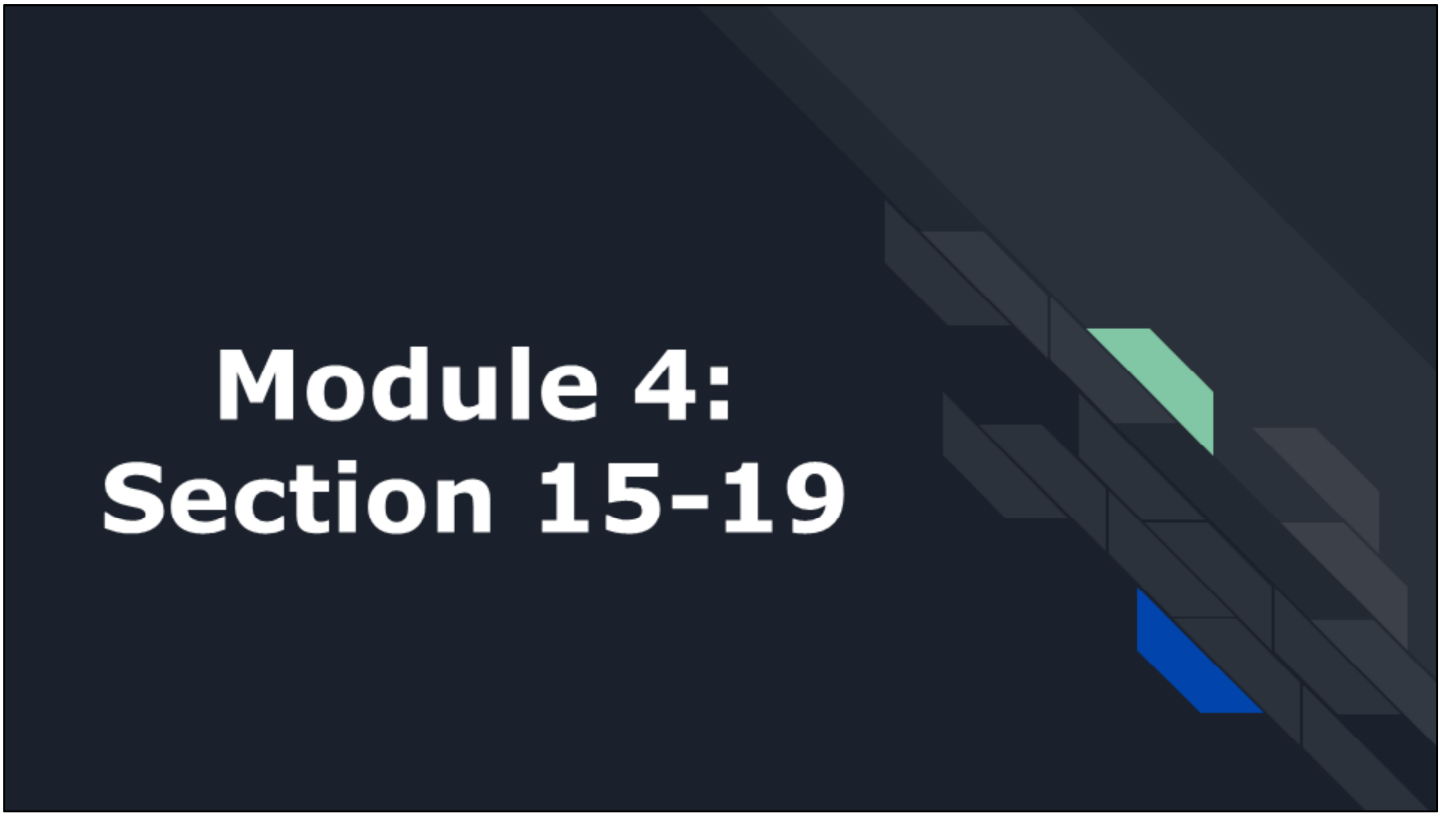
Categories of Back Check Requirements

Section 14
Background Check Requirements

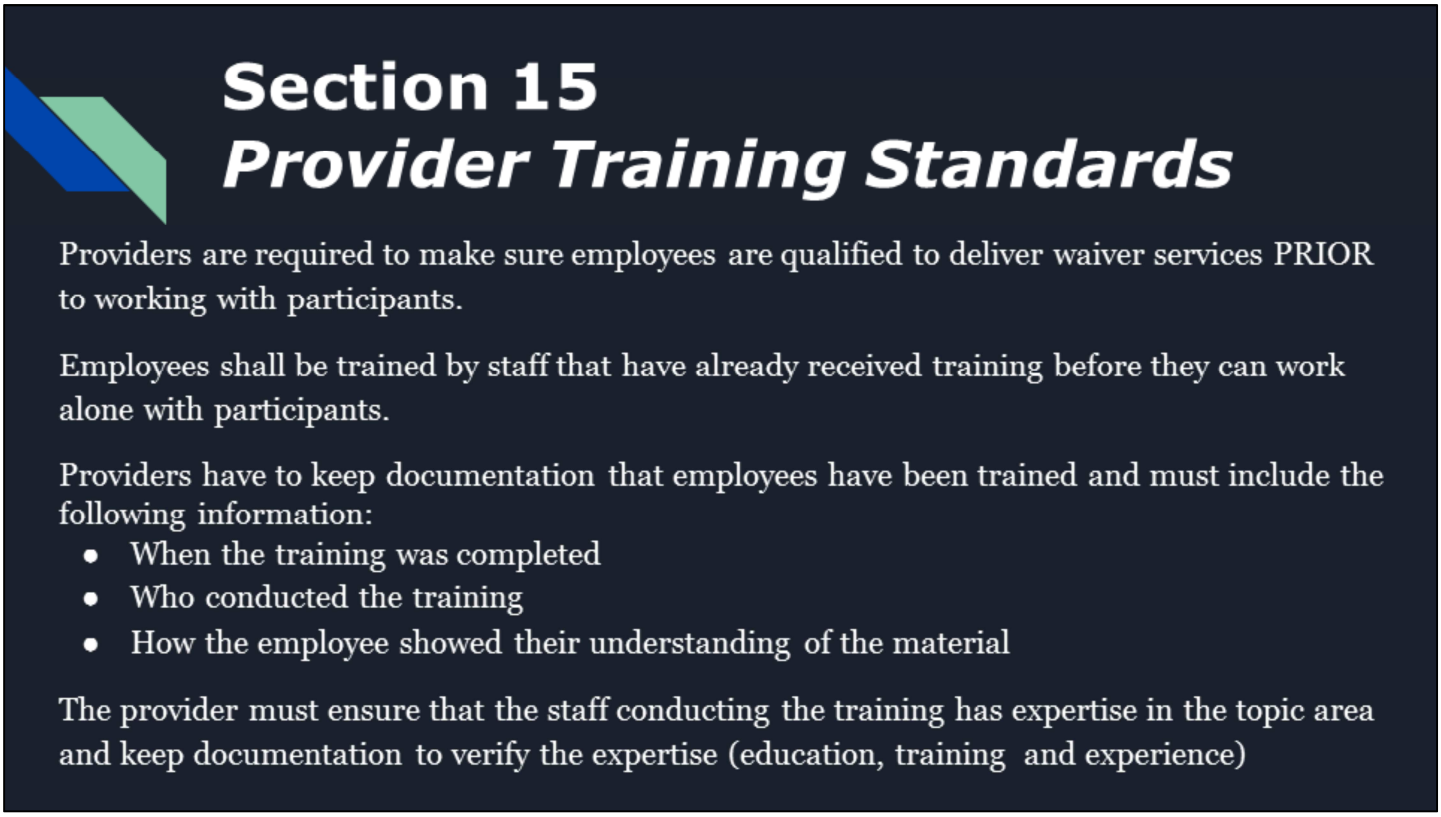
- Individuals who do not pass the background screening may not supervise, provide or bill for waiver services nor have unsupervised access to participants.
- Providers must keep evidence of current background screening for all required persons.
- Screenings must be maintained in the corporate name(s) or organization and any trade name(s) used in this state.
- Individuals who do not pass the screening may be denied certification or terminated.
- Providers who employee individual(s) without the required background checks may be subject to sanctions.
- Volunteers under 18 years of age must be supervised by an adult with a successful background screening.



Wyoming Developmental Disability Waiver providers may transfer successful background checks between provider agencies with some conditions. There must be a notarized and signed release to the receiving provider entity to release the background check. Next, the background check cannot be more than 60 months old. Finally, the individual being hired by the new agency must have been employed by another DD waiver provider within 30 calendar days otherwise a new background check must be completed.



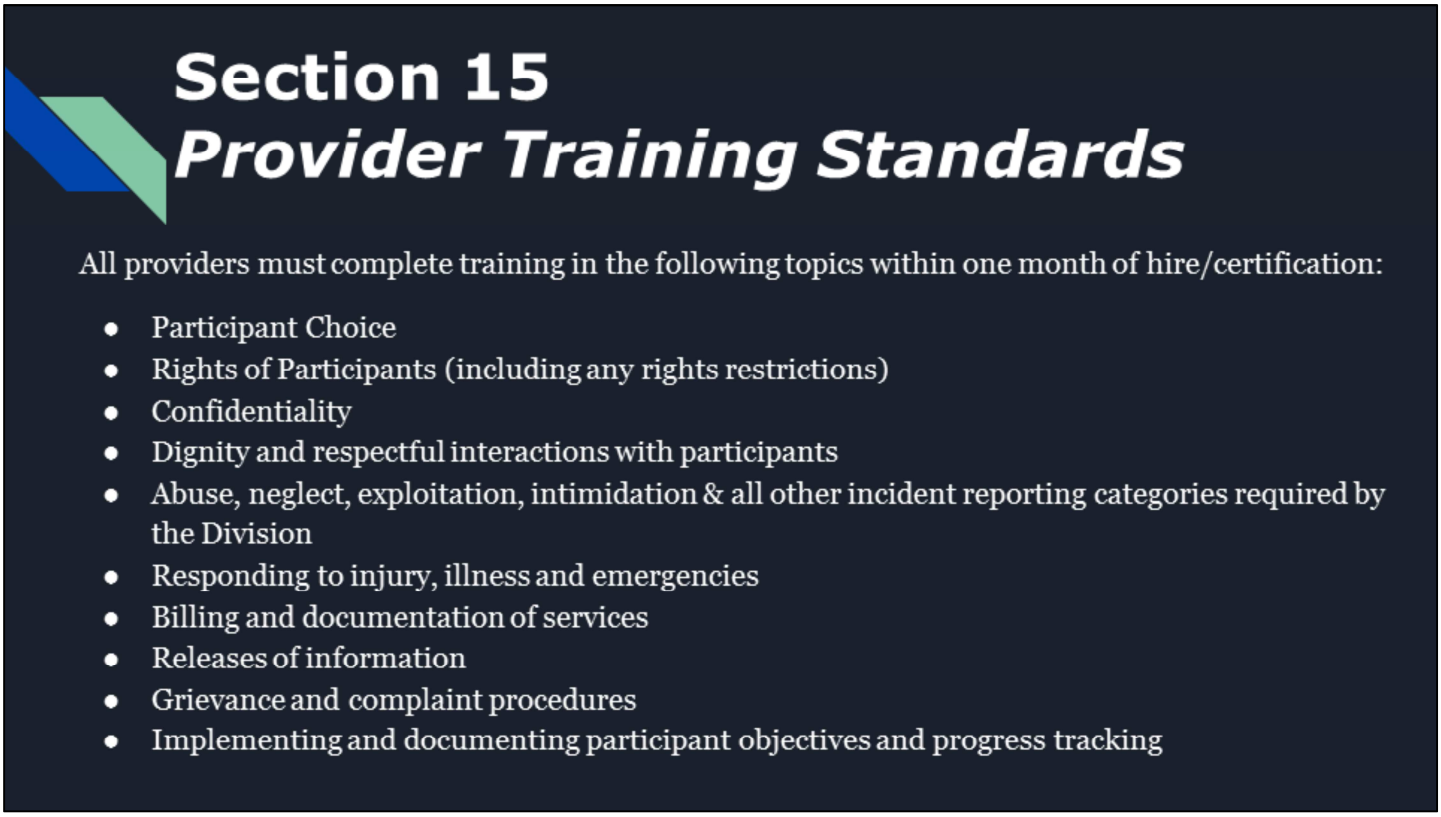
Module 4 covers
Section 15: Provider Training Requirements
Section 17: Positive Behavior Supports
Section 18: Restrictive Interventions
Section 19: Psychoactive Medication Standards



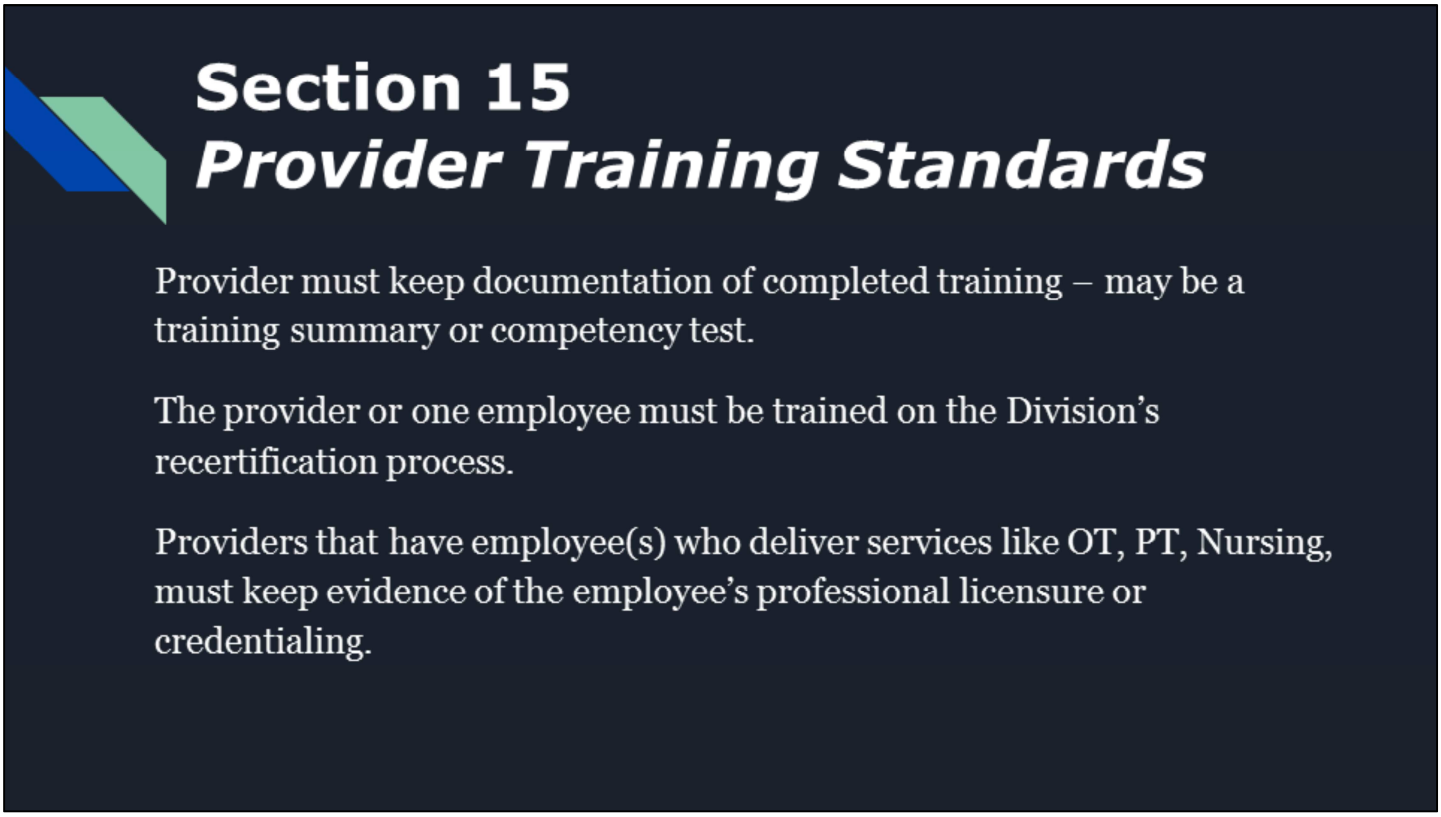
Section 15 outlines training for providers and staff. The section is does not include all training areas required by other Medicaid rules or sections within Chapter 45 (for example, positive behavior support plans or restrictive interventions)

The rule states that providers and their employees must receive the appropriate training before working with any participants. It also says that providers/staff should work with and be trained by another staff that has already received the training before he or she works alone with the participant. For those participants that may be transitioning to a new provider, we recommend that the new provider staff work with the outgoing provider staff to learn about the participant to the extent possible for the situation.

Providers are required to keep documentation/evidence of meeting this rule for each staff member that includes information on when they were trained, who completed the training and how the employee was able to show their understanding of the information. The trainer must also have documentation in his or her file that shows they are an expert in this subject area. The documentation can include certificates, educational information, etc.

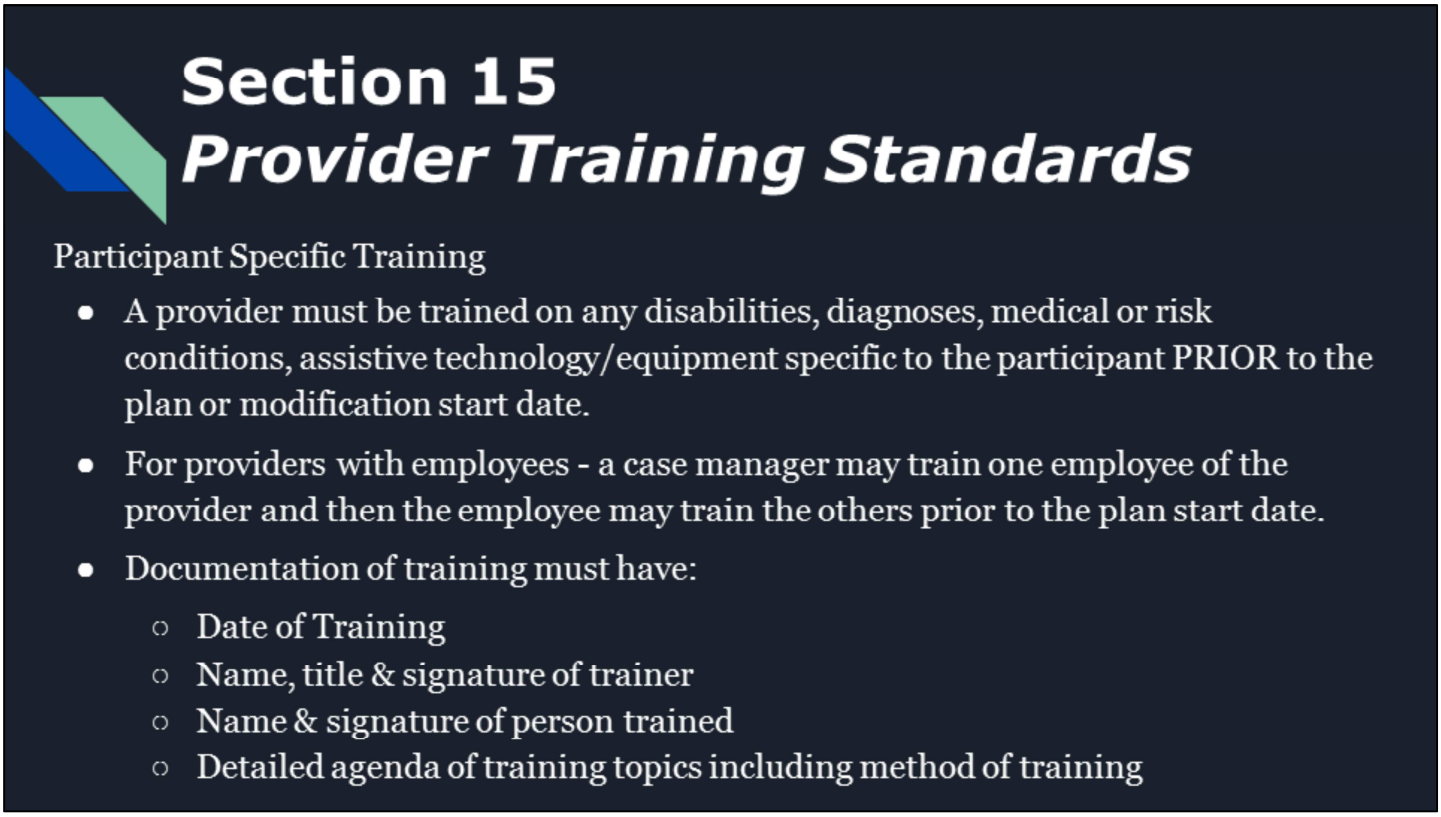


This slide shows the topic areas that need to be trained on no later than one month of the hire date or initial certification date if new provider. The categories are:



The provider can have employees complete a summary or a test to show understanding of training information. The provider must keep documentation of this information on file for each staff member. Each provider must have one representative trained on the Division's recertification process.

If a provider is certified in a service that requires a license or credential, the provider must keep documentation of that licensure/credentialing for the person delivering the service



Participant specific training

Providers and their staff must be trained on the participant and his/her support needs in the plan of care prior to the start or modification date. This would include any disabilities, diagnoses, medical or risk conditions and protocols/assistive technology needed to support the participant. The case manager may train one person from each provider on the plan of care. That person can then train the others in the provider agency prior to plan or modification start date. The documentation for completing Participant Specific Training must have the following components: Date of training, Trainer's name, title & signature, name and signature of the person trained and detailed list of training including the training method utilized.

Section 17
Positive Behavior Supports

Providers must implement positive behavior supports as behavioral intervention **PRIOR** to the use of any restrictive intervention.

- Participant's with a challenging behavior identified by the team shall have a current functional behavioral analysis conducted within the last year.
  - The functional analysis shall include data compiled regarding all behavior exhibited.
  - The functional analysis should be completed by a provider staff who is knowledgeable about the participant with additional input from the team.
- Challenging behaviors may include:
  - Actions by the participant that constitute an immediate threat to the person's health and safety.
  - The health and safety of others in the environment.
  - A persistent pattern of behaviors that prevent the participant from participating in integration in the community.
  - Uncontrolled symptoms of physical or mental condition(s).

Section 17
Positive Behavior Supports

A positive behavior support plan, based on the current functional behavioral analysis, must be developed for a participant in order for staff working with the person to understand and recognize the communication and behaviors exhibited by the person.

- At a minimum, a positive behavior support plan must:
  - Maintain the dignity, respect and values of the participant
  - Use a person-centered approach involving the participant, as applicable
  - Minimize the use of restrictive interventions
  - Be specific and easily understood, so direct care staff can implement it appropriately and consistently
  - Be approved by verification of a signature by the participant or their legally authorized representative.
    - The participant and their legally authorized representative must also be educated regarding the risks and benefits of any supplemental plan that includes restrictive interventions or psychoactive medications used if the plan fails.

Section 17
Positive Behavior Supports

- Define the antecedents and the targeted behaviors.
- List positive behavioral supports that assist the participant in replacing targeted or challenging behaviors with replacement behaviors.
- Provide protocols for providers and provider employees to recognize emerging targeted behaviors and determine appropriate interventions.
- Provide protocols that focus on positive interventions that are least restrictive.
- Include protocols for the use of any PRN that may be a part of the positive behavior support plan.

- The plan must be reviewed every six months by the provider and case manager
- Any provider employee implementing the PBSP shall receive participant specific training on the plan and on specific positive de-escalation techniques and interventions prior to working with the participant.

Section 18
Restrictive Intervention Standards

Note: *This training is not meant to provide a comprehensive guide to Restrictive Interventions. This section of this training is only for participants who currently have restrictive interventions approved in their plan of care.*

Providers using restrictive interventions must have at least one employee with completed training on positive behavior supports through any program approved by the Division. *(Only for providers with more than 5 participants with restrictive interventions, and add an additional supervisor certified for every ten additional participants with restrictive interventions in their plan)*

Providers must notify a participant's case manager within 3 business days of any use of an emergency restrictive intervention not written in the participant's plan of care

Provider and Provider staff must have current certification in CPI, MANDT or other entity approved by the Division.

Section 18
Restrictive Intervention Standards

Provider staff trained to use restrictive interventions also must be trained in:

- ✓ The needs and behaviors of the population served
- ✓ Relationship building
- ✓ Alternatives to restrictive interventions
- ✓ The difference between natural consequences and punitive consequences
- ✓ Avoiding power struggles
- ✓ Thresholds for restraint
- ✓ Monitoring signs of distress and obtaining medical assistance
- ✓ Legal issues related to restrictive interventions
- ✓ Position related asphyxia
- ✓ Time limits
- ✓ The process for obtaining approval for continued restraints
- ✓ Procedures to address problematic restrictive interventions
- ✓ Documentation
- ✓ Any participant specific medical concerns and processes
- ✓ Follow-up with staff and the participant
- ✓ Investigation of injuries and complaints

Section 18
Restrictive Intervention Standards

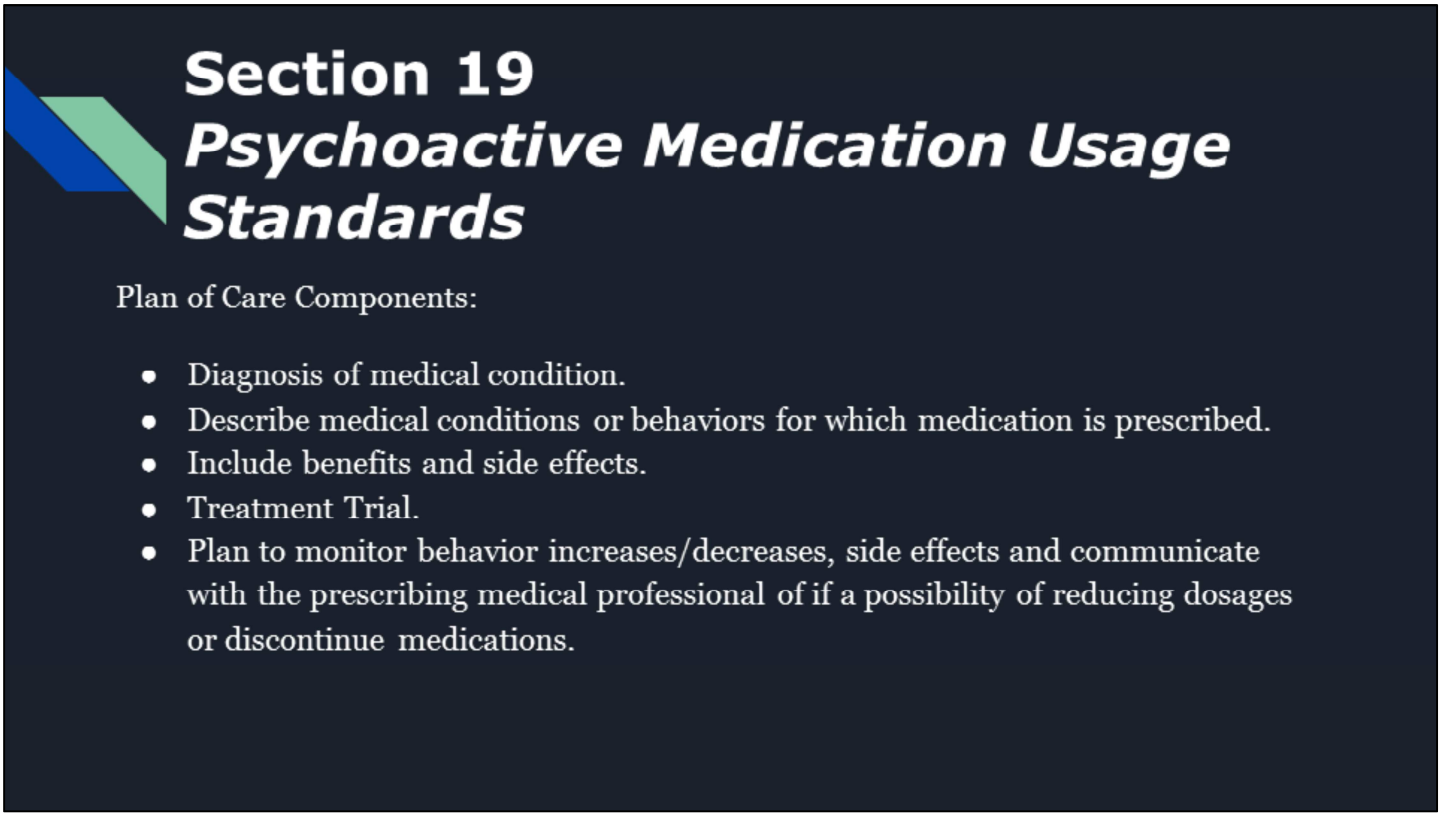
Providers must maintain internal documentation to track and analyze:

- Each use of a restrictive intervention
- Its antecedents
- Reasons for the use of restrictive interventions
- The participants reaction to the restrictive intervention
- Actions that may make future restrictive interventions unnecessary

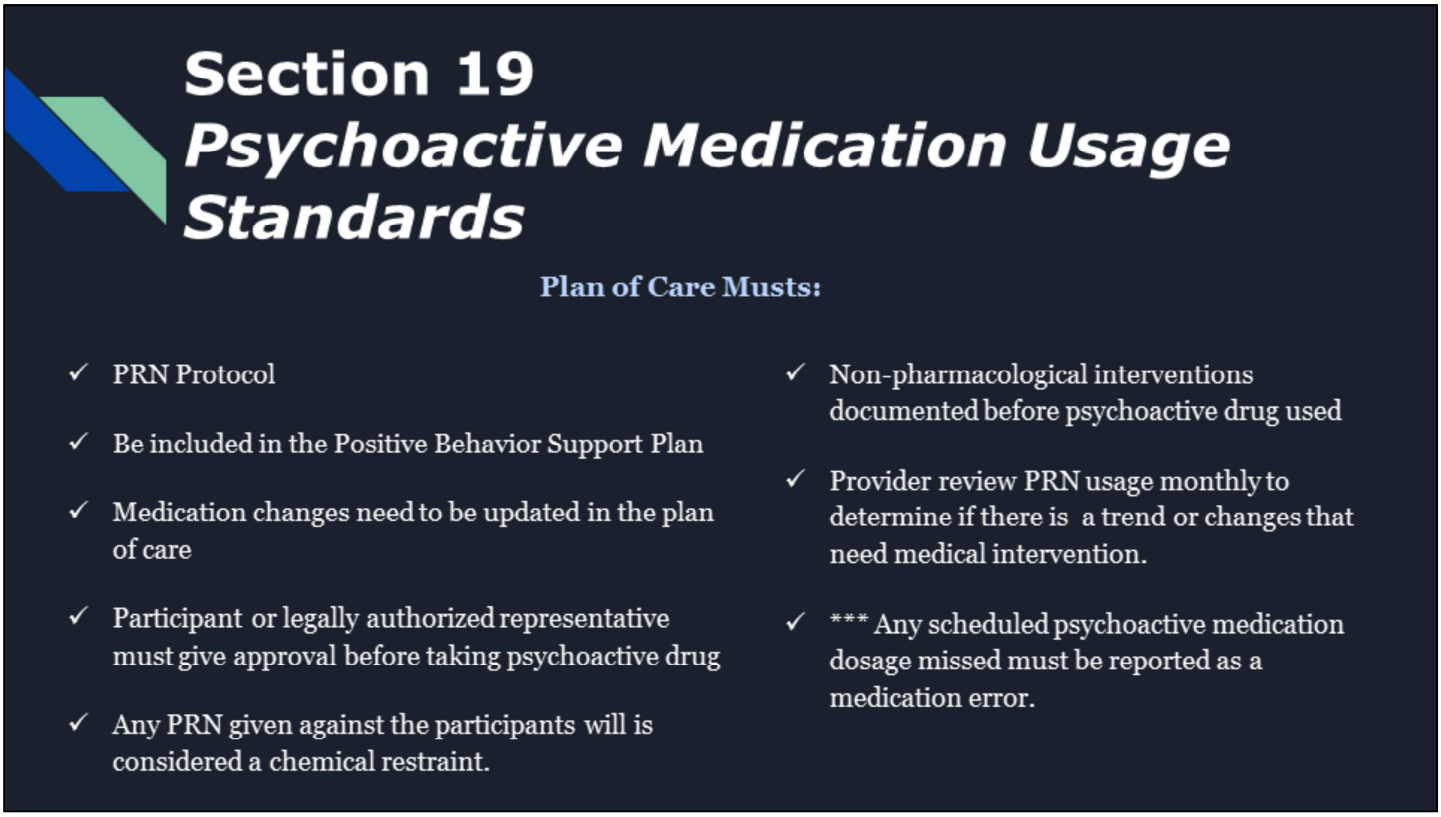
Section 18
Restrictive Intervention Standards

Other requirements for Providers after implementing a Restrictive Intervention on a participant:

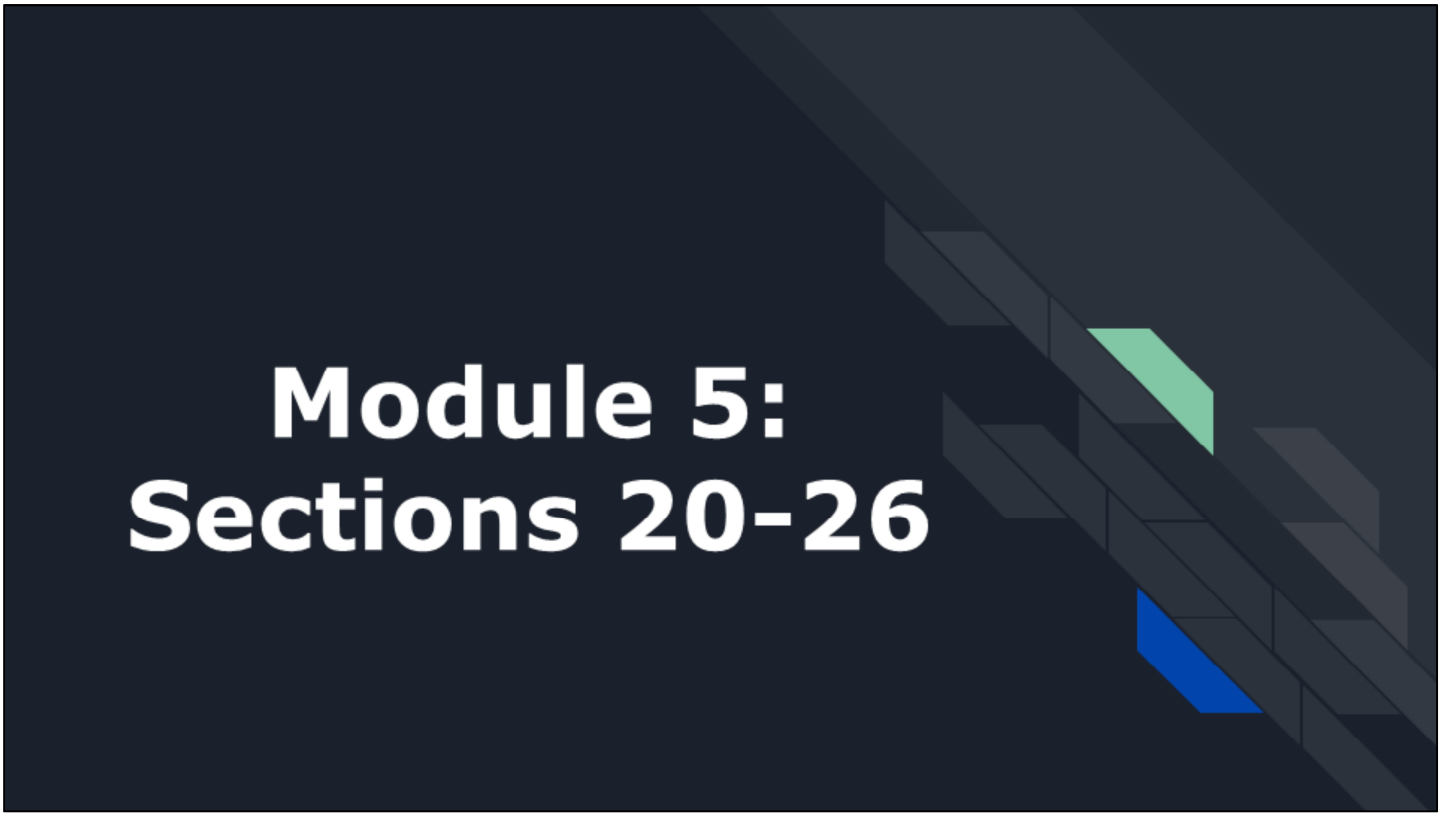
- Providers must hold a debriefing meeting with the participant, legally authorized. representative, and case manager after the incident to discuss use of a restriction.
- Provide case managers with a copy of the provider's completed internal tracking form within 3 days.
- Provide legally authorized representative with a copy of the provider's internal tracking form within 5 days.
- Submit a critical incident report to the Division for each instance when a restraint is used as a restrictive intervention; **AND**
- Providers must regularly collect and review all available data regarding the use of restraints and demonstrate work to reduce their duration and frequency, and eliminate their occurrence.



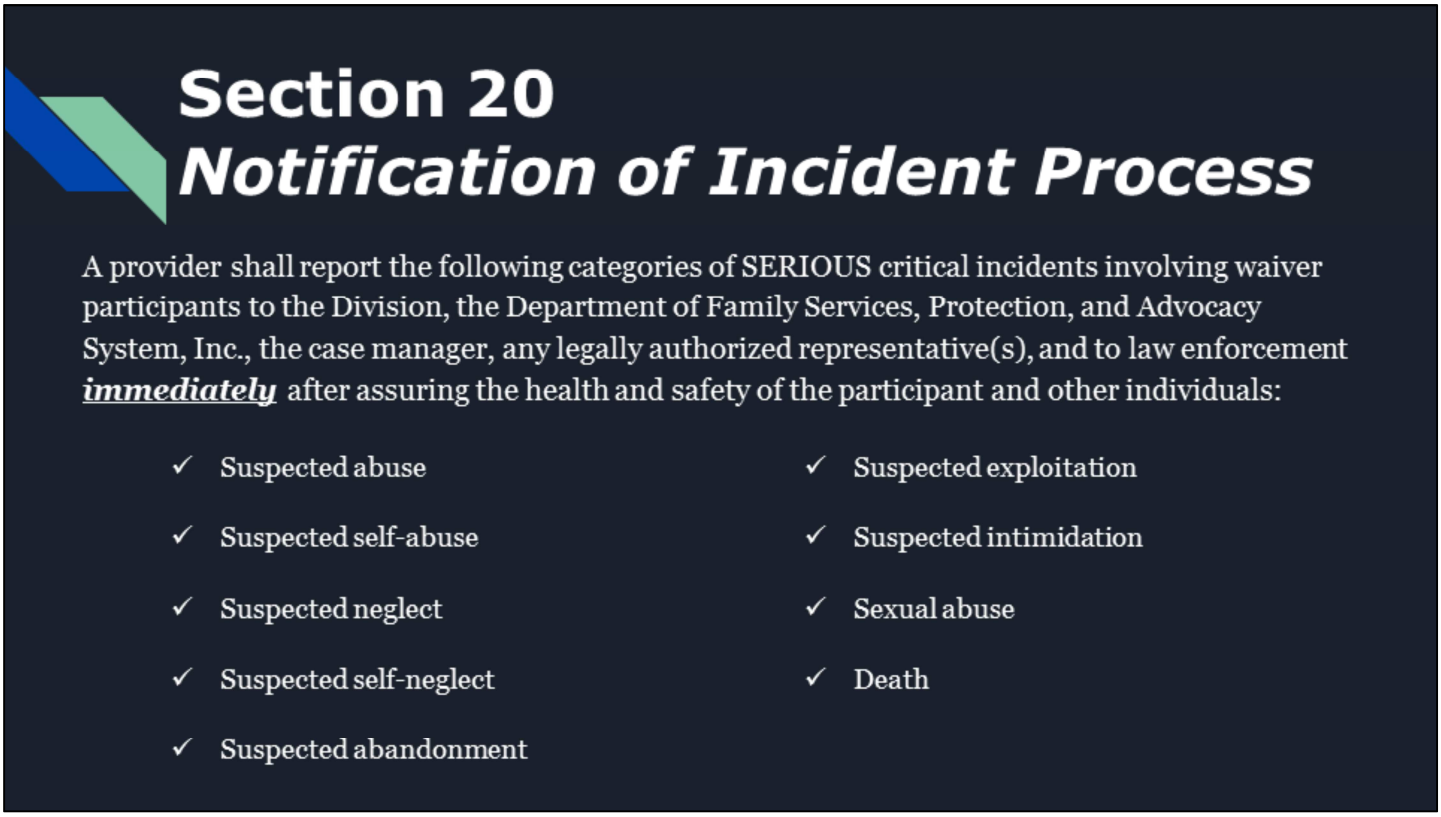
When a participant is prescribed a psychoactive medication, both the provider and the case manager should have a fairly well rounded knowledge of the drug, what it does and why it's being used. If a participant is being prescribed a psychoactive medication as a standard treatment, this information needs to be included in the plan of care.



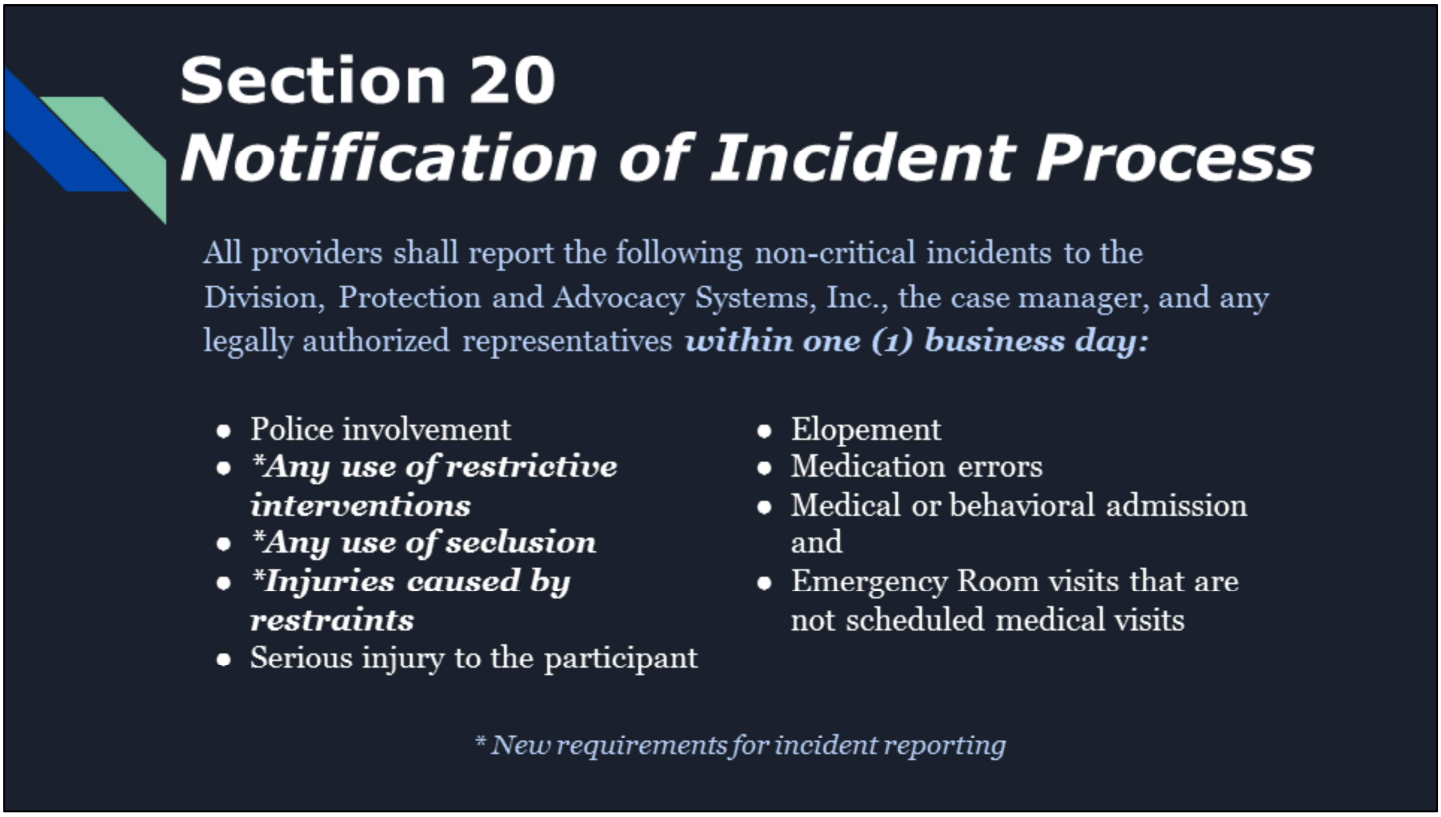
The Plan of Care must be very detailed when using psychoactive medications. This includes information it the Positive Behavior Support Plan about the use of the drug. There must also be a protocol to train staff on the drug and how/when to use it. Any changes made to the psychoactive medication must be documented in the plan of care. Any time a dosage is missed of a scheduled drug, this must be reported as a medication error. If this is a PRN psychoactive medication, the participant or their legally authorized representative must give approval before taking the drug. If the participant is given a drug against their will, this is considered a chemical restraint and will be subject to review and the eight points in the plan of care. The provider should review PRN usage and see if there is an increase/decrease in use to suggest if the participant should receive any medical intervention.



Module 5 includes
Section 20: Notification of Incident Process
Section 21: Complaint Process
Section 22: Transition Process
Section 23: Notice of Costs to the Participant
Section 24: Participant Funds and Property
Section 25 Additional Standards for Providers that Require National Accreditation
Section 26: Mortality Review Committee



Read First: Providers are to report Critical Incidents to the Division in the categories in this Powerpoint. The Division's number one priority is the health and safety of participants. The Division uses Critical Incidents to not only ensure health and safety and compliance with the rule, but it is a snapshot into the participant's life that can spur resources for providers and support staff serving clients. If a life threatening incident happens, please call emergency services or law enforcement FIRST before notifying the Division. So let's get to the reporting categories!



Please refer to Section 18, Restrictive Interventions for reporting and how to report the use of any restrictive intervention or seclusion.

Section 20
Notification of Incident Process

Medication errors include:

- Wrong medication
- Wrong dosage
- Missed medication
- Wrong participant
- Wrong route
- Wrong time, which is any deviation from accepted standard time frame for the medication assistance

Medication error reports that do not result in emergency medical attention must be filed ***no later than three (3) business days*** after the event is discovered, in order to give the provider time to complete all follow-up prior to reporting.

A wrong time example would include if the medication is tied to an event, such as 30 minutes prior to a meal or a sleeping medication that is tied to bedtime, etc..

Section 20
Notification of Incident Process

In addition to the other provisions in this section, 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.

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:

- People involved in the incident
- Preceding events
- Follow-up conducted
- Causes of recurrent critical incidents
- Other trendsActions taken to prevent similar events from reoccurring
- Evaluation of actions taken
- Education and training of personnel
- Internal and external reporting requirements

Section 20
Notification of Incident Process

- ✓ Providers shall provide access of internal incident data to case managers within five (5) business days.
- ✓ Providers shall comply with Division or other agency requests for additional information relating to the incidents.

To report an incident to the Division, please visit:

https://health.wyo.gov/behavioralhealth/dd/file-incident-report/

Please provide as much detail as possible when filing an incident.

Section 20
Notification of Incident Process

When reporting critical incidents using the online form you must also notify the following entities:

- Department of Family Services (for serious critical incidents)
- Protection and Advocacy Systems, Inc.
- Case manager
- Any legally authorized representative(s)
- Law enforcement (if applicable, ex: abuse, neglect, abandonment, exploitation, or intimidation)

When completing the Critical Incident Report form, please be specific, including names, and phone/email information in the Notifications section of the form. This assists the Division to ensure proper follow-up with those agencies

On the online form, please include the name and phone number of the person you spoke while reporting. This is extremely important for the Division to know who to follow up with at the Department of Family Services, Law Enforcement, legally authorized representatives, or Protection and Advocacy.

Section 21
Complaint Process

- **Accredited Providers:** All accredited providers (i.e. CARF, CQL) shall adhere to the current accreditation requirement for complaints and grievances as well as requirements in this chapter.
    - Should there be a complaint or grievance that does not involve a health and safety issue, the person will be asked by the Division to contact the provider first and work through their identified policy prior to making a formal complaint with the Division.
- A provider who believes a participant's health and safety is in jeopardy shall ***immediately*** contact:
    - The Division
    - Protection and Advocacy
    - Other applicable governmental agencies such as law enforcement or Department of Family Services. (DFS)

Section 21
Complaint Process

- Upon receipt of any complaint from any person, the Division shall:
  - Notify the complainant within ten (10) calendar days, in writing, that a complaint was received.
  - Notify the provider, in writing, when a complaint is received involving the provider, unless an on-site visit is warranted, at which time the provider will be notified at the time of the visit.
  - Notify the complainant when a complaint has been investigated and closed.
  - Submit a written report to the provider(s) involved summarizing the results and including any findings, recommendations and timeframes to address recommendations through the corrective action process.
    - A provider's failure to complete a corrective action plan may result in sanctions.

Section 22
Transition Process

- A provider who is terminating services with a participant shall notify the participant in writing *at least 30 days prior* to ending services.
  - *Failure by the provider to deliver services during this 30 day period shall be considered abandonment of services and may result in decertification of the provider.*
- When a participant wishes to change a provider, case managers shall notify the provider of a participant's decision to discontinue services *within 3 business days.*
- If a residential provider requires a participant to move, a 30 day notice *must* be provided so the participant can exercise choice in the matter.

A participant may choose to change any provider at any time and for any reason!

Section 21
Transition Process

When a transition occurs, the case manager shall:

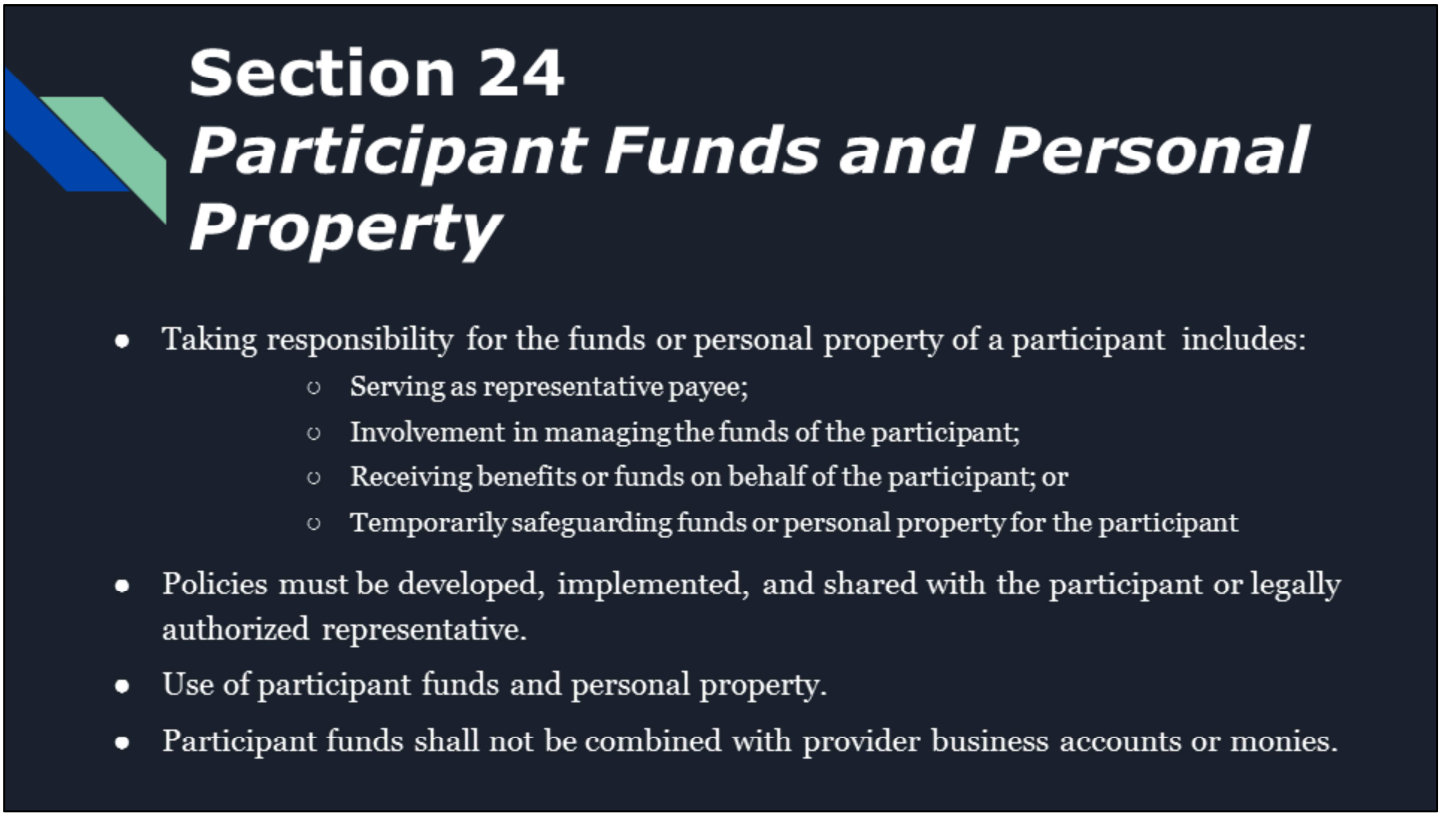
- Notify the Division of the request for change within 5 business days.
- Complete the Transition Checklist as needed.
- Schedule a team meeting and provide notification to members two (2) weeks prior to meeting.
- Modify the Plan of Care.

Section 23
Notice of Costs to the Participant

- Providers shall develop and implement a system to notify participants and legally authorized representatives of associated costs to the participant for a service or item and the terms of payment.
- A written notice must be given to participants before the initiation of services and before any change. Time must be allowed for the participant or the legally authorized representative to review the notice before choice is made or changes are implemented.
- A provider's cost notice must specify that participants will not be charged for services or items that are covered through other funding sources.

Section 23
Notice of Costs to the Participant

- A cost notice must identify who is responsible for compensation when the participants' personal items are damaged or missing; and 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.
- Participants may not be charged for changes to provider staffing, facilities, or services.



Standards in this Section apply to any provider who takes responsibility for the funds or personal property of a participant.

The provider's policies must include:

(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, legally authorized representative, and regulatory agencies, such as Social Security Administration or the Division of Healthcare Financing;
(iv) Safeguards used to ensure that funds are used for the designated and appropriate purposes;
(v) If interest is accrued, how interest is credited to the accounts of the participant;
(vi) How 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.

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

- *The Division recognizes accreditation from the following agencies:
- Commission on the Accreditation of Rehab Facilities (CARF)

AND

- Council on Quality Leadership (CQL)
- **Other accrediation agencies must be approved by the Division prior to becoming accredited*

Who needs to get National Accreditation?

- Deliver one or more of the following services to 3 or more participants:
  - Residential Services, Supported Living, Community Integration, Adult Day Services, Prevocational, any Supported Employment Service

AND

- Total annual waiver income equals or exceeds $125,000 (all participants/services)

Section 25
Additional Standards for Providers that Require National Accreditation

- Providers shall obtain accreditation in the area applicable to each services within 18 months of qualifying under this provision.
- The Provider will maintain the accreditation as long as they provide the qualifying services to 3 or more participants.
- The Division will decertify any provider who fails to maintain accreditation.
- If the provider fails to maintain their accreditation, the Division will require the provider to submit a transition plan for each participants who is leaving the provider's services and the participant will be re-located to a provider of their choice within 90 Days that Division receives confirmation that the provider is no longer accredited.
- The provider's decertification date will begin 90 days from the date of the written notice from the accrediting entity stating the provider did not receive accreditation.

Section 25
Additional Standards for Providers that Require National Accreditation

- An accredited provider shall submit all national accreditation report documents to the Division within 30 days of receiving the report documents from the accrediting agency.

Section 26
Mortality Review Committee

The Division shall maintain a Mortality Review Committee* to review deaths of participants receiving waiver services.

The 1915c Waiver Committee meets monthly to review participant deaths and other serious critical incident information.

The Committee may make provider specific recommendations or systemic recommendations.

Please note: *The Mortality Review Committee is now known as the 1915c Waiver Committee, which reviews deaths and other participant health and safety issues on all waivers administered by the Wyoming Department of Health.*

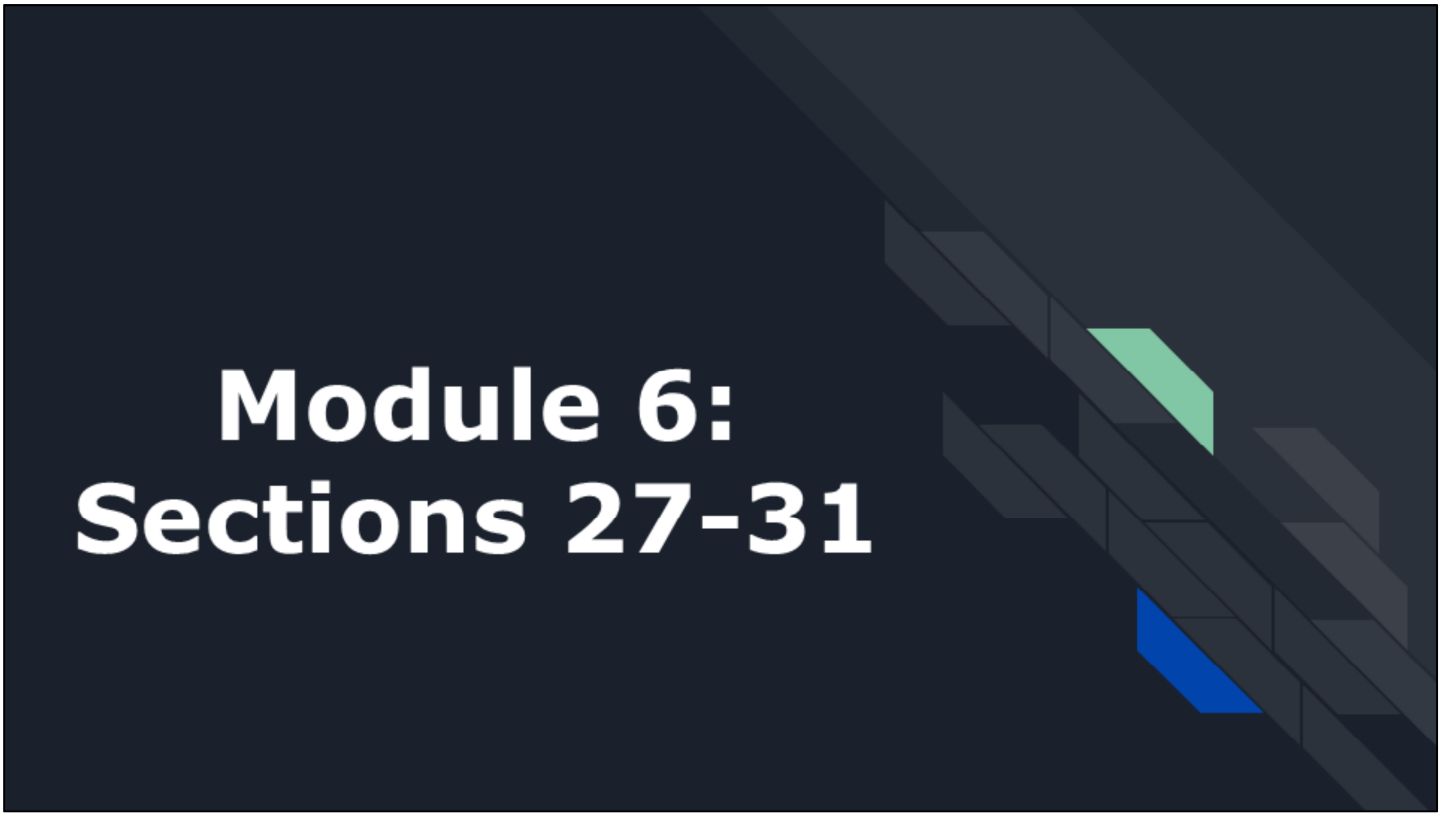
Section 26
Mortality Review Committee

Providers shall provide information requested by the Mortality Review Committee (1915c Committee).

Information requested may include, *but is not limited to*:

- Copies of service documentation
- Copies of incident reports
- Copies of any health related records, assessments, and
- Results of physician's office visits and hospital visits

Please respond to requests for information in a timely manner to ensure proper review of cases



Module 6 covers
Section 27: Initial Provider Certification
Section 28: Recertification of Providers
Section 29: Corrective Action Plans
Section 30: Sanctions
Section 31: Relative Providers

Section 27
Initial Provider Certification

- An individual or entity may apply to become a provider by completing the Division's initial provider certification packet and all required trainings.
- Evidence will need to be supplied that demonstrates that the applicant meets all of the necessary qualifications for each service in which the applicant is seeking waiver certification.
- The Division shall initially certify a new provider agency for one year. The agency must complete an on-site recertification at the end of the first year to continue providing services.

Mark Sparks- General Providers
Jennifer Adams - Case managers

Section 27
Initial Provider Certification

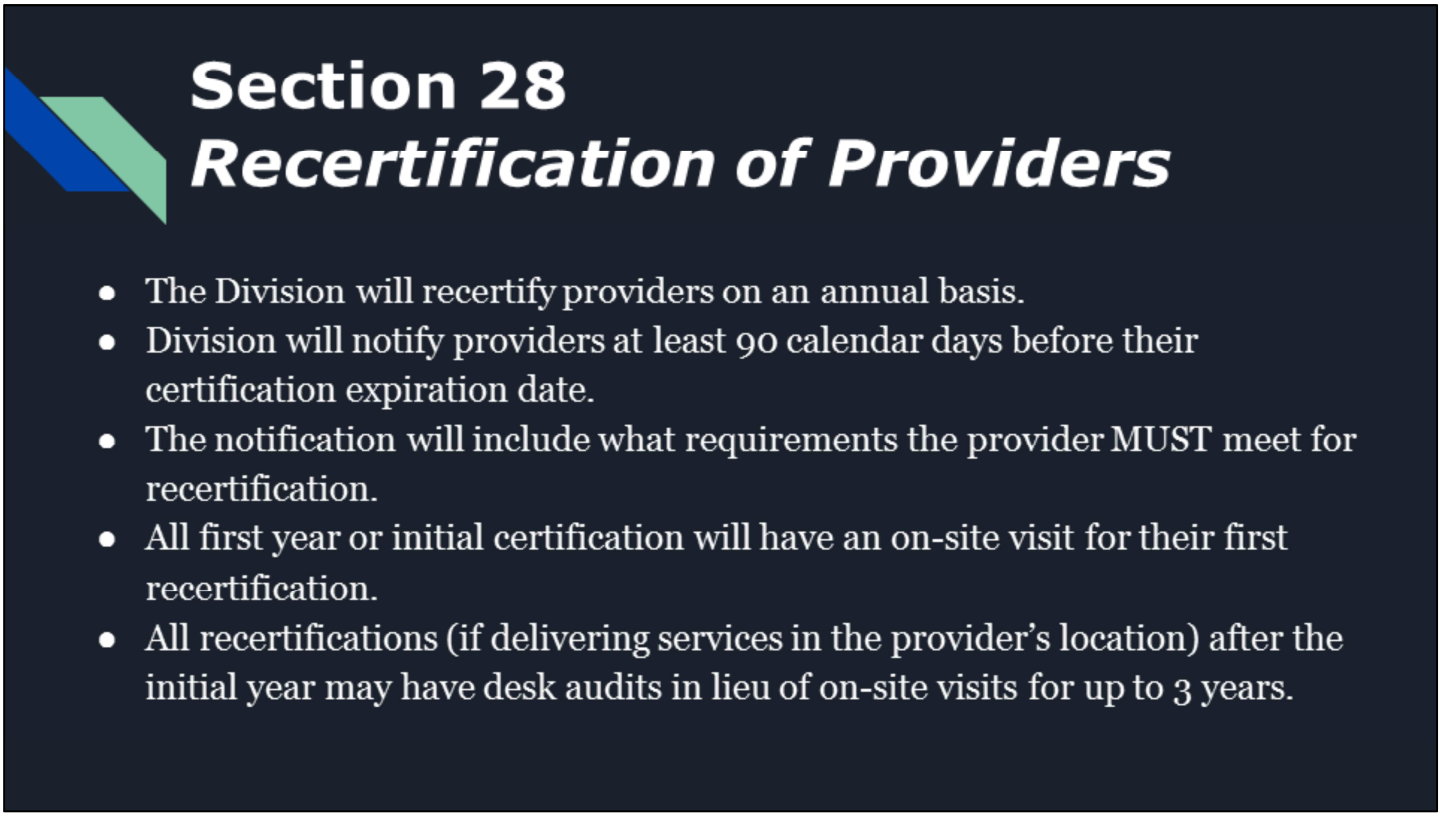
- If the Division receives information that the provider no longer meets the qualifications for each service in which the provider is certified, a notice will be sent to the provider within one business day regarding the missing qualification and applicable sanction.
- If the missing qualification is not obtained within the timeframe given, the provider will be disqualified from providing such waiver services.

Section 27
Initial Provider Certification

The Division may refuse to certify or decertify providers under the following circumstances:

- The person or entity has an open or pending corrective action plan with the Division.
- The person or entity has any open cases with the Medicaid Fraud Control Unit.
- The entity has an officer, administrator, or board member previously sanctioned by the Division.
  - This refusal applies to a period of two years from the date the person was sanctioned.
- The person or entity fails to disclose any conviction in a court of law on the provider application or organization's application.

Any falsification of statements, documents, or any concealment of material fact may result in a denial of certification, subsequent decertification, or referral for criminal prosecution.



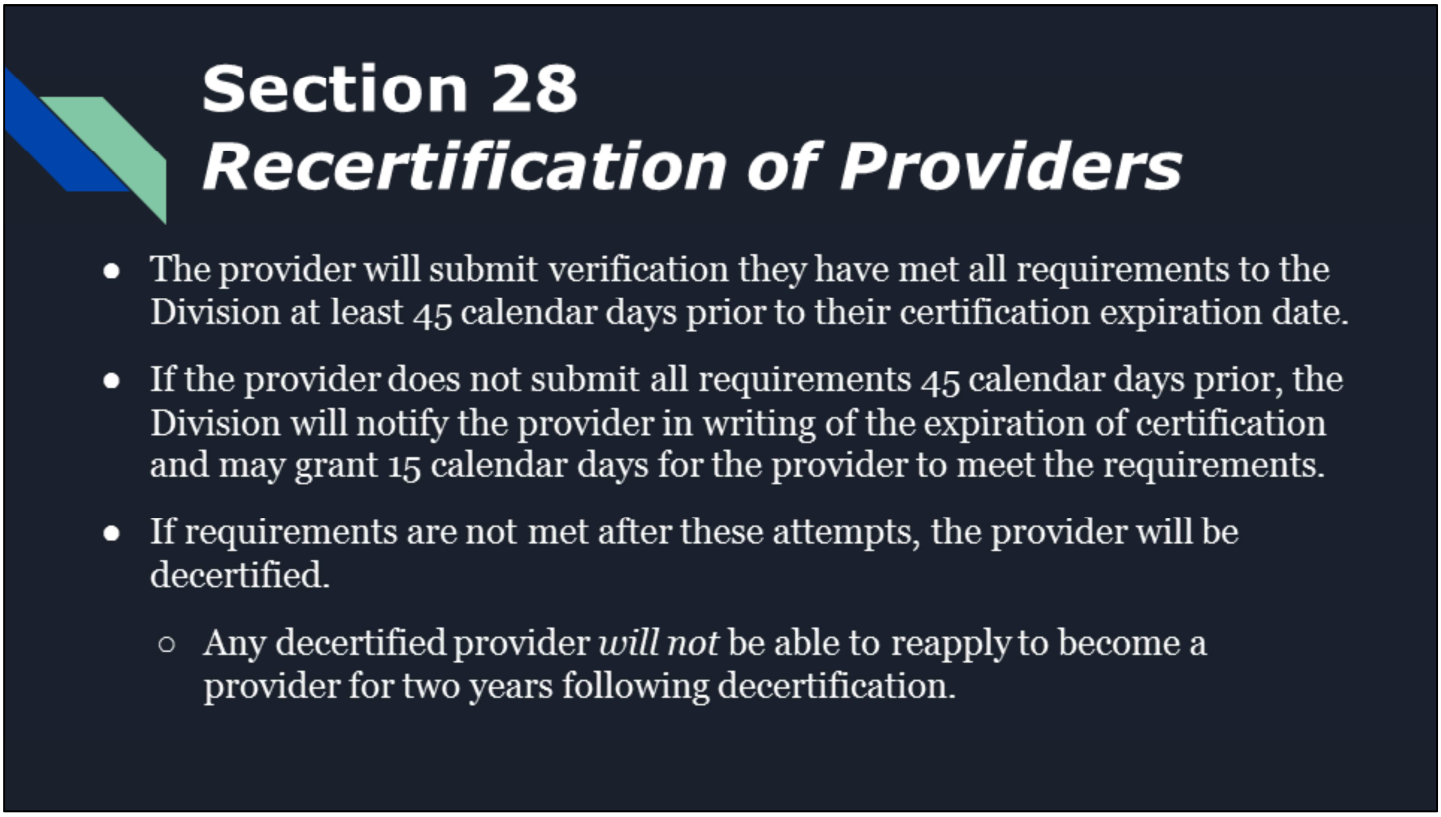
Purpose of recertification: To ensure compliance with Chapter 45 rules and the program.

Section 28
Recertification of Providers

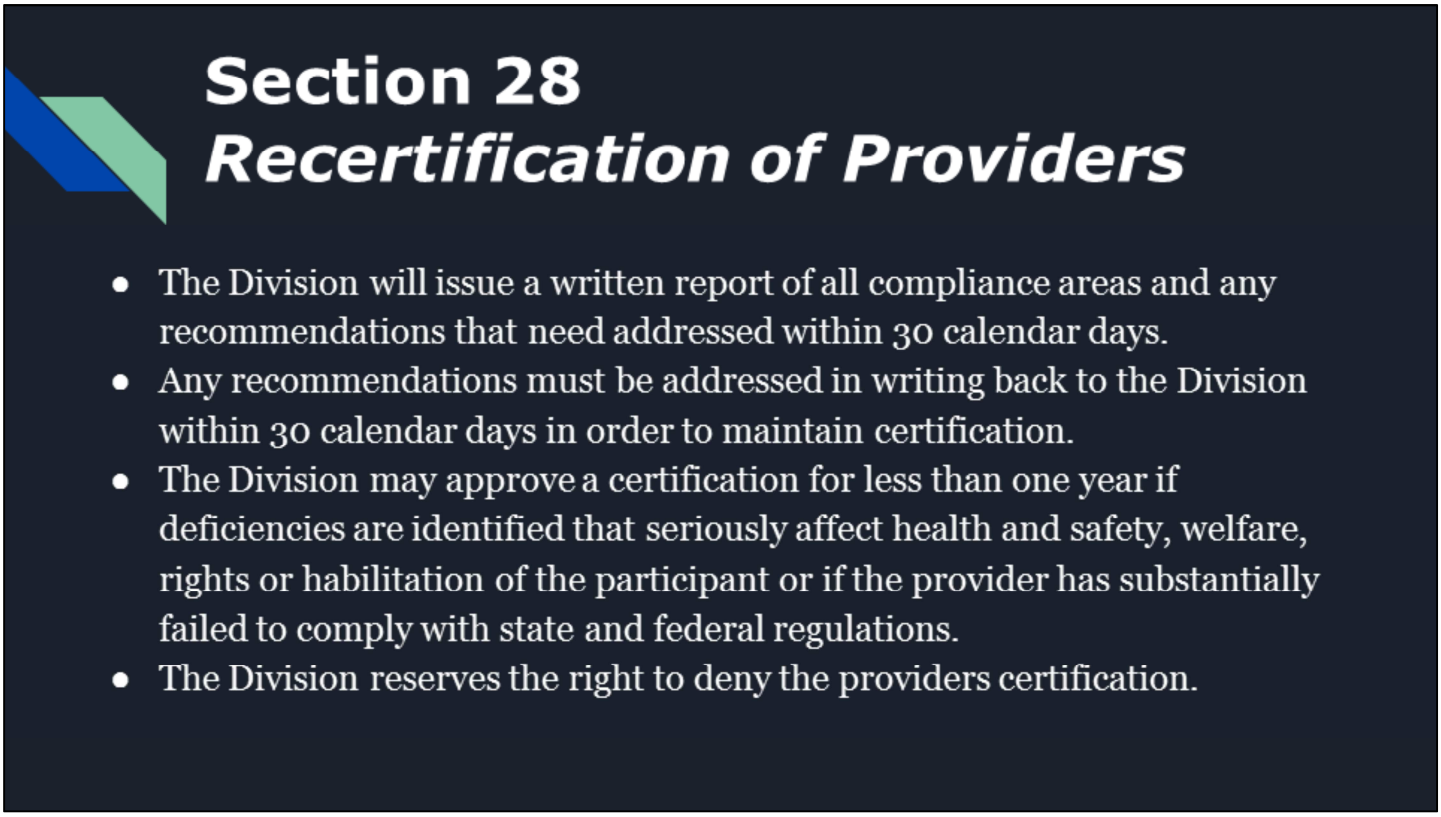
What is a Recertification?

- Provider will submit evidence of compliance with Wyoming Medicaid Rules and federal regulation for Home and Community Based Services.
- For providers who control, own or lease any settings, the Division shall review provider's self-inspections as well and any inspection reports from outside entities.

Note: *At any time, the Division may conduct on-site visits when a concern is identified during a complaint, incident report or internal referral if there is indication the agency is not complying with state and federal regulations or at the Division's discretion.*

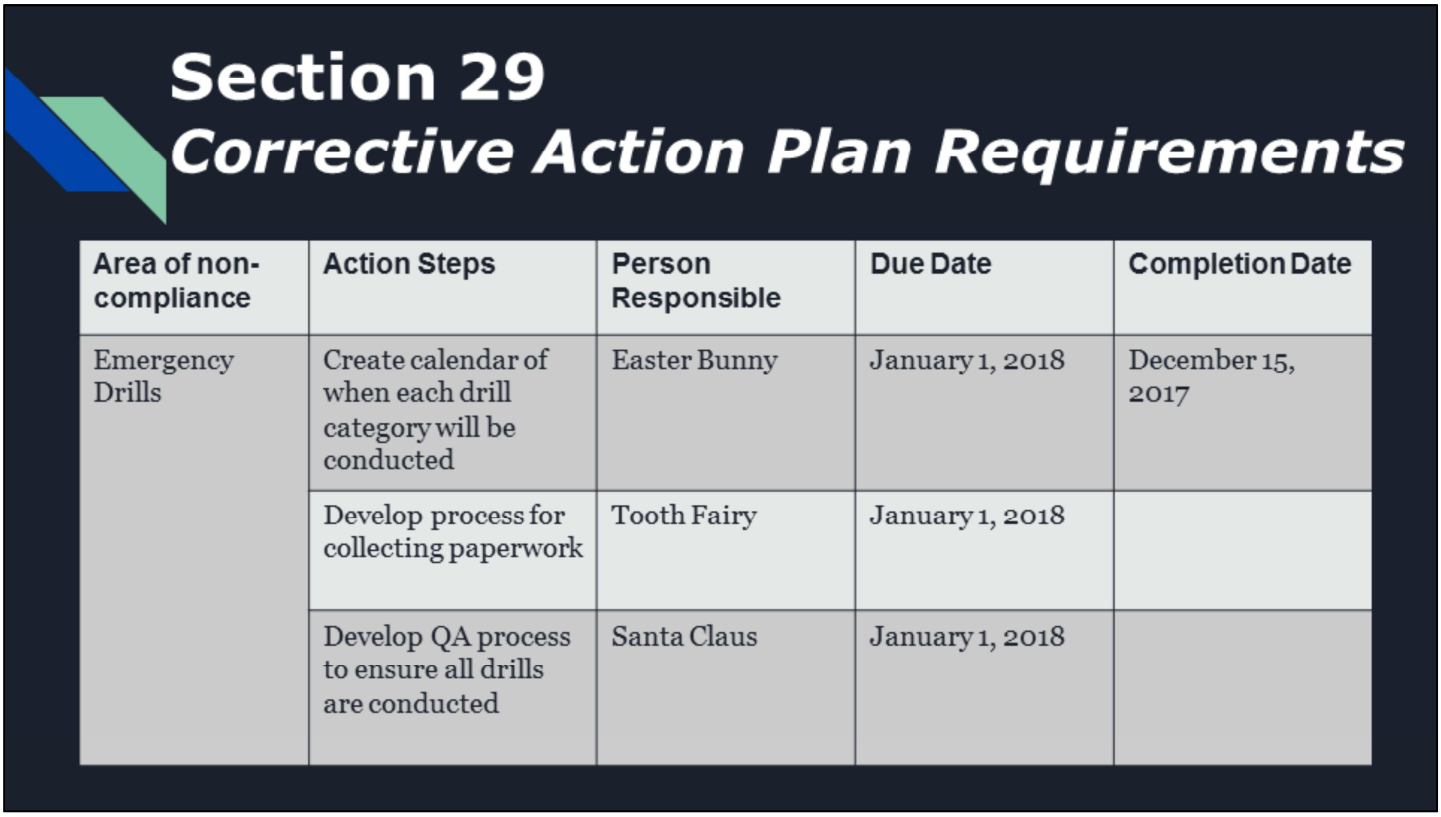


- If the provider fails to meet the requirements at the end of the 15 day period, the Division will notify the provider that he or she will be decertified. The provider will need to transition all participants they serve and cannot reapply to be a provider until a two year period from the decertification date has passed.



What's next after my recertification?

You will receive a report outlining the compliance and recommendations for areas found to be in non-compliance within 30 calendar days.
For all recommendations identified in the report, the provider MUST complete a corrective action plan and submit it to the Division in writing within 30 days.
If serious health, safety, welfare or rights concerns are identified, the Division can issue a certification period that is less than one year.
The Division reserves the right to deny the providers certification.



What is a Corrective Action Plan?

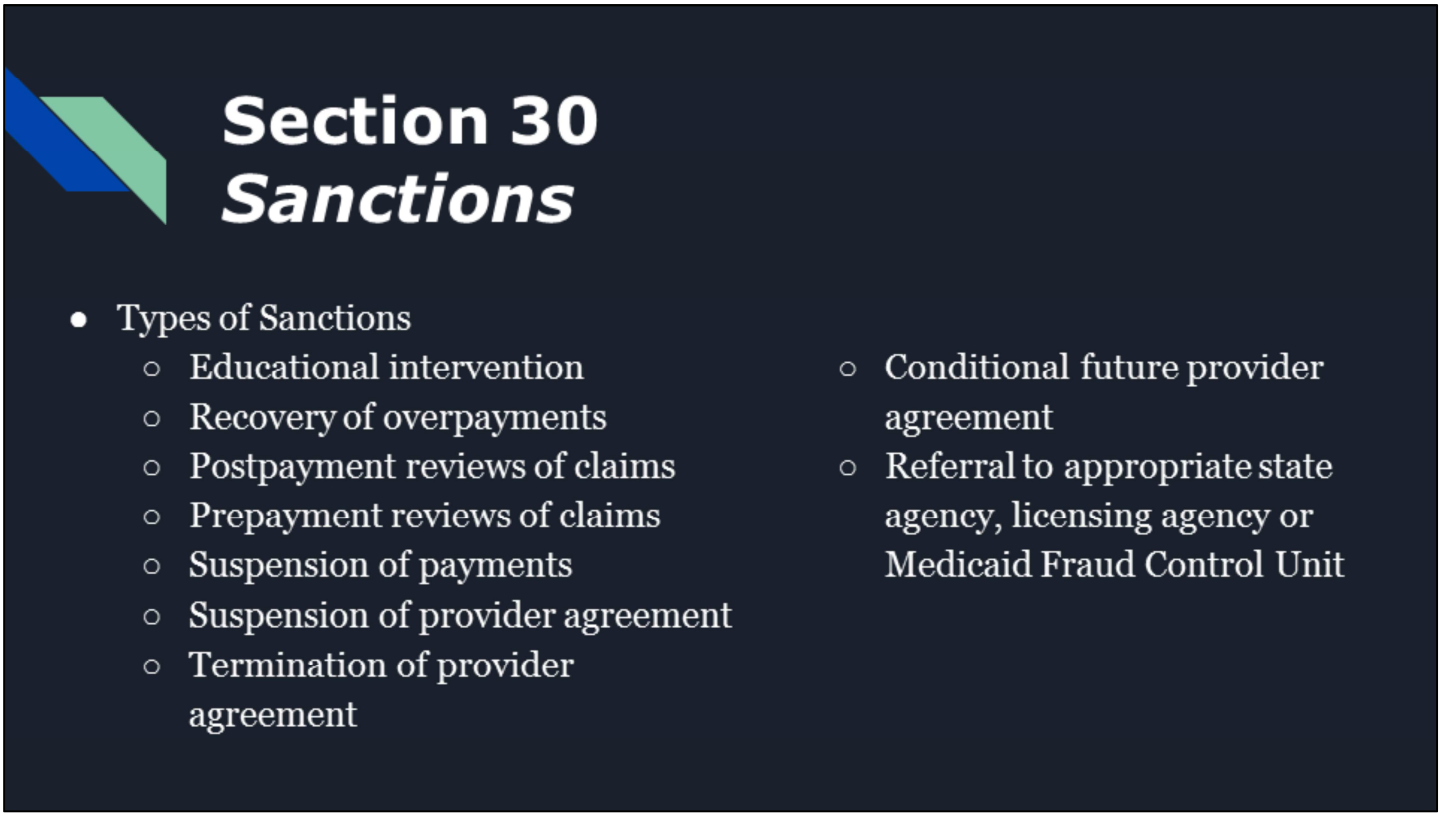
- A plan that addresses areas found to be non-compliant with Wyoming Medicaid rules during provider recertification, incident reports or complaint reviews.
- The plan outlines the area(s) of non-compliance, action steps for addressing the area(s) of non-compliance, the provider and/or staff responsible for completing the action step, due dates for completion and when it was completed.
    - The action steps do not have to be completed at the time of the submission of the corrective action plan.

Section 29
Corrective Action Plan Requirements

- Corrective action plans must address each area of suspected non-compliance. This includes action steps of how the provider will come into compliance with the rule.
- Suspected non-compliance that is related to immediate health and safety, welfare, or rights of participants, shall be immediately addressed. The Provider will have 15 business days from the date a report is issued to submit their corrective action plan, but the situation must be dealt with immediately.
- If a Corrective Action Plan is not implemented to address all areas of non- compliance, the Division may impose sanctions.

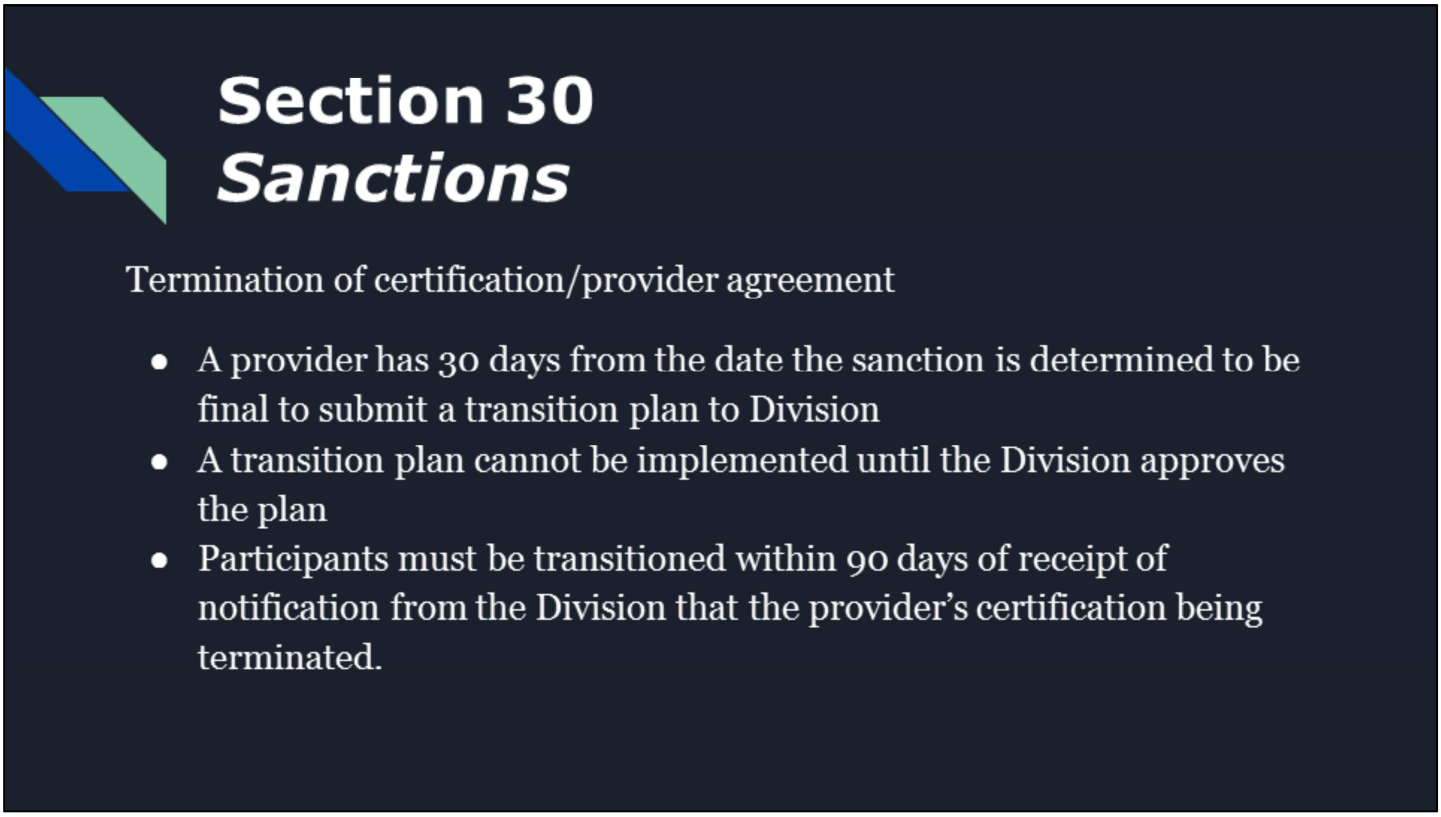
Section 29
Corrective Action Plan Requirements

- The Division will notify the provider within 30 business days after the receipt of a Corrective Action Plan whether or not approval or disapproval was given to the plan.
- The Division will ask for monthly monitoring by the provider to get the Corrective Action Plan completed. ***This monitoring must be submitted to the Division.*** If not submitted, the Division can choose to sanction the provider.
- The Division can request follow up or additional items during the recertification process to assure the provider has fully implemented and evaluated participant safety during the Corrective Action Plan implementation.



Sanction may be issued to a provider for non-compliance with the rules. The types of sanctions available are listed on the screen however the list is not all inclusive.

Education intervention – Required education to the provider; training may be conducted by Division staff or other entity as determined by the Division
Recovery of overpayments – Referral to Medicaid Program Integrity unit.
Postpayment review of claims – Review of providers documentation and billing information after claims have been paid
Prepayment review of claims – Review of providers documentation and submitted claim PRIOR to claims being paid
Suspension of payments – Payments suspended in part or entirety until all corrective action associated with the sanction has been completed.
Suspension of provider agreement – No longer considered a Medicaid provider, therefore cannot provide services on the Waiver.
Conditional future provider agreement- Conditions must be met in order to provide services. This is discussed with the Program Integrity Unit.
Referral to appropriate state agency – Licensing boards, medical review boards, Medicaid Progam Integrity or Medicaid Fraud Control unit



If it is determined that the provider's certification shall be terminated as a result of non-compliance with the rules, the provider must:

- Submit a transition plan for the participants served by the provider to the Division within 30 dates of the final sanction.
- Plan must be approved before implementing.
- Transitions must be complete within 90 days of notification of decertification.

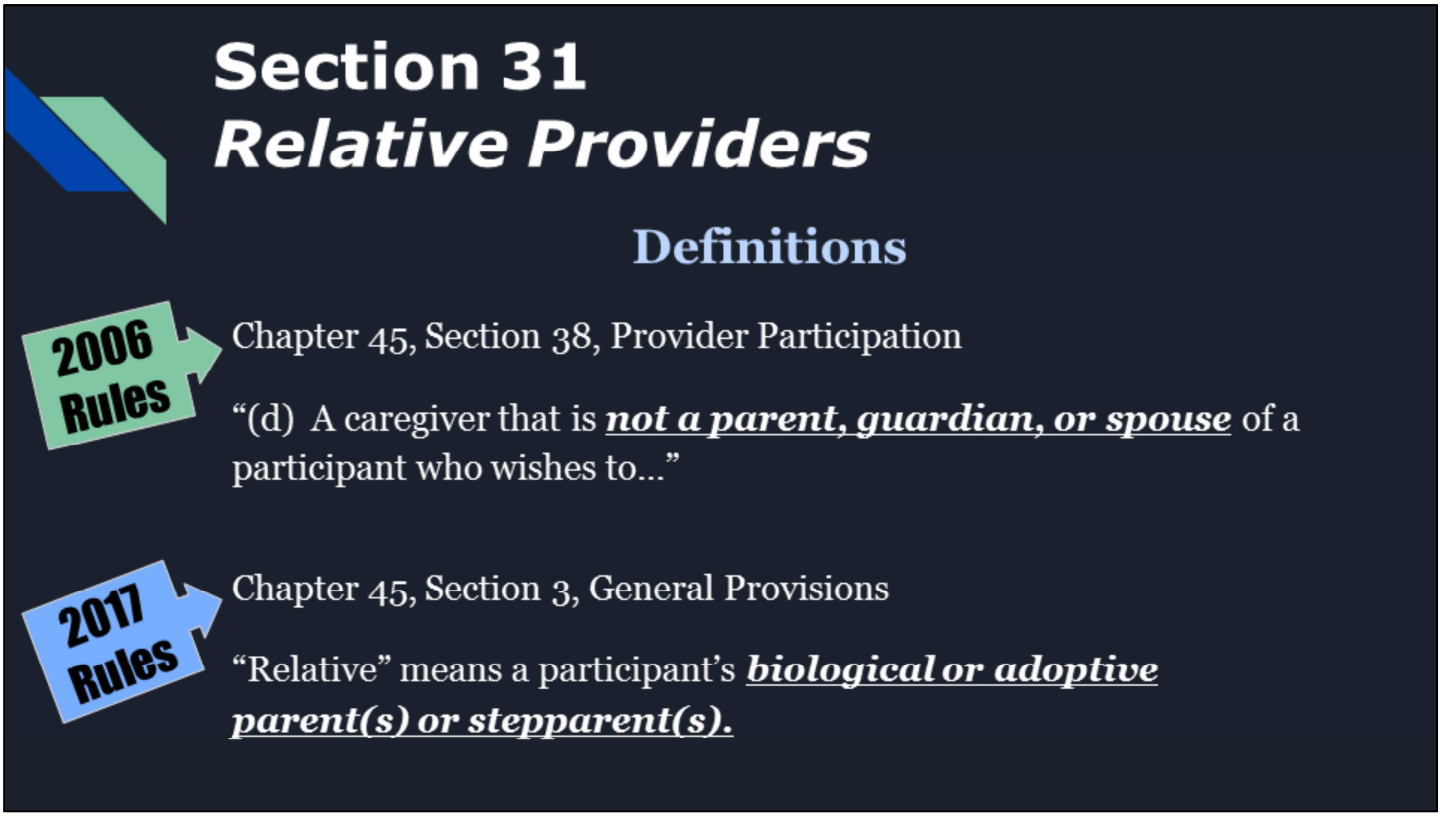
Section 31
Relative Providers

This section covers the requirements for relative providers as allowed by Wyoming Statute § 42-4-102(a)(ii), which was amended during the 2011 Legislative Session.

The section is new language to the rules and defines:

- Relative
- Services that may be provided
- Scope & limitations on allowed services

Read slide



Previously, the rules defined relative as a parent, guardian or spouse.

The definition of relative in the new rules can be found in Section 3 of Chapter 45.

Section 31
Relative Providers

Relatives, as defined in Section 3 (b)(iii), may be reimbursed for services provided to the related participant **IF** they become a certified waiver provider **AND** form a Limited Liability Company (LLC) or other corporation.

Section 31(e) states: "No parent, stepparent or legally authorized representative may be hired to provide services through self-direction."

Read slide

Section 31
Relative Providers

Certified waiver providers *MAY HIRE* relatives or legally authorized representatives to provide services to the related participant.

The certified provider must have written policy on:

- Addressing potential conflicts that may arise from the relationship(s).
- How the conflict will be mitigated

The policy will need to be shared with the participant and the relative/legally authorized representative.

Section 31
Relative Providers

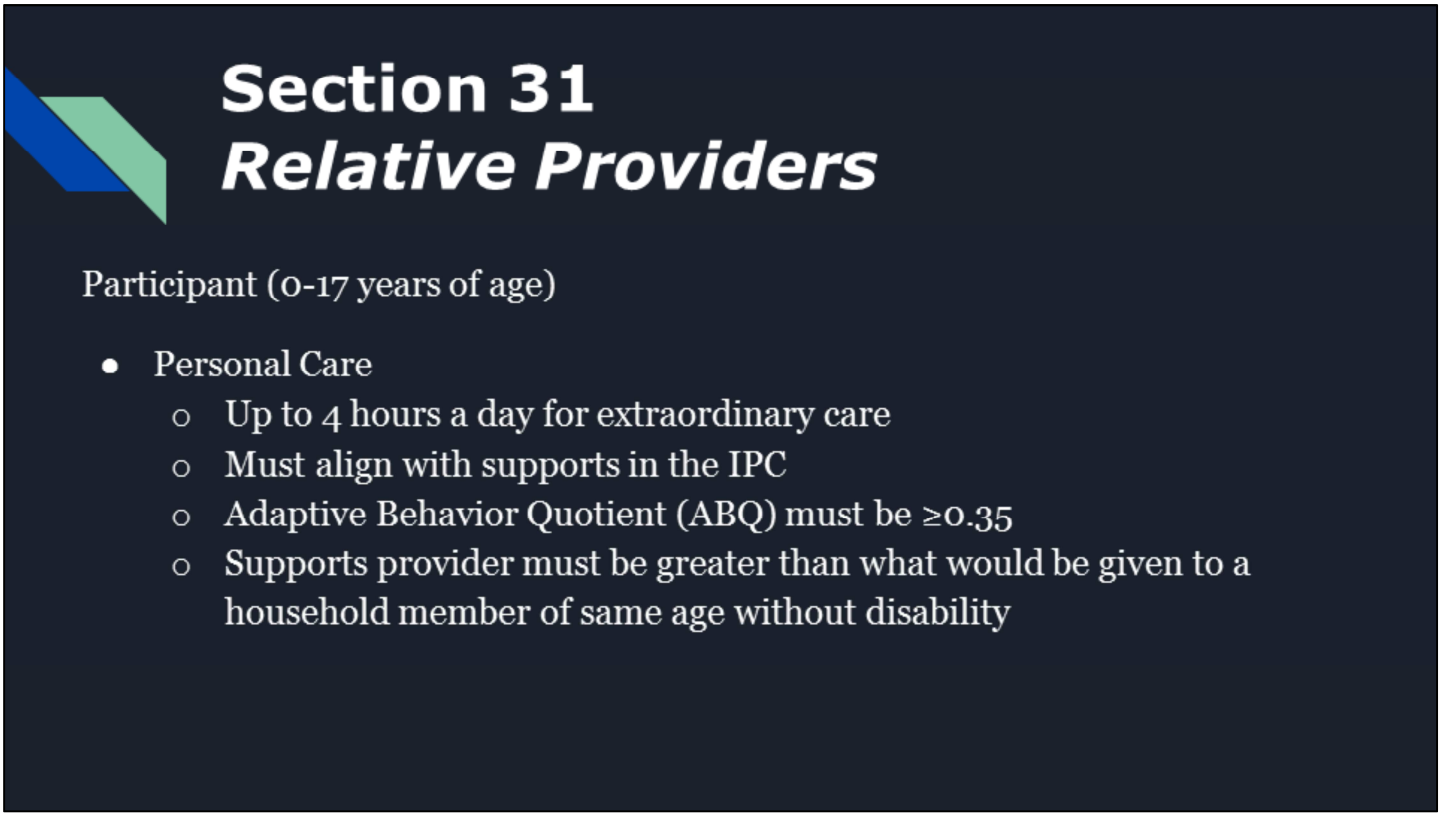
What services can be provided by a relative?

Participant (18 years of age or older)

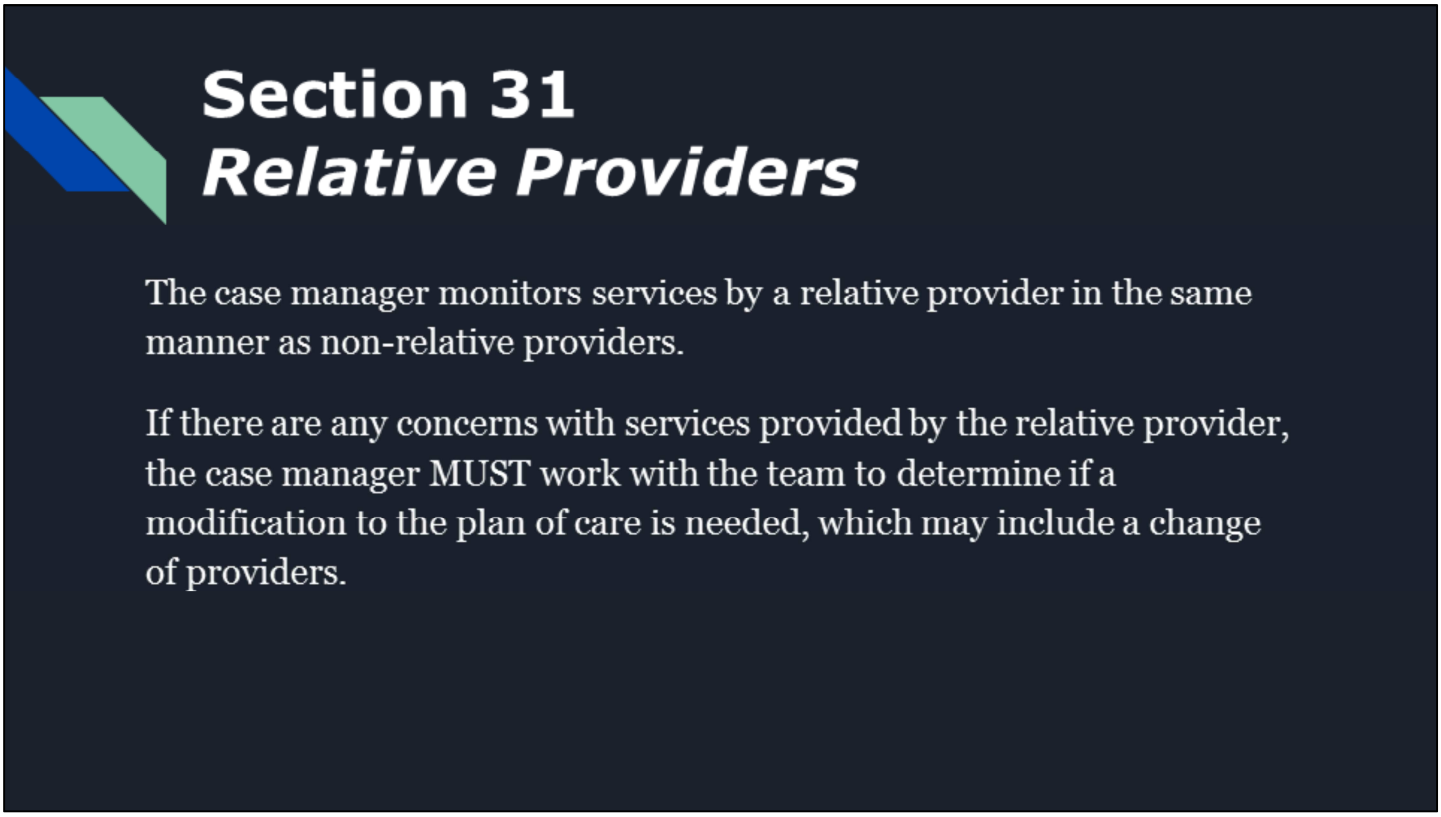
- Residential Habilitation*
- Supported Living**
- Personal Care**
- Specialized Equipment
- Supported Employment
- Prevocational
- Environmental Modifications

**Relative Provider cannot live in the same residence as the participant.*

*** Cannot exceed 4 hours per day of service if the provider lives in the same residence as the participant.*



Relative providers who are delivering services to children (0-17) may only receive payment for Personal Care services up to 4 hours per day for extraordinary care purposes only.
Extraordinary personal care must align with the needs and supports in the IPC **AND** the participant's ABQ must be 0.35 or lower.
The supports provided by the relative (ADL's/IADL's) has to be greater than the supports that would be given to a household member of same age without a disability/illness and is for their health and safety.

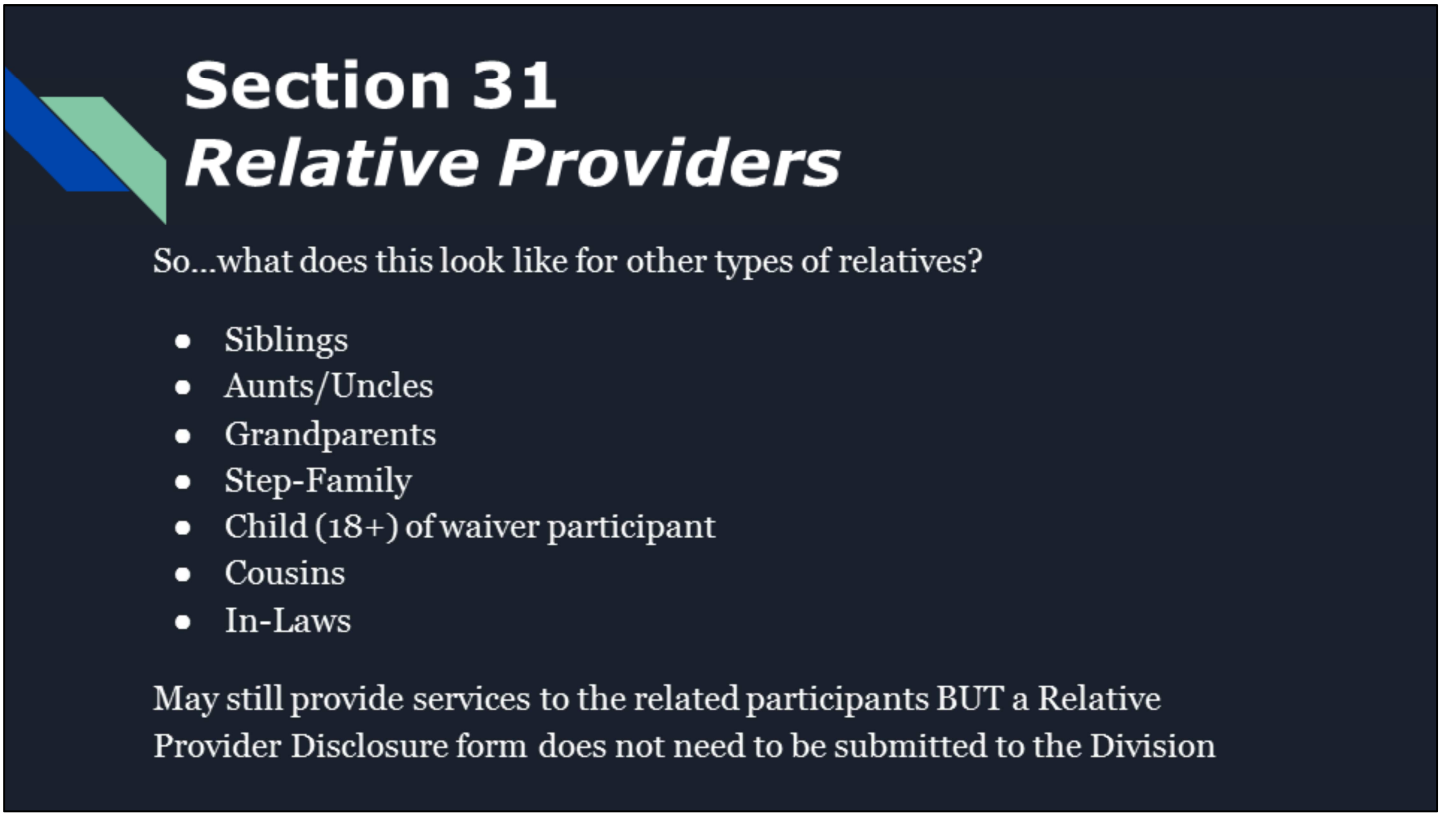

Section 31
Relative Providers
The case manager monitors services by a relative provider in the same manner as non-relative providers.
If there are any concerns with services provided by the relative provider, the case manager MUST work with the team to determine if a modification to the plan of care is needed, which may include a change of providers.

Read slide

Section 31
Relative Providers

Relative providers or relatives that intend to provide services to the related participant have to inform the team of the relationship during the annual team meeting. The relative provider is also required to acknowledge and address safeguards outlined by the Division.

Relative Disclosure forms have been updated to incorporate the requirements in the rules. Teams must complete the form when the relative provider is added to the IPC and any time there is a change to waiver, service or case manager for the relative provider and participant.



Since the rollout of HEA 91 in 2011, the Division requires ALL relatives require a disclosure and safeguards acknowledgement form to be on file with the Division. The rules do not include the other types of relatives mentioned on the slide. Because the rule is silent on these types of relative providers, the Division will not require a relative disclosure form to be completed for these relative types after December 31, 2017.

Section 32-34

- These sections are in every State of Wyoming Rule set and will not be reviewed during this training.

Closing

- Thank you for joining us through our journey of the Chapter 45 Rules
- If you have questions, please refer to your Provider Support Specialist and they can help you out.
- We appreciate your time and all of the hard work you do.