CHAPTER 46

MEDICAID SUPPORTS AND COMPREHENSIVE WAIVERS

Section 1. Authority. This Chapter is promulgated by the Department of Health pursuant to Wyoming Statute 9-2-102 and the Wyoming Medical Assistance and Services Act at W. S. 42-4-104 through -121.

Section 2. Purpose and Applicability.

(a) This Chapter shall apply to and govern Medicaid services provided under the Wyoming Medicaid Supports and Comprehensive Waivers.

(b) This Chapter, in addition to Chapters 44 and 45 of the Department of Health's Medicaid Rules, shall govern services and provider requirements of the Supports and Comprehensive Waivers.

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

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

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

Section 3. General Provisions.

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

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

(c) "Level of Service score" means a participant's support needs for various parts of their everyday routine and their level of independence, which are tied to a Level of Service score ranging from 1 (lowest level of support) to 6 (highest level of support). The Level of Service scores are based on comprehensive assessments that determine an individual's level of functioning related to behavioral and health factors, and identify essential staffing and support requirements.

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

Section 4. Eligibility Requirements.

(a) Eligibility under this Chapter is limited to persons who complete the application process and who meet the requirements for clinical and financial eligibility established under this Section. An individual is not eligible for the Wyoming Medicaid Supports Waiver unless the individual meets the following criteria:

(i) The individual satisfies the citizenship, residency, and financial eligibility requirements established in Chapter 18 of the Department of Health's Medicaid Rules;

(ii) The individual qualifies for the relevant institutional level of care pursuant to Section 6 of this Chapter;

(iii) The individual has received a clinical eligibility diagnosis pursuant to Section 7 of this Chapter; and

(iv) The individual has received a qualifying Inventory for Client and Agency Planning (ICAP) score pursuant to Section 8 of this Chapter.

(b) An individual is not eligible for the Wyoming Medicaid Comprehensive Waiver unless the individual meets the following criteria:

(i) The individual meets the eligibility criteria pursuant to subsection (a) of this Section;

(ii) The individual has assessed service needs in excess of the established cost limit on the Supports Waiver; and

(iii) The individual meets one of the following:

(A) The emergency criteria as approved by the Extraordinary Care Committee (ECC); or

(B) The criteria for reserved capacity as specified in Section 13(f) or (g) of this Chapter.

(c) Diagnoses and assessments used to meet initial clinical eligibility shall be accurate and shall be completed within the past five (5) years. Any assessment or reassessment for eligibility is subject to review by the Division before acceptance, and may require additional evidence or verification.

(d) Case managers shall complete all eligibility paperwork within thirty (30) calendar days of being selected. Submitted paperwork shall be reviewed by the Division within thirty (30) calendar days of receipt.

Section 5. Loss of Eligibility

(a) The Division shall determine a participant has lost eligibility for waiver services when the participant:

(i) Does not meet clinical eligibility;

(ii) Does not meet financial eligibility; or

(iii) Changes residence to another state.

(b) The Division may terminate a participant's eligibility when the participant:

(i) Voluntarily does not receive waiver services for three (3) consecutive months;

(ii) Is in a nursing home, hospital, residential treatment facility, in-patient hospice, institution, or ICF/IID for thirty (30) or more consecutive calendar days;

(iii) Is in an out-of-state placement or residence for six (6) consecutive months or resides out of state for six (6) consecutive months; or

(iv) Chooses another waiver outside of the Comprehensive or Supports waiver.

(c) If the participant is determined not to be eligible for services due to one of the criteria in subsection (b) of this Section, the participant or the participant's legally authorized representative shall be notified in writing within fifteen (15) calendar days.

(d) The Division shall notify an applicant, participant, or legally authorized representative, in writing, of the determination of clinical ineligibility or loss of clinical eligibility within fifteen (15) calendar days of the determination or loss.

(i) Upon written notification of ineligibility, the applicant, participant, or legally authorized representative may submit, in writing, a request for reconsideration within thirty (30) calendar days of the notice of ineligibility, which shall include the reasons why the participant should still be considered eligible for the services.

(ii) If the participant requests reconsideration, the Division Administrator or Designee shall review the request and make a final determination, in writing, within thirty (30) calendar days of the request. A participant who is aggrieved or adversely affected by a reconsideration decision may also request an administrative hearing within thirty (30) calendar days following the adverse reconsideration decision.

(iii) Requests for an administrative hearing will be administered pursuant to Chapter 4 of the Department of Health's Medicaid Rules.

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

(e) Wyoming Medicaid shall send written notification of financial ineligibility.

(f) An applicant who is determined ineligible, or a participant whose eligibility is terminated under this Section, may reapply at any time.

Section 6. Institutional Level of Care Requirements

(a) An individual with a developmental or intellectual disability diagnosis is not eligible for waiver services pursuant to Section 4 of this Chapter unless the individual qualifies for an intermediate care facility for individuals with an intellectual or developmental disability (ICF/IID) level of care, as measured by the LT-104 assessment.

(b) An individual with an acquired brain injury diagnosis is not eligible for waiver services pursuant to Section 4 of this Chapter unless the individual qualifies for a nursing facility level of care, as measured by the LT-101 assessment.

Section 7. Clinical Eligibility Diagnoses

(a) An individual is not eligible for waiver services pursuant to Section 4 of this Chapter unless the individual meets one of the following clinical eligibility diagnoses:

(i) A diagnosis of an intellectual disability, as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM 5), which is incorporated by reference, and is determined by a Medicaid enrolled psychiatrist, neurologist, or clinical psychologist who is licensed in Wyoming and is free of conflicts with other providers chosen by the participant.

(A) The diagnosis shall be verified in a written and signed psychological evaluation that is submitted to the Division.

(B) The psychological evaluation shall reflect adaptive behavior scores as determined through a standard measurement of adaptive behavior using a validated test of adaptive functioning such as the most current form of the Vineland Adaptive Behavior Scales or Adaptive Behavior Assessment System.

(C) A child applicant who takes an Intelligence Quotient test shall meet a qualifying clinical diagnosis like an adult. A child too young to complete an Intelligence Quotient test may meet the criteria of a developmental disability as described in subsection (a)(i)(B) through medical records of a related condition using a standardized test of development, such as the Bayley Scales of Infant and Toddler Development or other similar instrument.

(ii) A developmental disability or a related condition determined by a Medicaid enrolled licensed medical professional, neurologist, or clinical psychologist who is licensed in Wyoming and is free of conflicts with other providers chosen by the participant.

(A) Determination shall include verification in medical records and a written psychological evaluation, which includes assessment scores. The evaluation or records shall be submitted to the Division and shall identify a severe, chronic disability, which:

(I) Manifested before the person turned age twenty-two;

(II) Reflects the need for a combination and sequence of special services, which are lifelong or of extended duration;

(III) Is attributable to a cognitive or physical impairment, other than mental illness;

(IV) Is likely to continue indefinitely; and

(V) Results in substantial functional limitations in three (3) or more of the following major life activity areas: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.

(B) Individuals with a diagnosis of Autism Spectrum Disorder (ASD) shall submit a current autism evaluation accepted by the Division, which demonstrates the diagnosis of ASD. The autism evaluation shall be completed by a Medicaid enrolled psychiatrist, neurologist, or clinical psychologist who is licensed in Wyoming and is free of conflicts with other providers chosen by the participant.

(iii) An Acquired Brain Injury (ABI), as defined by Chapter 1 of the Department of Health's Medicaid Rules. An individual with an ABI shall:

(A) Be between the ages of twenty-one (21) and sixty-four (64); and

(B) Have received a qualifying score on at least one of the evaluations accepted by the Division, which shall be completed by a Medicaid enrolled psychiatrist, neurologist, or clinical psychologist who is licensed in Wyoming and is free of conflicts with other providers chosen by the participant. Accepted evaluations, which shall be submitted to the Division to confirm the diagnosis, include:

(I) A score of 42 or more on the Mayo Portland Adaptability Inventory (MPAI);

(II) A score of 40 or less on the most current version of the California Verbal Learning Test Trials 1-5 T; or

(III) A score of 4 or more on the Supervision Rating Scale.

(b) A participant shall be reassessed for clinical eligibility at least annually or more frequently should a change in circumstances occur, which requires a participant to receive a higher level of services or support to ensure the participant's health, safety, and welfare.

(i) A subsequent psychological evaluation, which shall be approved by the Division prior to scheduling, must be necessary due to the participant's change in condition or as determined by the Division.

(ii) A subsequent neuropsychological evaluation, which shall be approved by the Division prior to scheduling, shall be performed every five (5) years.

(iii) Psychological and neuropsychological reassessments shall be completed by a Medicaid enrolled psychiatrist, neurologist, or clinical psychologist who is licensed in Wyoming and is free of conflicts with other providers chosen by the participant.

Section 8. Inventory for Client and Agency Planning Assessment

(a) An individual is not eligible for waiver services pursuant to Section 4 of this Chapter unless the individual receives a qualifying Inventory for Client and Agency Planning (ICAP) assessment score for the individual's age.

(i) If an individual is age zero (0) through one (1), the adaptive behavior quotient shall be .50 or below.

(ii) If an individual is age two (2) through five (5):

(A) The ICAP service score shall be between 30 and 44, depending on age; or

(B) The adaptive behavior quotient shall be .50 or below.

(iii) If an individual is age six (6) through twenty (20):

(A) The ICAP service score shall be between 48 and 70, depending on age; or

(B) The adaptive behavior quotient shall be .70 or below.

(iv) If an individual is age twenty-one (21) or older:

(A) The ICAP service score shall be 70 or less; or

(B) The individual shall have a functional limitation in at least three (3) of the following ICAP areas: self-care, language, learning/cognition, mobility, self-direction, or independent living.

(b) The ICAP assessment shall be administered by the Division's designee, and shall be completed every five (5) years, or more frequently at the option of the Division, to provide continued verification that the participant meets waiver clinical eligibility.

Section 9. Statewide Data Registry. All individuals who have been determined eligible for waiver services shall be included in the statewide data registry used by the Division for planning, monitoring, and analysis for the waiver system. Information in the registry is

considered confidential and will not be released without proper authorization, or otherwise as required by law. Providers shall submit data on programs, participant outcomes, costs, and other information as required by the Division.

Section 10. Waiver Services, Service Requirements, and Restrictions.

(a) Waiver services specified in the individualized plan of care shall be based on the participant's assessed needs; meet the service definition(s); be considered medically or functionally necessary; align with the participant's preferences for services, supports, and providers; and be prioritized based on the availability of funding in the participant's individual budget amount.

(b) Services shall have prior authorization before being provided to a participant.

(c) Waiver services shall support and assist the participant in acquiring, retaining, and improving the skills necessary for the individual to function with as much independence as possible, exercise choice and self-management, and participate in the rights and responsibilities of community membership.

(d) The individualized plan of care shall reflect the services and actual units that providers agree to provide over the plan year. The individualized plan of care shall also include details regarding the specific support, settings, times of day, and activities requiring more support than others.

(e) Providers shall not serve children under age eighteen (18) and adults at the same time unless authorized in writing by the Division.

(f) Waiver services shall not be used to duplicate the same service or a similar service that is available to the participant through one of the following programs:

(i) Section 110 of the Rehabilitation Act of 1973;

(ii) Section 504 of the Rehabilitation Act of 1973;

(iii) Individuals with Disabilities Education Act (IDEA) (20 U.S.C. 1401 et seq.); or

(iv) Medicaid State Plan.

(g) Participants may request an exemption from subsection (f) by submitting a third party liability form as part of the participant's individualized plan of care. This form shall document that the service is not available through another program or agency to meet the individual participant's assessed needs. Exemptions may be granted at the direction of the Division.

(h) Routine transportation for activities provided during the service is included in the reimbursement rate for the service regardless of the number of trips. The provider shall not charge a participant separately for transportation during these waiver activities unless the special activity is outside of the participant's community or normal routine.

(i) Participants receiving levels three (3) through six (6) community living services may receive up to an average of thirty-five (35) hours of day services per week, which include adult day, community support, and companion services.

(j) Waiver services are outlined in the Comprehensive and Supports Waiver Service Index, which is incorporated by reference.

Section 11. Waiver Cost Limits and Individual Budget Amounts.

(a) The allocation of Medicaid waiver funds that may be available to a participant to purchase services shall be based on his or her assessed needs.

(b) Eligible individuals shall be assigned a Level of Service score.

(c) Participants enrolled in the Supports Waiver shall be assigned a designated budget amount outlined in the most current Supports Waiver application, which is incorporated by reference. Transition to the Comprehensive Waiver shall only occur as funding and a slot on the Comprehensive Waiver becomes available.

(d) Participants shall meet criteria outlined in Section 4(d) of this Chapter to be eligible for Comprehensive Waiver Services.

(i) Participants enrolled on the Comprehensive Waiver shall be assigned an individual budget amount based on the following factors:

(A) Functional and medical assessments;

(B) The participant's age group;

(C) The participant's living situation;

(D) The participant's need for a higher level of services;

(E) An amount for annual case management services; and

(F) Any temporary or permanent increase or decrease as determined by the ECC.

(ii) The factors in subsection (d)(i) determine the participant's Level of Service score in order to plan for appropriate services and supports.

(iii) A participant's individual budget amount on the Comprehensive Waiver shall not exceed the institutional cost limit specified in the most current Comprehensive Waiver application approved by CMS, which is incorporated by reference. A participant who needs services in excess of this amount shall have the individualized plan of care and budget approved by the ECC.

Section 12. Self-Directed Service Delivery.

(a) The services that may be self-directed are outlined in the Comprehensive and Supports Waiver Service Index, which is incorporated by reference.

(b) At least once a year, each participant's case manager shall provide the participant or legally authorized representative information regarding the option to self-direct waiver services. Information shall include requirements of the employer of record, not limited to:

(i) Hiring, firing, and training staff;

(ii) Setting staff work schedules; and

(iii) Monitoring and working within the participant's individual budget amount.

(c) Self-Directed services are available to a participant who:

(i) Lives in his or her own private residence or the home of a family member; or

(ii) Resides in other living arrangements where services, regardless of funding source, are furnished to three (3) or fewer persons unrelated to the proprietor.

(d) To self-direct waiver services, the participant or legally authorized representative or other designee shall act as the Employer of Record and use a Financial Management Service on contract with the Division.

(e) A participant shall only self-direct services if the Financial Management Service contractor has open slots for new people to enroll, based upon the contracted capacity.

(f) The Financial Management Service shall assist the participant in being the Employer of Record.

(g) The Division shall provide the recommended wage ranges for all self-directed services.

(h) The Employer of Record shall be responsible to recruit, hire, schedule, evaluate, and supervise self-directed employees. The Employer of Record shall have the budgetary authority to negotiate and set wages and payment terms for all services received.

(i) The Employer of Record shall hire employees to provide waiver services, and work with the Financial Management Service to determine that the potential employee meets the general and specific provider standards for the service being provided. A provider that has had their certification revoked under Chapter 45 of the Department of Health's Medicaid Rules shall not provide self-directed services.

(j) Consistent with the service definitions as outlined in the Comprehensive and Supports Waiver Service Index, which is incorporated by reference, the Employer of Record shall work with the employee hired through self-direction to determine the specific tasks to be completed during the provision of services, the employee's schedule, and how to document services and report documentation and timesheets to the Employer and Financial Management Service. The Employer of Record shall ensure documentation is available to the case manager by the tenth (10th) business day of the month following the month in which services were provided.

(k) When the Employer of Record and the employee have reached agreement on the services, schedule, and rate, the Financial Management Service shall track the rate and services authorized and ensure the employee wages are paid in accordance with state and federal laws.

(l) Employees hired through self-direction shall document services provided in accordance with Chapter 45 and the agreed upon manner between the Financial Management Service and the Employer of Record. The Employer of Record shall maintain documentation in accordance with the Department of Health's Medicaid Rules.

(m) The Employer of Record, with assistance from the case manager as needed, shall review employee documentation of the services provided and the employee timesheets to ensure accuracy with the type, scope, amount, frequency, and duration of services agreed upon in the individualized plan of care.

(n) A participant or legally authorized representative may choose to voluntarily terminate self-direction at any time during the plan year and shall work with the case manager to transition to other available services or providers. The case manager shall disenroll the participant from the Financial Management Service within thirty (30) calendar days of notification that the participant chooses to terminate self-direction services.

(o) A participant may be involuntarily terminated from the use of self-direction if:

(i) The participant or Employer of Record is found to misuse waiver funds;

(ii) The participant's health and welfare needs are not adequately being met;

(iii) The participant exceeds the budget amount for self-directed services identified in the individualized plan of care;

(iv) The Division or the Medicaid Fraud Control Unit identifies situations involving the commission of fraudulent or criminal activity associated with the self-direction of services; or

(v) The participant chooses not to receive self-directed services for ninety (90) calendar days after active enrollment begins.

(p) A participant who is involuntarily terminated from this service under subsection (o) of this Section shall receive written notice from the Division and may request an administrative hearing as provided in Chapter 4 of the Department of Health's Medicaid Rules.

Section 13. Wait List Process.

(a) The Division shall maintain a Supports Waiver wait list to add additional participants as funding is appropriated and as approved by CMS.

(b) The Division shall prioritize eligible individuals on the Supports Waiver wait list on a first come, first serve basis. Funding opportunities shall be given to the person who has waited the longest for services, based on the date that the individual was determined eligible.

(c) Before being added to the Supports Waiver wait list, the individual shall be determined eligible as specified in Section 4 of this Chapter.

(d) For people with the same date of eligibility, the Division shall use the date that the Case Manager Selection form was received by the Division to determine which individual shall receive the next funding opportunity.

(e) The Level of Service score and individual budget amount shall be determined for each individual on the wait list. An eligible individual who needs services in excess of the Supports Waiver may request placement on the Comprehensive Waiver, and may be placed on the Comprehensive Waiver wait list, if a funding opportunity is not available. Preference on the Comprehensive Waiver wait list is given to individuals with a Level of Service score of four (4) or higher.

(f) The Comprehensive Waiver shall reserve capacity each year for eligible individuals who have resided in a Wyoming institution, such as an ICF/IID, nursing home, Psychiatric Residential Treatment Facility, residential treatment facility, BOCES, or an inpatient psychiatric hospital, and who have been:

(i) In residence at the institution;

(ii) On a Division wait list; or

(iii) On a Division waiver prior to being institutionalized.

(g) The Comprehensive and Supports Waivers shall reserve capacity each year for qualifying dependents of active military service members who have been assigned to serve in Wyoming, or who are retiring or separating from active duty military service and intend to reside in Wyoming within eighteen (18) months.

(h) If additional capacity is available after the Comprehensive Waiver makes the required reservations under subsections (f) and (g) of this Section, the Comprehensive Waiver may reserve capacity for other individuals transitioning out of institutional services upon the request of the individual.

Section 14. Emergency Waiver Services.

(a) An emergency case involves an eligible person who requires immediate action or has an urgent need for waiver services, including placement in the least restrictive and most appropriate environment necessary to maintain the person's vital functions because of one of the following criteria:

(i) An immediate threat, or a high probability of immediate danger to the life, health, property, or environment of the eligible person or another individual because of the eligible person's medical, mental health, or behavioral condition.

(ii) A loss of the person's primary caregiver due to death, incapacitation, critical medical condition, or inability to provide continuous care. A caregiver is defined as any person, agency, or other entity responsible for the care, both physical and supervisory, of a person because of:

(A) A family relationship;

(B) Voluntary assumption of responsibility for care;

(C) Court ordered responsibility or placement;

(D) Rendering services in a residential program;

(E) Rendering services in an institution or in a community-based program; or

(F) Acceptance of a legal obligation or responsibility of care to the person.

(iii) Homelessness, which means a situation where, for a period of thirty (30) days, a person lacks access to an adequate residence with appropriate resources to meet his or her support and supervision needs, and without such support, there is evidence of serious harm to the person's life or health.

(iv) A case involving a person removed from the home by an appropriate agency due to abuse, neglect, abandonment, exploitation, or self-neglect.

(v) A residential service request for a waiver participant or a person on the wait list not receiving 24-hour residential services, whose health or safety is at significant risk due to extraordinary needs that cannot be met in the current living arrangement because of one of following criteria:

(A) A substantial threat to a person's life or health that is corroborated by the Department of Family Services, Protection & Advocacy System, Inc., or law enforcement;

(B) A situation where the person's health condition or significant and frequently occurring behavioral challenges pose a substantial threat to the person's own life or health, or to others in the home;

(C) A situation where the person's critical medical condition requires ongoing twenty-four (24) hour support and supervision to maintain the person's health and safety that cannot be met in the current living situation; or

(D) The loss of the eligible person's primary caregiver due to death, incapacitation, critical medical condition, or inability to provide continuous care.

(b) Any person who requests that the Division consider an emergency case shall be directed to work with the person's chosen case manager, the Division, and other community resources to review options for emergency services. The case manager shall submit the request for emergency services on behalf of the person.

(c) Emergency cases shall be referred to the ECC pursuant to Section 15 of this Chapter.

(d) An individual who has not been deemed eligible for waiver services may complete the eligibility process and request emergency services. No emergency services may be provided to ineligible persons.

(e) Emergency placement in waiver services shall not be made as an alternative to incarceration or jail.

Section 15. Extraordinary Care Committee.

(a) The ECC shall be composed of a Division waiver manager, a Medicaid manager, the Participant Support Specialist presenting the case, and a representative from the Department's fiscal unit. When appropriate, the ECC may also include the Division's licensed psychiatrist, the Medicaid Medical Director, the Division's registered nurse, or a behavioral specialist. Members may also consult other specialists in the field as appropriate.

(b) The ECC shall only approve additional funds for participant cases if funding is available in the Division's waiver budget appropriation.

(c) The ECC shall review:

(i) Emergency cases as defined by Section 14 of this Chapter;

(ii) Extraordinary cases that include a significant change in service need due to the onset of a behavioral or medical condition or injury including:

(A) A temporary change in circumstances, which requires a higher level of service or support to ensure the health, safety, and welfare of the participant;

(B) Temporary funding increases under Section 11(d) of this Chapter;

(C) Concerns about a Level of Service score; or

(D) Requests requiring ECC approval under these Rules; and

(iii) Other supplemental requests as defined in the Comprehensive and Supports Service Index, which is incorporated by reference.

(d) Emergency cases can arise for a person who is eligible for covered services but is on the wait list, or for participants currently receiving Comprehensive or Supports waiver services who may be determined to be in an emergency situation pursuant to Section 14(a) of this Chapter.

(e) The ECC shall have the authority to approve, partially approve, or deny a submitted funding request for any person deemed eligible for a waiver operated by the Division.

(f) Before submission, the participant's plan of care team shall meet and come to a consensus that an ECC request is necessary and other support or resource options have been explored. The case manager shall ensure the request contains, at a minimum:

(i) Written statements or reports from the other state or regional agencies that support the emergency case including specific incidents, notes related to the type of condition or injury, witnesses, follow-up, treatment summaries, and any documented accounts of events by witnesses;

(ii) Documentation of other approaches or supports that have been attempted;

(iii) Written statements from a credentialed professional related to the area of concern, explaining the significant change in the participant's functioning limitations that result in an assessed need for additional supports or services and how the person's life or health is in jeopardy without such supports and services;

(iv) Evidence that the person does not qualify for funding or services through any other agency that would alleviate the emergency situation; and

(v) For persons requesting services or supports due to homelessness, evidence that:

(A) Either:

(I) Other community resources, such as a victim's shelter, or other temporary residence are not available or appropriate; or

(II) Other community resources are insufficient to meet the person's immediate health and safety needs, and there is evidence of immediate and serious harm to the person's life or health; and

(B) Due to other conditions of the emergency or the person's condition, waiver services would be the necessary and appropriate intervention.

(g) A request may be made by the participant's plan of care team if they can demonstrate that a participant's Level of Service score does not reflect the participant's assessed need.

(h) A request shall be submitted on the form provided by the Division, and accompanied by additional information that the participant and the participant's plan of care team does not see adequately captured in the ICAP or in the information stored electronically by the Division.

(i) ECC requests that do not meet the criteria outlined in subsection (f) of this Section shall not be considered by the ECC.

(j) The ECC may request additional assessments, referrals, or outside consultation. The additional assessments and information may result in a level of service score increase, decrease, or no change. If the participant or plan of care team declines the additional requests, the ECC request shall be denied.

(k) Decisions of the ECC shall be by majority vote and issued in writing within twenty (20) business days of the ECC review.

(l) In cases of a tie vote among members, the Section Administrator or his/her designee shall issue the final vote.

(m) The Section Administrator or his/her designee may approve time limited funding while the ECC is rendering a final decision.

(n) An eligible individual denied services under this Section may request administrative review of that decision pursuant to Chapter 4 of the Department of Health's Medicaid Rules.

Section 16. Prohibited Use of Waiver Funds.

(a) The following services are not eligible for waiver services reimbursement:

(i) The care of individuals residing in a hospital, nursing facility, ICF/IID, or other institutional placement;

(ii) Wavier services provided by:

(A) A spouse of the participant, if the spouse is also the participant's legally authorized representative;

(B) A legally authorized representative of a participant who is eighteen (18) years of age or older; or

(C) An owner or officer of a provider organization if the organization is serving a participant for whom they are the legally authorized representative;

(iii) Room and board, except when provided as part of respite in a facility, other than a private residence, approved by Medicaid;

(iv) Services currently covered under the Medicaid State Plan;

(v) Services to an individual if it is reasonably expected that the cost of these services would exceed the institutional cost limit specified in the most current Comprehensive Waiver application approved by CMS, which is incorporated by reference; or

(vi) Service settings reimbursed by another state agency, such as the Department of Family Services or Department of Education.

(b) No direct service that is the responsibility of the school system shall be authorized as a waiver service. The Division shall not authorize direct waiver services for the hours the child is attending school or in a vocational program.

(i) Regular school hours and days apply for a child who receives home schooling or an adjusted school day.

(ii) Waiver services may be used if an individualized educational plan identifies specific times when the school system shall not cover services for the individual.

(c) Any individual eligible for funding for specialized services under the Developmental Disabilities Services Act shall apply for and accept any federal Medicaid benefits

for which they may be eligible and benefits from other funding sources within the Department of Health; the Department of Education; the Department of Workforce Services and Division of Vocational Rehabilitation; and other agencies to the maximum extent possible.

Section 17. Denial of Funding for Waiver Services.

(a) The Division may deny or revoke authorization for waiver services for any of the following reasons:

(i) The individual fails to meet waiver eligibility criteria as established in Section 4;

(ii) The eligible individual has not met emergency criteria and no other waiver funding opportunities are available;

(iii) The individual or legally authorized representative has not consented to waiver services;

(iv) The individual or legally authorized representative has chosen to receive ICF/IID or nursing facility services;

(v) The individual, his or her legally authorized representative, or other person on his or her behalf has not supplied needed information;

(vi) The participant's needs are not being met through waiver services;

(vii) The individualized plan of care has not been implemented;

(viii) The legislature has not appropriated sufficient fiscal resources to fund all services for all persons determined eligible for waiver services;

(ix) Funding for requested waiver services is available as a similar service from other sources, such as a school district or the Division of Vocational Rehabilitation;

(x) The eligible individual or legally authorized representative has failed to apply for, and accept any federal Medicaid benefits for which she or he may be eligible, or benefits from other funding sources within the Department of Health, the Department of Education, Department of Workforce Services, or other agencies to the maximum extent possible.

(xi) The eligible individual or legally authorized representative has not signed documentation required by the Department;

(xii) The eligible individual or legally authorized representative has failed to cooperate with, or refused the services funded by the Division; or

(xiii) The individual could receive educational services during a regular or adjusted school day, through the end of the school year in which the individual turns twenty-one (21) years old.

Section 18. Interpretation of Chapter.

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

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

Section 19. Superseding Effect. This Chapter supersedes all prior rules or policy statements issued by the Division, including provider manuals and provider bulletins, which are inconsistent with this Chapter.

Section 20. Severability. If any portion of this Chapter is found to be invalid or unenforceable, the remainder shall continue in full force and effect.

Section 21. Incorporation by Reference.

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

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

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

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

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

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

(ii) Referenced in Section 2 and 10 of this Chapter is Wyoming Medicaid's State Plan, incorporated as of the effective date of this Chapter and can be found at http://www.health.wyo.gov/healthcarefin/medicaid/spa.

(iii) Referenced in Section 2, 11, and 16 of this Chapter is Wyoming's Comprehensive and Supports Waiver Applications, incorporated as of the effective date of this Chapter and can be found at https://health.wyo.gov/behavioralhealth/dd/bhd-public-notices/.

(iv) Referenced in Section 2, 10, 12, and 15 of this Chapter is Wyoming's Comprehensive and Supports Waiver Service Index, incorporated as of the effective date of this Chapter and can be found at https://www.health.wyo.gov/behavioralhealth/dd/servicesandrates/.

(v) Referenced in Section 4 of this Chapter is the Diagnostic and Statistical Manual of Mental Disorders (DSM 5), incorporated as of the effective date of this Chapter and can be found at American Psychiatric Association Publishing, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209.

(vi) Referenced in Sections 10 and 11 of this Chapter is Section 110 of the Rehabilitation Act of 1973, incorporated as of the effective date of this Chapter and can be found at https://www.ssa.gov/.

(vii) Referenced in Sections 10 and 11 of this Chapter is Section 504 of the Rehabilitation Act of 1973, incorporated as of the effective date of this Chapter and can be found at https://www.ssa.gov/.

(viii) Referenced in Sections 10 and 11 of this Chapter is the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. 1401 *et seq.*), incorporated as of the effective date of this Chapter and can be found at https://www.ssa.gov/.