

## CHAPTER 45

### DD WAIVER PROVIDER STANDARDS, CERTIFICATION, AND SANCTIONS

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

#### **Section 2. Purpose and Applicability.**

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

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

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

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

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

#### **Section 3. General Provisions.**

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

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

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

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

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

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

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

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

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

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

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

(i) The right to privacy;

(ii) The right to freedom from restraint;

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

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

(v) The right to choose with whom and where they live;

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

- (vii) Freedom and support to control their own schedules and activities;
- (viii) Freedom and support to have access to food at any time;
- (ix) Freedom to have visitors of their choosing at any time, and associate with people of their choosing;
- (x) Freedom to communicate with people of their choosing;
- (xi) Freedom to keep and use their personal possessions and property;
- (xii) Control over how they spend their personal resources;
- (xiii) The right to access the community; and
- (xiv) The right to make and receive telephone calls. No person shall limit a participant's right to make calls to Protection & Advocacy, or state and federal oversight or protection agencies as protected by 42 U.S.C. 10841(1)(M), such as the Division or Department of Family Services.

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

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

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

(e) A provider that offers direct services shall have and implement policies and procedures that ensure:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(D) A clear description of the condition that is directly proportionate to the specific assessed need;

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

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

(G) Informed consent of the individual; and

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

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

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

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

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

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

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

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

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

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

(i) Behavioral Support Services. A Behavioral Support Services provider or provider staff shall meet credentials as outlined in the Comprehensive and Supports Waiver Service Index, which is incorporated by reference.

(ii) Case Management.

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

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

- (1.) Counseling;
- (2.) Education;
- (3.) Gerontology;
- (4.) Human Services;
- (5.) Nursing;
- (6.) Psychology;
- (7.) Rehabilitation;
- (8.) Social Work;
- (9.) Sociology; or
- (10.) A related degree, as approved by the Division.

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

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

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

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

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

(I) Identify a back-up case manager from the list of Division certified case managers for each participant, and have policies and procedures for backup case management for each person's caseload, which include a process for how and when the case

manager will notify the plan of care team that the backup case manager should be the primary contact. Case managers shall meet with their designated backup to review all participant cases on a quarterly basis. The review shall be documented in case notes.

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

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

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

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

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

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

(5.) The case management agency shall not:

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

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

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

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

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

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

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

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

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

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

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

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

(vii) Individual Habilitation Training. Within one (1) year of being certified in this service, and annually thereafter, the provider or staff providing the service shall successfully complete at least eight (8) hours of continued education in any of the following areas: specific disabilities or diagnosed conditions relating to the population served, writing measurable objectives, gathering and using data to develop better training programs, or training modules posted by the Division.



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

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

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

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

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

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

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

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

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

- (a) Consistent with the provisions of this chapter, providers shall:
- (i) Protect participants from abuse, neglect, mistreatment, intimidation, and exploitation;
  - (ii) Treat participants with consideration, respect, and dignity;
  - (iii) Honor participants' preferences, interests, and goals;
  - (iv) Provide participants with daily opportunities to make choices and participate in decision making;
  - (v) Facilitate activities that are meaningful and functional for each participant;

- (vi) Direct services toward maximizing the growth and development of each participant for maximum community participation and citizenship;
  - (vii) Provide services in the most appropriate, least restrictive, most integrated environment;
  - (viii) Encourage participants to express their wishes, desires, and needs;
  - (ix) Protect and promote the health, safety, and well-being of each participant;
  - (x) Design services to meet the needs of all participants served by the provider; and
  - (xi) Establish and implement written policies and procedures that:
    - (A) Are available to staff, participants, legally authorized representatives and, upon request, the general public;
    - (B) Are updated or revised as needed by rule or policy changes;
    - (C) Are reviewed at least annually with employees; and
    - (D) Describe the provider's operation and how systems are set up to meet participants' needs.
- (b) Before providing services to a participant, the provider shall gather and review referral information regarding the participant so, to the greatest extent possible, the provider is aware of the participant's preferences, strengths, and needs. The provider shall use this information to:
- (i) Make a determination as to whether the provider is capable of providing services to meet the participant's needs;
  - (ii) Consider the safety of all participants who the provider serves in the decision to accept new participants to services or the location for the services; and
  - (iii) Consider whether the provider has the capacity, commitment, and resources necessary to provide supports to the participant served. The provider shall not serve a participant if the provider cannot reasonably assure the participant, legally authorized representative, and case manager that it has the ability to meet the participant's needs.
- (c) The provider shall orient, train, and manage staff with the skills necessary to meet the needs of participants in their services, and be able to respond to emergencies.
- (d) The provider shall facilitate opportunities for all participants to receive services consistent with the needs and preferences of the participant.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## **Section 8. Documentation Standards.**

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

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

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

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

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

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

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

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

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

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

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

(i) The full legal name of the participant;

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

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

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

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

(i) The location of services;

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

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

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

(v) A detailed description of services provided that:

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

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

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

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

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

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

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

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

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

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

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

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

(i) Failure to make documentation available by the tenth (10<sup>th</sup>) business day of the month may result in a corrective action plan or sanctioning.

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

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

### **Section 9. Case Management Services.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(vii) The case manager shall ensure all providers on the participant's individualized plan of care sign off on the plan, receive a copy of the plan, receive team meeting



notes, and complete participant specific training as required in Section 15(g) of this Chapter. Documentation of participant specific training shall be available to the Division upon request.

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

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

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

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

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

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

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

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

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

other advocate, family member, or entity chosen by the participant or the participant's legally authorized representative(s).

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

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

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

(e) The individualized plan of care shall include:

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

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

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

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

(v) Cultural and religious considerations;

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

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

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

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

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

(xi) Clinical and support needs;

- (xii) Participant's desired outcomes;
- (xiii) Risk factors and plans to minimize them;
- (xiv) Individualized backup plans and strategies, when needed;
- (xv) Individuals important in supporting the participant, such as friends, family, professionals, specific staff or providers;
- (xvi) Learning objectives for habilitation services that address the training activities, training methods, and the measurement used to gauge learning;
- (xvii) Relevant protocols that have been updated within the past year;
- (xviii) Informed consent of the participant or legally authorized representative in writing; and
- (xix) Signatures of all providers listed in the individualized plan of care after the draft plan, as written, is completed by the team including participant's signature for informed consent.

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

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

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

#### **Section 11. Rate Reimbursement Requirements.**

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

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

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

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

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

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

(i) Cost data;

(ii) Claims data; and

(iii) Participant needs assessment data.

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

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

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

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

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

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

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

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

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

(v) Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including daily activities, recreational activities, physical

environment, and with whom to interact;

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

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

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

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

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

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

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

(e) Provider service setting inspections.

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

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

(A) A fire marshal or designee;

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

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

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

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

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

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

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

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

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

(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.

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

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

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

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

- (g) Emergency plans.
  - (i) Providers shall have written emergency plans and procedures for:
    - (A) Fires;
    - (B) Bomb threats;
    - (C) Natural disasters, including but not limited to earthquakes, blizzards, floods, tornadoes, wildfires;
    - (D) Power and other utility failures;
    - (E) Medical emergencies;
    - (F) Missing person;
    - (G) Provider incapacity;
    - (H) Safety during violent or other threatening situations;
    - (I) Staffing shortages due to other emergency situations;
    - (J) Vehicle emergencies; and
    - (K) If applicable, how the provider is able to care for or provide supervision to both participants and any children under the age of 12 or other individuals requiring support and supervision.
  - (ii) The emergency plans shall include a contingency plan that assures that there is a continuation of essential services when emergencies occur.
  - (iii) The provider shall document the review of all applicable emergency plans, with staff and participants, at least once every twelve (12) months on routine shifts. The documentation shall include:
    - (A) Written identification of concerns noted during the review of plans;
    - (B) Written documentation of follow-up to concerns noted during the review of plans; and
    - (C) Evidence of one fire drill, including an evacuation of the premises.
- (h) All service settings owned or controlled by a provider shall meet the following requirements:

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

(C) Freedom to access the community;

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

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

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

(II) The services provided are episodic;

(III) The arrangement is determined medically necessary; or

(IV) The participants request to share a bedroom.

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

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

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

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

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

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

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

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

(xv) Written policies to address health, safety, and rights. Providers shall share policies with participants and the legally authorized representative before the participant formally chooses the provider. Print information shall be written in plain language. Policies shall include, but are not limited to:

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

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

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

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

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

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

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

(i) Maintain vehicles in good repair;

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

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

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

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

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

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

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

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

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

#### **Section 14. Background Check Requirements.**

(a) All persons providing waiver services including: managers, supervisors, direct care staff, participant employees hired through self-direction, and any other person who may

have unsupervised access to participants shall complete and pass a background screening as referenced in this Section. Persons who do not successfully pass a background screening shall not supervise, provide, or bill for waiver services, or otherwise have unsupervised access to participants on behalf of a provider.

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

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

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

(e) A successful background screening shall include:

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

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

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

(A) An Offense Against the Person, including:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(j) If a criminal history screening does not include a disposition of a charge, or if an individual is charged with an offense listed in subsection (e)(iii) of this Section, the individual

shall not have any unsupervised access or provide billable services to participants until the provider is able to provide proof of a successful background check.

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

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

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

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

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

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

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

#### **Section 15. Provider Training Standards.**

(a) In addition to the other training standards in this Chapter and the Department of Health's Medicaid Rules, providers shall ensure that employees, including management staff responsible for providing supports and services to participants, receive training in the areas specified in this Section prior to working unsupervised with participants in services.

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

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

(d) All persons qualified to provide waiver services shall complete training in the following areas prior to delivering services. Providers may choose to develop their own training

modules for employees or use Division modules, as long as the provider covers the key elements of each topic specified in the Division module with Division approval. General training topics include:

- (i) Participant choice;
  - (ii) The rights of participants in accordance with state and federal laws, and any rights restrictions for each participant with whom a person works;
  - (iii) Confidentiality;
  - (iv) Dignity and respect;
  - (v) Preventing, recognizing and reporting abuse, neglect, intimidation, exploitation, and all other categories listed on the Division's Notification of Incident form;
  - (vi) Responding to injury, illness, and emergencies;
  - (vii) Billing and documentation of services;
  - (viii) Releases of information;
  - (ix) Grievance and complaint procedures for participants, legally authorized representatives, provider employees, and community members; and
  - (x) Implementing and documenting participant objectives and progress on objectives.
- (e) To verify each provider and provider staff meets the qualification standards, evidence of a completed training summary or test of each training topic shall be retained in the employer's files.
- (f) Participant specific training.
- (i) Each provider and provider staff shall receive participant specific training prior to the individualized plan of care start date. Impacted staff shall receive participant specific training prior to changes to the individualized plan of care.
  - (ii) All case managers shall train one employee from each provider on the individualized plan of care. The provider shall ensure that all other employees of the provider receive plan of care training. The case manager and the participant or any legally authorized representative(s) may request verification of the provider's participant specific training. Training shall occur before the individualized plan of care start date and before each employee provides services.

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

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

- (i) The date of the training;
- (ii) The name, signature, and title of the trainer;
- (iii) The name and signature of the person receiving the training;
- (iv) A detailed agenda of the training topic(s), including the method of training; and
- (v) How the person receiving training demonstrated understanding.

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

**Section 17. Positive Behavior Supports.**

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

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

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

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

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



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

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

- (i) Include the components of the template provided on the Department's website.
- (ii) Maintain the dignity, respect, and value of the participant;
- (iii) Use a person-centered approach with the participant involved in the development of the plan on a level appropriate for that person;
- (iv) Aim to minimize the use of restraints;
- (v) Be specific and easily understood, so direct care employees can implement it appropriately and consistently;
- (vi) Include a signature of the participant or legally authorized representative(s), which verifies informed consent;
- (vii) Define the antecedents and the targeted behavior(s) that need to be replaced or reduced;
- (viii) List positive behavioral supports that assist the participant in replacing targeted or challenging behaviors with appropriate replacement behaviors;
- (ix) Provide protocols for providers and provider employees to recognize emerging targeted behaviors, and determine the appropriate interventions to implement positive behavioral supports;
- (x) Provide protocols, which focus on positive interventions that are deemed least restrictive and most effective, for employees to use when targeted behaviors take place;
- (xi) Reference the protocol for the use of any PRN medication that may be a part of the positive behavior support plan, as recommended by the treating medical professional and can be requested by the participant to help manage stress, anxiety, or behaviors;
- (xii) Be reviewed every six (6) months by the provider(s) and the case manager to assess the effectiveness of the plan, or more frequently if needed;

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

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

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

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

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

#### **Section 18. Restraint Standards.**

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

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

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

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

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

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

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

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

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

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

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

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

(k) Providers employing restraints shall:

(i) Adopt policies and procedures that:

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

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

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

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

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

(l) The provider and provider staff shall maintain certification, and provider shall

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

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

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

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

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

(C) If a provider uses three (3) or more chemical restraints on a participant within a consecutive six (6) month period, the participant's plan of care team shall arrange for the participant to see his or her treating medical professional for a formal medical review in case the treatment plan needs to change. The participant's plan of care team shall meet to determine if the positive behavior support plan or crisis intervention protocol needs to change. The formal medical review shall be documented in the participant's file with the restraining provider and the case manager. If it is determined that the treatment plan or individualized plan of care will not be changed, then the case manager shall document the reasons it is not being changed in the individualized plan of care.

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

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

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

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

eighteen (18).

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

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

(o) A provider using restraints shall:

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

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

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

(iv) Address and correct staff using restraints incorrectly;

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

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

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

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

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

(x) Regularly collect and review all available data regarding the use of

restraints and work to reduce their duration and frequency, and eliminate their occurrence.

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

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

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

(i) For the convenience of the provider;

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

or

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

(s) The following restraints are prohibited:

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

(ii) A restraint procedure or device that obstructs a person's airway or constricts the person's ability to breathe;

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

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

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

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

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

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

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

- (i) Suspected abuse as defined by W.S. 35-20-102 or W.S. 14-3-202;
- (ii) Suspected self-abuse;
- (iii) Suspected neglect as defined in W.S. 35-20-102 or W.S. 14-3-202;
- (iv) Suspected self-neglect as defined W.S. 35-20-102;
- (v) Suspected abandonment as defined in W.S. 35-20-102;
- (vi) Suspected exploitation as defined in W.S. 35-20-102;
- (vii) Suspected intimidation as defined by W.S. 35-20-102;
- (viii) Sexual abuse as defined in W.S. 35-20-102; and
- (ix) Death.

(b) Providers shall report the following incidents to the Division, Protection & Advocacy System, Inc., the case manager, and legally authorized representative(s) within one (1) business day:

- (i) Police involvement, such as arrests of participants or the participant's direct care provider, while they are providing services, or questioning of participants by law enforcement;
- (ii) Any use of restraint;
- (iii) Any use of seclusion;
- (iv) Injuries caused by restraints;
- (v) Serious injury to the participant;
- (vi) Elopement;
- (vii) Medication errors that result in emergency medical attention; and

(viii) Medical or behavioral admission and emergency room visits that are not scheduled medical visits.

(c) Providers shall report the following medication errors to the Division, the case manager, and legally authorized representative(s) within three (3) business days:

(i) Wrong medication;

(ii) Wrong dosage;

(iii) Missed medication;

(iv) Wrong participant;

(v) Wrong route; and

(vi) Wrong time, which is any deviation from the accepted standard time frame for the medication assistance.

(d) In addition to provisions of subsection (a) and (b) of this Section, if, at any time, a significant risk to a waiver participant's health and safety is identified, the provider shall report the incident to the Division.

(e) Providers shall have incident reporting policies and procedures that include the requirements of this Section and shall maintain internal incident reports for all incidents identified in this Section.

(i) Providers shall review internal incident data including the people involved in the incident, the preceding events, follow-up conducted, causes of reoccurring critical incidents, other trends, actions taken to prevent similar incidents from reoccurring, evaluation of actions taken, education and training of personnel, and internal and external reporting requirements.

(ii) Providers shall provide access of internal incident data to case managers within five (5) business days.

(f) Providers shall comply with Division or other agency requests for additional information relating to any reported incident.

## **Section 21. Complaint Process.**

(a) A provider or provider employee who has a reasonable suspicion that a participant's health or safety is in jeopardy shall immediately contact the Division, Protection & Advocacy Systems, Inc., and other governmental agencies, such as law enforcement or DFS to report incidents or concerns.



- (b) A provider shall have policies and procedures for handling complaints, including:
  - (i) How it will attempt to resolve the complaint;
  - (ii) How it will document actions, follow-up, and resolution of the complaint;
  - (iii) How and when information shall be shared with the complainant, legally authorized representative, and the case manager; and
  - (iv) How the complainant will be informed of the process to file a formal complaint with the Division.

(c) Complaints may be filed with the Division in writing or verbally. If a provider files a complaint, the complaint shall be submitted in writing unless the complaint involves a participant whose health or safety is in jeopardy. Upon receipt of a complaint from any person, the Division shall:

- (i) Send written notification to the complainant, within fifteen (15) business days, that the complaint has been received. The notification shall address:

- (A) Anticipated timeframes for completing the follow-up and resolution of a complaint; and

- (B) The authority for taking actions.

- (ii) Send written notification to the provider, within fifteen (15) business days, when a complaint involving that provider is received, unless the complaint involves significant health, safety, or rights concerns, which require an unannounced on-site visit. In these cases, the Division shall provide written documentation to the provider at the time of the on-site visit that indicates a complaint has been received, the nature of the complaint, and that complaint follow-up is being conducted.

- (iii) Within fifteen (15) business days of complaint resolution, send written notification to the complainant that the complaint has been resolved.

- (iv) Within fifteen (15) business days of the complaint resolution, submit a written report to the provider(s) that are the subject of the complaint summarizing the results of the complaint findings. The report may include findings, recommendations, and timeframes to address the recommendations through corrective action. If the complaint involves a specific participant, the report will also be sent to the participant and legally authorized representative.

- (d) Accredited providers shall adhere to the current accreditation requirements for complaints or grievances.

(e) A provider's failure to submit and successfully implement an approved corrective action plan, as outlined in Section 29 of this Chapter, may result in sanctions per Section 30 of this Chapter.

## **Section 22. Transition Process.**

(a) The participant or legally authorized representative may choose to change any provider at any time and for any reason.

(b) A provider who is terminating services with a participant shall notify the participant and the Division in writing at least thirty (30) calendar days prior to ending services, unless the Division approves a shorter transition period in advance. Failure to provide services during this thirty (30) calendar day period shall be considered abandonment of services and may result in decertification of the provider.

(c) When a participant or legally authorized representative chooses to change providers, they shall inform the case manager of the decision. The case manager shall notify the provider of a participant's or legally authorized representative's decision to discontinue services within three (3) business days.

(d) When a transition is requested, the case manager shall notify the Division of the request for change within three (3) business days of the request.

(i) If the participant or legally authorized representative requests a change of case manager, the case manager shall review choice and make provider lists available to the participant and legally authorized representative.

(ii) If the participant or legally authorized representative requests a change of a provider other than the case manager, the case manager shall review choice and provider lists with the participant or legally authorized representative.

(e) When a transition occurs, the case manager shall complete the transition checklist(s) as required by the Division, and schedule a transition meeting with the plan of care team.

(i) Notify all current and new providers, the participant, legally authorized representative, and the Division at least two (2) weeks prior to the meeting.

(ii) Team meetings may be scheduled sooner than two (2) weeks due to an emergency situation. The case manager shall notify the Division of any emergency requiring a faster transition schedule.

(f) After the transition meeting, the case manager shall complete and submit plan of care modifications to the Division at least seven (7) business days prior to the scheduled start date of the new services.

(g) All providers on the individualized plan of care shall share pertinent information with the case manager and the plan of care team in a timely manner.

(h) If a community living services provider requires a participant to move to another service setting, the participant shall be given the opportunity to choose from all available options, without limitation to that provider's settings.

(i) The participant may choose from other setting options that are appropriate for the participant, which may include a new provider.

(ii) The provider shall notify the participant, family, case manager, and any legally authorized representative of the move at least thirty (30) calendar days in advance so the participant can exercise the choice to find a new residence or provider.

(i) It is the responsibility of the case manager to ensure providers have received training on all participant information, including health and safety, behavioral concerns, and the individualized plan of care.

### **Section 23. Notice of Costs to the Participant.**

(a) The provider shall develop and implement a system to notify participants and legally authorized representatives of any associated cost to the participant for a service or item, and the terms of payment.

(b) Written notice shall be given to the participant before initiation of service and before any change. Providers shall allow participants and their legally authorized representative adequate time to review the notice before the participant chooses services from the provider, or before the changes are implemented.

(c) A provider's cost notice shall specify that participants will not be charged for services or items that are covered through other funding sources. This includes, but is not limited to, items necessary to provide habilitation and transportation related to habilitation. The cost notice shall also identify:

(i) Who is responsible for replacement or compensation when the participants' personal items are damaged or missing; and

(ii) How participants will be compensated when staff, guests, or other participants in service, who do not reside in the location (i.e., respite), utilize the environment and eat food paid for by participants.

(d) Providers shall not charge participants for changes to the provider's staffing, service settings, or services, if the change is required by state or federal law.

### **Section 24. Participant Funds and Personal Property.**

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

- (i) Serving as representative payee;
- (ii) Managing the funds of the participant;
- (iii) Receiving benefits or funds on behalf of the participant; or
- (iv) Temporarily safeguarding funds or personal property for the participant.

(b) The provider shall develop and implement written policies and procedures to identify and detail the system used to protect participant's funds and property. These policies and procedures shall be communicated to the participant or legally authorized representative, including:

(i) How the participant or any legally authorized representative will give informed consent for the expenditure of funds;

(ii) How the participant or legally authorized representative may access the records of the funds;

(iii) How funds are segregated for accounting and reporting purposes to the participant, legally authorized representative, and regulatory agencies, such as Social Security Administration or the Division;

(iv) Safeguards used to ensure that funds are used for the designated and appropriate purposes;

(v) If interest is accrued, how interest is credited to the accounts of the participant;

(vi) How service fees are charged for managing funds; and

(vii) How the person's funds or personal property will be replaced or recouped in the event of theft or an unexplainable disappearance at the provider service setting, or during the provider's provision of services.

(c) Providers shall not use or allow participant funds or personal property to be used:

(i) As a reward or punishment, unless specified in the individualized plan of care as a restriction of rights that complies with the requirements in this Chapter and is approved by the participant and legally authorized representative;

(ii) As payment for damages, unless otherwise specified in the lease or other written agreement, evidence shows the charge is appropriate, the rationale is documented, and

the participant or legally authorized representative gives written informed consent to make restitution for damages;

(iii) As payment for damages when the damage is the result of lack of appropriate supervision;

(iv) To purchase inventory or services for the provider; or

(v) As a loan to the provider or the provider's employees.

(d) Participant funds shall not be comingled with provider business accounts or monies.

**Section 25. Additional Standards for Providers that Require National Accreditation.**

(a) Providers that are certified in Adult Day, Case Management, Community Living, Community Support, Companion, or Supported Employment Services shall receive and maintain national accreditation in the accreditation areas specific to the service being provided if the services listed in this subsection and delivered by the provider collectively equal or exceed \$150,000 per calendar year.

(b) Providers shall obtain accreditation in the area applicable to each service within eighteen (18) months of qualifying under this provision. The eighteen (18) month clock begins on the date the accreditation criteria are met.

(c) Provider accreditation options include the Council on Quality and Leadership (CQL) and CARF International. Regardless of the accreditation attained, all references to accredited providers in this rule apply to the provider.

(d) The Division shall decertify a provider who fails to obtain or maintain accreditation.

(e) If a provider fails to obtain or maintain accreditation, a transition plan shall be implemented for each participant who is leaving the provider's services.

(i) Each waiver participant shall be relocated to a different provider within ninety (90) days of the date the Division receives confirmation that the provider did not receive accreditation. If a provider fails to obtain or maintain accreditation, the Division shall complete an immediate site survey and onsite assessment.

(ii) The provider's decertification date shall begin ninety (90) days from the date of written notice from the accrediting entity that the provider did not receive accreditation.

(f) An accredited provider shall submit all national accreditation report documents to the Division within thirty (30) days of receiving the report documents from the accrediting

entity.

**Section 26. Mortality Review.**

- (a) The Division shall review deaths of participants receiving waiver services.
- (b) Providers shall submit information requested by the Division. This may include, but is not limited to:
  - (i) Copies of documentation of services;
  - (ii) Copies of incident reports; and
  - (iii) Copies of any health related records, including assessments, results of licensed medical professional's office visits, and hospital visits.
- (c) The Division may make provider specific recommendations or systemic recommendations.

**Section 27. Initial Provider Certification.**

- (a) An individual or entity may apply to become a provider by completing the Division's initial provider certification process and all required trainings. The applicant shall supply evidence that the applicant meets the qualifications for each service in which the applicant is seeking waiver certification.
- (b) The Division shall only certify one provider per physical location.
- (c) The Division shall not certify any person or entity as a waiver provider if:
  - (i) The person or entity has an open or pending corrective action plan with the Division;
  - (ii) The person or entity has an open case with the Medicaid Fraud Control Unit; or
  - (iii) The person has not successfully passed a background screening as provided in Section 14 of this Chapter.
- (d) The Division may refuse to certify an entity that has an officer, administrator, or board member who was previously sanctioned by the Division. This refusal shall apply for a period of two (2) years from the date the person was sanctioned. The Division may also refuse to certify such person related to his or her involvement in any open or pending corrective action plan, or Medicaid Fraud Control Unit case until after the two (2) year period.
- (e) A person who has been convicted of Medicaid fraud shall not be certified.

(f) The Division shall refuse to certify or shall subsequently decertify a provider applicant who fails to disclose any convictions in a court of law on the Division's provider application or organization's application.

(g) Falsifications of statements or documents, or any concealment of material fact may result in a denial of certification, decertification, or referral for criminal prosecution.

(h) The Division shall initially certify a new provider or provider agency providing any service for one (1) year. The provider must complete a provider certification renewal at the end of the first year to continue providing services

(i) A person or entity may dispute an adverse action related to provider initial certification by a request for an administrative hearing, which will be administered pursuant to Chapter 4 of the Department of Health's Medicaid Rules.

## **Section 28. Provider Certification Renewal.**

(a) The Division shall notify all providers that their waiver certification is expiring at least ninety (90) calendar days prior to the certification expiration date. The notification shall detail requirements that the provider shall meet in order to renew their certification.

(b) The Division shall renew a provider certification at least once every three years. Based on the services provided, an on-site visit may be required. If an on-site visit is required, the Division shall provide notification to the provider at least thirty (30) calendar days prior to the visit.

(c) Provider certification renewal includes a Division review of the provider's evidence of compliance with state and federal regulations for home and community based services, and a review of the provider's self-assessment of compliance. For providers who offer services in a setting they own, operate, or lease, the Division shall also review the provider's self-inspection of service settings and a current inspection report from an outside entity.

(d) At any time, the Division shall conduct an on-site visit when a concern is identified during a complaint, incident report, or internal referral, if there is an indication the provider is not complying with state or federal rules and regulation, or at the Division's discretion.

(e) Providers may sign a form verifying that they do not provide services in their home or a provider-owned, leased, or operated setting. The Division will not conduct on-site evaluations for providers signing these forms, but may verify the accuracy of these statements. Falsification of these forms may result in sanctions.

(f) The Division does not require an on-site visit for a case manager, specialized equipment, or environmental modification certification renewal.

(g) Providers shall submit verification that they have met all applicable certification renewal requirements to the Division at least forty-five (45) calendar days prior to their certification expiration date.

(h) If a provider fails to submit the applicable certification renewal requirements to the Division as described in subsection (g) of this Section, the Division shall notify the provider in writing of the expiration of the certification.

(i) If the provider does not meet the certification renewal requirements within twenty (20) calendar days of the certification expiration, the Division shall begin the decertification process.

(ii) The provider shall be notified in writing through certified mail that their certification has expired.

(i) During any certification renewal, the Division shall review provider certification requirements and compliance with all home and community based regulations, then complete a written report, including a statement of the recommendations that shall be addressed within thirty (30) calendar days in order to maintain certification.

(i) The Division may approve a certification period for up to three (3) years depending on deficiencies noted during the certification renewal process.

(ii) The Division may approve the certification for a period of less than one (1) year if deficiencies are identified that seriously affect the health, safety, welfare, rights, or habilitation of a participant, or if the provider has otherwise substantially failed to comply with the rules and standards applicable to the services they are providing.

(iii) The Division may deny the certification.

(j) Providers shall submit all certification renewal documentation and information. Providers shall not use outside entities to submit certification renewal information.

(k) A provider may dispute an adverse action related to renewal of certification by a request for an administrative hearing, which will be administered pursuant to Chapter 4 of the Department of Health's Medicaid Rules.

## **Section 29. Corrective Action Plan Requirements.**

(a) The Division shall, to the extent practicable and consistent with the provisions of applicable law, seek the cooperation of providers in obtaining compliance with these standards. The Division may provide technical assistance to providers to help them voluntarily comply with any applicable provision of these rules.

(b) The Division may attempt to resolve any suspected noncompliance with this Chapter by requiring the provider to submit a corrective action plan.



(c) Corrective action plans shall address each area of suspected non-compliance to the Division's satisfaction. This includes identifying the suspected noncompliance area, action steps needed to address the area of noncompliance, the people in the organization responsible for each action item, due dates, and dates of completion for each recommendation.

(d) The Division may require specialized training for the provider organization or individual employees as part of a corrective action. Specialized training may include, but is not limited to, training on positioning, feeding protocols, positive behavior supports, person-centered planning, or trauma-informed care, and shall be included in the corrective action plan submitted by the provider.

(e) Suspected non-compliance that relates to the immediate health, safety, welfare, or rights of participants shall be addressed immediately after the situation is discovered. Providers addressing suspected non-compliance under this Section shall be given fifteen (15) business days from the date of the report issued by the Division to submit a corrective action plan.

(f) If a corrective action plan is not submitted and implemented to address all areas of suspected non-compliance, the Division may impose sanctions as warranted in Section 30 of this Chapter.

(g) The Division shall notify the provider in writing within thirty (30) business days after receipt of the provider's corrective action plan regarding the approval or rejection of the plan.

(i) If a corrective action plan is rejected, the provider shall receive notification in writing of the reasons for the rejection, and shall submit a revised plan within ten (10) business days from the notification of the written rejection from the Division.

(ii) The Division shall notify the provider in writing within thirty (30) business days after receipt of the provider's revised corrective action plan regarding the approval or rejection of the plan.

(iii) If the revised corrective action plan is rejected, the provider shall have ten (10) business days from the notification of rejection to submit an acceptable corrective action plan, or the Division may proceed with the sanctioning process as outlined in Section 30 of this Chapter.

(h) The provider shall complete appropriate follow-up monitoring to assure that the actions identified in their corrective action plan have been completed within the specified time frame(s) and, at the discretion of the Division, shall submit a monthly status report to the Division in the form and manner required by the Division until all action items have been satisfactorily completed. If the Division does not receive the monthly status report from the provider, the Division may proceed with the sanctioning process as outlined in Section 30 of this Chapter.

(i) The Division may complete follow-up or review additional items during the provider's certification renewal process to assure the provider has fully implemented and evaluated the corrective action plan, and that participants remain safe during the implementation.

### **Section 30. Sanctions.**

(a) Sanctions shall be imposed in accordance with the provisions of Chapter 16 of the Department of Health's Medicaid Rules.

(b) Notwithstanding the provisions of Section 29 of this Chapter, the Division may impose sanctions or revoke provider certification for any violation of these rules.

(c) If the Division revokes a provider's certification or suspends a national provider identification number, the provider shall submit transition plans to the Division detailing the transition of each participant to other settings within twenty (20) calendar days of the date that the sanction is deemed final.

(i) The transition plans shall not be implemented until approved by the Division.

(ii) The transition plans shall be implemented and participants shall move to different certified providers or receive non-waiver supports and services from persons approved by the participants or any legally authorized representative(s) within ninety (90) calendar days of the date the Division informed the provider of the revocation of certification.

(iii) Transition plans shall adhere to the requirements in Section 22 of this Chapter.

(d) A provider who has had their certification revoked under this Section shall not provide waiver services.

(e) A provider may dispute a sanction under this Section or any other adverse action, including those related to certification or renewal of certification, by a request for an administrative hearing, which will be administered pursuant to Chapter 4 of the Department of Health's Medicaid Rules.

### **Section 31. Relative Providers.**

(a) The Division shall allow a participant's relative, as defined in Section 3 of this Chapter, to become a certified waiver provider and receive reimbursement for services provided to the related participant.

(b) A participant's legally authorized representative shall not directly or indirectly receive reimbursement for providing waiver services for their ward, except as indicated in the Comprehensive and Supports Waiver Service Index, which is incorporated by reference. Direct or indirect reimbursement shall include, but is not limited to, providing direct services for, or serving as the owner or officer of, a provider organization, residing in a provider owned service setting, or being married to a person providing waiver services to the participant.

(c) A participant's spouse may receive direct or indirect reimbursement only if they present the Division with a certified copy of a court order establishing another party as the legally authorized representative of the participant.

(d) To provide waiver services to a related participant, the relative provider shall:

- (i) Form a Limited Liability Company (LLC) or other corporation; and
- (ii) Maintain provider certification in accordance with this Chapter.

(e) A relative provider, spouse, or legally authorized representative shall not be hired to provide services through self-direction.

(f) Services that may be furnished by a relative provider are identified in the Comprehensive and Supports Waiver Index, which is incorporated by reference.

(g) If a relative provider or legally authorized representative is providing personal care to his or her ward, the individualized plan of care shall be developed and monitored by a case manager without a conflict of interest.

(h) If the relative provider is not providing services in the best interest of the participant, the case manager shall work with the participant, appropriate team members, and the Division as needed to choose other providers as appropriate and modify the individualized plan of care to better suit the needs of the participant.

(i) Payment to a relative provider specified in subsections (f) and (g) of this Section shall only be made when the service provided is not a function that the relative would normally provide for the individual without charge as a matter of course in the usual relationship among family members, and the service would otherwise need to be provided by a qualified provider.

(j) A relative who provides services either as an owner, employee, or officer of a provider or who intends to provide services to a related waiver participant shall disclose the relationship in the participant's team meeting and acknowledge and address the safeguards set forth in documentation required by the Division.

(k) If a provider permits the hiring of a legally authorized representative of a participant receiving services from the provider, or if a provider permits the hiring of relatives of provider employees working for the organization, the provider shall have a written policy on how it addresses potential conflicts that arise from these relationships and how the conflict of interest is mitigated. The policy shall be shared with the participant and legally authorized representative(s).

## **Section 32. Interpretation of Chapter.**

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

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

**Section 33. Superseding Effect.** This Chapter supersedes all prior rules or policy statements issued by the Division, including provider manuals and provider bulletins, which are inconsistent with this Chapter.

**Section 34. Severability.** If any portion of this Chapter is found invalid or unenforceable, the remainder shall continue in full force and effect.

**Section 35. Incorporation by Reference.**

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

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

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

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

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

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

(ii) Referenced in Sections 2 and 9 of this Chapter is Wyoming Medicaid's State Plan, incorporated as of the effective date of this Chapter and can be found at <http://www.health.wyo.gov/healthcarefin/medicaid/spa>.

(iii) Referenced in Sections 2 and 11 of this Chapter is Wyoming's Comprehensive and Supports Waiver Applications, incorporated as of the effective date of this Chapter and can be found at <https://health.wyo.gov/behavioralhealth/dd/bhd-public-notice/>.

(iv) Referenced in Sections 2, 5, 6, 8, and 31 of this Chapter is Wyoming's Comprehensive and Supports Waiver Service Index, incorporated as of the effective date of this Chapter and can be found at <https://health.wyo.gov/behavioralhealth/dd/servicesandrates/>.

(v) Referenced in Section 7 of this Chapter is W.S. 35-2-607, incorporated as of the effective date of this Chapter and can be found at <https://legisweb.state.wy.us/>.

(vi) Referenced in Section 8 of this Chapter is W.S. 40-21-107, incorporated as of the effective date of this Chapter and can be found at <https://legisweb.state.wy.us/>.

(vii) Referenced in Section 13 of this Chapter is W.S. 1-21-1201 through - 1211, incorporated as of the effective date of this Chapter and can be found at <https://legisweb.state.wy.us/>.

(viii) Referenced in Section 14 of this Chapter is Title 6 of the Wyoming Statutes Annotated, incorporated as of the effective date of this Chapter and can be found at <https://legisweb.state.wy.us/>.

(ix) Referenced in Section 20 of this Chapter is W.S. 35-20-102, incorporated as of the effective date of this Chapter and can be found at <https://legisweb.state.wy.us/>.

(x) Referenced in Section 20 of this Chapter is W.S. 14-3-202, incorporated as of the effective date of this Chapter and can be found at <https://legisweb.state.wy.us/>.