Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Wyoming** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
Comprehensive Waiver

C. Waiver Number:WY.1061

D. Amendment Number:WY.1061.R01.08

E. Proposed Effective Date: (mm/dd/yy)

02/01/21

Approved Effective Date: 03/30/21
Approved Effective Date of Waiver being Amended: 04/01/19

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

Due to catastrophic revenue declines in the State of Wyoming, Governor Mark Gordon has required all state agencies to reduce expenditures in order to meet new budget realities. The amendments to the Comprehensive Waiver program that address this directive have been identified in a thoughtful manner that aims to have the least impact on participants.

Proposed Changes
Appendix B - Participant Access and Eligibility
- Removed Inventory for Client and Agency Planning (ICAP) Assessment as a level of care assessment. The LT-104 assessment is used to determine level of care.
- Removed the LT-104 as a level of care assessment for individuals with an acquired brain injury. The LT-101 is the level of care assessment used to determine nursing facility level of care.
- Clarified that placement on the Comprehensive Waiver is based on:
  - Emergency cases approved by the ECC;
  - Participants on the Supports Waiver who choose to be on the Comprehensive Waiver, with selection based on participant needs.
- Decreased the unduplicated and point in time number of participants for waiver years 3, 4, and 5. Decreases will be realized through attrition. A like number of waiver slots will be added to the Supports Waiver.

Appendix I - Financial Accountability
- Noted the 2.5% across the board reduction of all provider rates, with the exception of the following services:
  - Homemaker
  - Dietician
  - Occupational Therapy Services
  - Physical Therapy Services
  - Skilled Nursing Services
  - Speech, Hearing, and Language Services

Appendix J - Cost Neutrality Demonstration
- Updated to reflect the 2.5% reduction of most provider rates.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☐ **Waiver Application**	
☐ **Appendix A Waiver Administration and Operation**	
☒ **Appendix B Participant Access and Eligibility**	2c, 3a, 3b, 3f, 6d, 6f, 6i
☐ **Appendix C Participant Services**	
☐ **Appendix D Participant Centered Service Planning and Delivery**	
☐ **Appendix E Participant**	

Component of the Approved Waiver	Subsection(s)
Direction of Services	
☐ Appendix F Participant Rights	
☐ Appendix G Participant Safeguards	
☐ Appendix H	
☒ Appendix I Financial Accountability	2a
☒ Appendix J Cost-Neutrality Demonstration	2a, 2d

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

- ☐ **Modify target group(s)**
- ☒ **Modify Medicaid eligibility**
- ☐ **Add/delete services**
- ☐ **Revise service specifications**
- ☐ **Revise provider qualifications**
- ☒ **Increase/decrease number of participants**
- ☒ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☐ **Other**

Specify:

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Wyoming** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Comprehensive Waiver

C. Type of Request: amendment

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Waiver Number:WY.1061.R01.08
Draft ID: WY.015.01.03

D. Type of Waiver *(select only one):*

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 04/01/19
Approved Effective Date of Waiver being Amended: 04/01/19

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (*check each that applies*):

☐ **Hospital**
Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**
If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☒ **Nursing Facility**
Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**
If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

The nursing facility level of care for the Comprehensive Waiver is limited to people with acquired brain injuries.

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☒ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**
If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

- (●) **Not applicable**
- ( ) **Applicable**

Check the applicable authority or authorities:

- [ ] **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**
- [ ] **Waiver(s) authorized under §1915(b) of the Act.**

  Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

  Specify the §1915(b) authorities under which this program operates *(check each that applies):*

  - [ ] **§1915(b)(1) (mandated enrollment to managed care)**
  - [ ] **§1915(b)(2) (central broker)**
  - [ ] **§1915(b)(3) (employ cost savings to furnish additional services)**
  - [ ] **§1915(b)(4) (selective contracting/limit number of providers)**
- [ ] **A program operated under §1932(a) of the Act.**

  Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:
- [ ] **A program authorized under §1915(i) of the Act.**
- [ ] **A program authorized under §1915(j) of the Act.**
- [ ] **A program authorized under §1115 of the Act.**

  Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

- [x] **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Comprehensive Waiver represents Wyoming's commitment to funding supportive and comprehensive services so eligible participants with intellectual and developmental disabilities (ID/DD) ages birth through the life span and people with an acquired brain injury ages 21 and older can actively participate in the community with friends and family, be competitively employed, be healthy and safe, and live as independently as possible according to their own choices and preferences. The waiver requires a person-centered approach to determine the support needs of participants in the individualized plan of care (IPC) and to assign the individual budgeted amount (IBA). Developing community connections, natural supports, and self-direction opportunities are essential components of the Comprehensive Waiver, along with providing traditional service delivery options.

Purpose
The purpose of the Comprehensive Waiver is to assist individuals and their families in obtaining person-centered services and utilizing both natural supports and paid providers to support individuals in their community. The self-direction option allows the flexibility for waiver participants to hire, fire, and train their own staff.

Organizational Structure
The Comprehensive Waiver is administered through the Wyoming Department of Health, which is the Single State Medicaid Agency (SMA). The Wyoming Department of Health, Division of Healthcare Financing (DHCF), administers and oversees the day to day operations of the Developmental Disability (DD) Waivers, which include the Supports (1060) Waiver and the Comprehensive (1061) Waiver. Through the State Medicaid Agent, the SMA maintains administrative authority over the DD Waivers and oversees DHCF performance of operational functions. DHCF performs daily operational and administrative functions, the application and eligibility process, prior authorization of services, utilization management, crisis resolution, critical incident reporting, complaint review and follow up, and quality management.

Service Delivery Methods
The Comprehensive Waiver provides participants and their families the opportunity for enhanced health, freedom, choice, control, and responsibility over services received through the statewide availability of self-directed service delivery. Waiver participants may also opt for traditional service delivery or a mix of the two.

Quality Management
Wyoming's quality management strategy is a continuous improvement model that includes tracking the efficiency and effectiveness of our operations, service offerings, and supports in achieving the desired outcomes for participants. This quality management strategy includes discovery, planning, monitoring, implementation, and evaluation of our processes to determine if the waiver operates in accordance with the program's quality design, to assure the health and welfare of participants, and to identify opportunities for continuous improvement.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and

other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ○ **Not Applicable**
- ◉ **No**
- ○ **Yes**

C. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ◉ **No**
- ○ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the state provides the following assurances to CMS:

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

The public comment period for the Comprehensive Waiver amendment (WY.1061.R01.08) ran from October 26 - November 25, 2020. DHCF collaborated with the Wyoming Governor's Council on Developmental Disabilities (WGCDD) to promote the public comment period. The WGCDD promoted the public comment period on the email lists and social media outlets available to them. Communications were sent to the Developmental Disability (DD) email lists on October 26th, November 4th, and November 20th. A public forum was conducted via phone conference on Thursday, November 5, 2020 from 11:00am – 12:00pm. Additionally, DHCF conducted provider and case manager support calls on October 26th and November 9th respectively. Case managers were strongly encouraged to ensure that participants and families were aware of the public comment period, and provide information on where the documents and other relevant information could be found.

The Comprehensive waiver amendment, a summary of the proposed changes, and the full waiver application were published to the DHCF website at https://health.wyo.gov/healthcarefin/dd/dd-public-notices/ on October 23, 2020. The Division distributed a Notice of Intent to Amend to Tribal Governments on September 14, 2020. The notice invited Tribal Governments to submit written comments and/or request additional consultation within 30 days of the notice. The Division did not receive any written comments or requests for additional consultation in response to the notice. The Tribal Governments were invited and encouraged to submit public comments through the broader public comment period as well.

A public notification was sent to the Casper Star Tribune, the statewide newspaper. This notification was published on October 25, 2020. The text of the public notice is available upon request.

Summary of Public Comment
DHCF received twenty-five (25) written public comment submissions, which applied to both the Comprehensive and Supports Waivers. In addition, twelve (12) individuals provided input during the phone conference conducted on November 5, 2020. Overall, 30 (thirty) unduplicated individuals provided comment, 6 of whom provided comment regarding the same participant of waiver services.

Comments centered on a couple of general themes:

* Elimination of identified services, specifically therapies and skilled nursing.
* Overall budget reductions to waiver services, and the impact the reductions could have on participants and providers.

Comments related to therapy services were focused on how the elimination of these services could affect the participant's overall health and quality of life. It is noted that several commenters indicated that they are already seeing decreases in participant functioning related to therapies (swallowing, range of motion, muscle contractures) due to decreased therapeutic care during the COVID-19 public health emergency. Concerns included the following:

* Decreased ability to communicate without ongoing therapy to assist and instruct on the use of communication devices
* More difficulty swallowing, which could result in increased hospitalizations
* Skin breakdown and increased muscle contractures due to decreased occupational and physical therapy
* Decreased dexterity and ability to perform activities of daily living, which could result in difficulty to communicate and decreased independence.

Comments related to skilled nursing were focused on how the elimination of this service could have fatal implications for the participants who currently receive skilled nursing. Of particular note is a participant who needs skilled nursing during nighttime hours while the family sleeps; the participant receives medical care from the family during daytime hours and at least one night a week. Overall, concerns centered on how the decrease in this service would result in more hospitalizations and potentially life threatening circumstances.

In three instances the commenter stated that the proposed elimination of services will reduce choice but will not reduce costs since a correlating reduction to the participant's budget would not be implemented. Additionally, several commenters stated that the anticipated increase in hospitalizations and institutionalizations would negate any cost savings from the elimination of the services and would, in theory, increase costs overall.

Comments related to the overall reductions to waiver programs were focused on how providers would be impacted, the ongoing concern with finding qualified staff members to work with participants, and how reductions, including those related to service elimination, would affect the overall economy with potential job losses.

DHCF also received one comment related to ICAP assessments and one comment related to the elimination of Homemaker services.

The full text of the public comment is available upon request.

In response to the public comments received, the State will not include removing any covered services from this waiver application. This will also allow for the 66th Wyoming State Legislature to consider state agency budget reductions and provide an appropriation for this program. Dependent upon the actions of the 66th Wyoming State Legislature, the State will proceed with any further changes to this waiver application as required.

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Pratt

First Name: Shirley

Title: Medicaid Waiver Policy Analyst

Agency: Division of Healthcare Financing

Address: 6101 Yellowstone Road, Suite 220

Address 2:

City: Cheyenne

State: **Wyoming**

Zip: 82002

Phone: (307) 777-2525 **Ext:** ☐ **TTY**

Fax:

(307) 777-6934

E-mail:

shirley.pratt@wyo.gov

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Wyoming**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature: Lee Grossman

State Medicaid Director or Designee

Submission Date: Mar 4, 2021

Note: The Signature and Submission Date fields will be automatically completed when the State

Medicaid Director submits the application.

Last Name: Lee

First Name: Grossman

Title: HCBS Administrator

Agency: Wyoming Department of Health, Division of Healthcare Financing

Address: 122 W 25th St, 4 West

Address 2:

City: Cheyenne

State: **Wyoming**

Zip: 82002

Phone: (307) 777-7460 **Ext:** ☐ **TTY**

Fax: (307) 777-6934

E-mail: lee.grossman1@wyo.gov

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☒ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

The decrease to the unduplicated count will be achieved through attrition. As participants leave the Comprehensive Waiver, that slot will be eliminated. The state does not anticipate that current Comprehensive Waiver participants will be affected by the decrease in unduplicated counts. The state does not anticipate that current Comprehensive Waiver participants will be affected by the decrease in unduplicated counts; therefore, participants were not notified of their right to a fair hearing. As a standard practice, any instance in which a waiver participant is no longer eligible for the program results in a participant receiving notification of their right to a fair hearing at the time they are informed of their eligibility determination.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The state assures that this waiver renewal will be subject to any provisions or requirements included in the state’s approved home and community-based settings Statewide Transition Plan. The state will implement any required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Behavioral support has been revised to include tiered service options. The Division used Colorado rates for graduate Board Certified Behavior Analyst (BCBA) and paraprofessional Registered Behavior Technician (RBT) tier levels. These rates were developed using SFY 2017 data. The Division used Alabama rates for the undergraduate Board Certified Assistant Behavior Analyst (BCaBA) tier level. This rate was developed using 2018 data. These rates are temporary, and do not include any adjustments for inflation or geographical differences. A Wyoming specific rate will be developed as part of the next rate rebasing, which is scheduled to be implemented in July, 2022.

These service tiers are specific to the professional who provides the service. These are not tier levels that necessarily correspond with a level of service or other specific assessment score. The behavioral professional will determine the mix of professional services needed (Master level Board Certified Behavioral Analyst versus a Registered Behavior Technician providing more paraprofessional services), and will bill accordingly, based on what was approved in the plan. Participants are not assigned to a specific tier. The participant will receive the appropriate professional level of service, based on the determination of the behavioral professional conducting the assessment and development of the Positive Behavior Support Plan.

The qualifications and description for the RBT can be found at https://www.bacb.com/rbt/. The qualifications and description for the RBT can be found at https://www.bacb.com/bcaba/. The qualifications and description for the BCBA can be found at https://www.bacb.com/bcba/.

Public Notice for initial rate methodology
Rate determination methods and rates are reviewed and approved by the SMA. In addition to the public process described above, DHCF also solicits public comments by means of a public notice when changes in methods and standards for establishing payment rates under the Waiver are proposed. The notice is published in accordance with federal requirements at 42 CFR 447.205, which prescribes the content and publication criteria for the notice. Whenever rates change, DHCF makes listings of all covered services and corresponding rates available to clients and their families and service providers.

Information on payment rates are available to participants during team meetings. Rates are posted on DHCFs website and are available upon request.

DHCF monitors provider enrollment data on a quarterly basis. Provider enrollment is monitored on a regional basis to assess the provider network adequacy in all areas of Wyoming. Fluctuations in the provider network precipitates further analysis to determine the cause, which would include provider payment rates.

DHCF will make changes to established rates based on the monies appropriated by the Wyoming Legislature. Participants, providers, and other stakeholders will be notified of across the board increases and decreases to these rates

Public notice for the 2.5% reduction of rates is explained in 6-I of the Main Section of this application.

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   ◉ **The waiver is operated by the state Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

   ◉ **The Medical Assistance Unit.**

   Specify the unit name:

   Division of Healthcare Financing (DHCF)

   (Do not complete item A-2)

   ○ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

   Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

○ **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

All contracts are written between the contracting entity performing waiver operational and administrative functions and the SMA. The SMA oversees DHCF, and has administrative oversight and supervision of contracts, and day to day operations.

Level of Care Evaluation
The Division maintains a memorandum of understanding (MOU) with the Wyoming Department of Health, Public Health Division to conduct level of care evaluations. The Public Health Division oversees a statewide network of Public Health Nursing County Offices. Public health nurses from the county offices conduct the level of care evaluations and submit evaluation data through the Division's case management information system. The Division establishes the level of care evaluation criteria and retains the authority to make final level of care determinations.

Medicaid Management Information System (MMIS)
DHCF has a contract for the operation and management of MMIS to review and pay all claims submitted by providers of the DD waivers. This contractor assists the State with prior authorization, provider enrollment, and the execution of provider agreements. Specific tasks include:
- Generating prior authorization numbers after the approved service plan has been loaded into the client database, which interfaces with the MMIS system;
- Processing the Medicaid provider enrollment application after the provider is certified;
- Executing and storing provider agreements according to contractor requirements.

Utilization Review and Quality Assurance
DHCF has a contract for utilization review. This Contractor conducts case review for DHCFs mortality review process.

Inventory for Client and Agency Planning (ICAP) Assessment
DHCF has a contract to conduct ICAP assessments for Waiver applicants and participants as part of the eligibility and level of care process.

Medical Evaluation
DHCF has a contract to conduct a review of medical documentation for participants diagnosed with an acquired brain injury to confirm brain injury diagnosis as outlined in Appendix B-1(b).This contractor also authorizes skilled nursing services.

Financial Management Services
DHCF monitors the performance of the Financial Management Services (FMS) agency. The primary function of the FMS in relation to participant-directed services, as outlined in the waivers, is to address federal, state, and local employment tax, labor, and workers compensation insurance rules and other requirements that apply when the participant functions as the employer of workers.

The Department’s contract with the FMS vendor outlines the requirements of the FMS to act as agent for the employer/participant in gathering and maintaining relevant employee information; maintaining employer and employee files with necessary tax, IRS, and payroll information; and providing a system for payment of services rendered (payroll to DSW) that takes into account any Department of Employment and waiver specific restrictions as applicable (e.g.: overlapping services, waiver-identified service caps, excess of 40 hours/week, over utilized budget) and verifies submitted timesheets against these expectations.

○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

◉ **Not applicable**

○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

DHCF is responsible for the oversight of existing contracts related to DD Waiver operations and administrative functions.

Level of Care Evaluation
DHCF reviews information provided under this contract related to the LT-101 assessment.

MMIS
DHCF reviews information provided under this contract related to prior authorization, provider enrollment, and provider agreements.

Utilization Review and Quality Assurance
DHCF reviews information provided under this contract related to mortality review.

ICAP Assessment
DHCF monitors the timeliness and quality of the ICAPs conducted to ensure compliance with the contract.

Medical Evaluation
DHCF reviews information related to neuropsychological and skilled nursing assessments, monitors timelines, and notifies the contractor of concerns or non-compliance with contract deliverables.

FMS
Oversight of the FMS includes a review of records to assure adherence to IRS and federal, state, and local rules and regulations, timely and accurate processing of time sheets, timely and accurate maintenance of current participant budget information, and assessment of participant/representative and worker satisfaction with FMS services. Processes are explained in Appendix E of this application.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

Level of Care Evaluation
DHCF ensures compliance with the provisions of the MOU through ongoing and periodic monitoring activities such as the review and acceptance of reports/deliverables, on-site/desk audits, data analyses, regular status meetings, and documentation reviews. Performance is assessed at least annually but may be assessed more frequently as determined necessary.

MMIS
DHCF continually assesses the performance and compliance of the MMIS contractor (Conduent) based on requirements in the contract and the business rules provided to the contractor. Monthly contract management meetings are held with the contractor to review the status of projects and to address any identified problems. Regular status meetings are held by the contractor to update DHCF, review project lists, and monitor timelines for completion.

Utilization Review and Management
DHCF continually assesses the performance and compliance of the Utilization Review contractor (OPTUM) based on requirements in the contract. Weekly contract management meetings are held with the contractor to review the status of projects and to address any identified problems. DHCF attends mortality review meetings and monitors the case review information provided by the contractor. Monitoring criteria includes but is not limited to ensuring the contractor requested and obtained records based on the appropriate claim period, conducted an objective and thorough case review, and submitted timely written reports of the findings.

ICAP
DHCF conducts monthly monitoring of the timeliness of the ICAP contractor to ensure compliance with the contract. The contractor records the time it took to complete each ICAP, and submits this information to DHCF monthly. DHCF monitors any concerns with the ICAPs conducted, and meets with the contractor as needed to address concerns. The State Medicaid Agent or designee reviews the quarterly management report, which details oversight activities and findings.

FMS
DHCF has developed a tiered approach to monitoring the performance of the FMS contractor, including oversight by the DHCF, the case manager, and the Medicaid Program Integrity Unit.

1. The case manager reviews the performance of the FMS contractor during the required monthly home visit with the participant. The case manager is required to document the specific concerns, complete and document follow-up actions to address the concerns, and assure the concerns are resolved. Follow-up actions include, as appropriate:
- Direct contact with the FMS contractor informing them of concerns, and working with them to resolve the issues.
- Meeting with appropriate parties involved, including the employee of the participant who is involved in situation and FMS contractor, to work through the concerns.
- Reporting issues to DHCF if significant concerns are identified that impact health and safety, indicate potentially fraudulent activity, or if concerns are not addressed by the FMS contractor after the case manager has worked directly with them. A summary of issues reported and action taken are forwarded to the State Medicaid Agent or designee.

2. DHCF monitors the FMS contractor through the following processes:
- Monitoring monthly budget utilization reports for all participants self-directing services to assure business rules are being followed and reports are accurately reflecting service utilization.
- Completing a bi-annual representative sample of individuals utilizing this service. The representative sample has a confidence interval of 95% +/- 5% error rate. The review includes:
  - o A review of individual files to verify the FMS contractor has all required employee information and verification of withholdings as detailed in Appendix E;
  - o Customer satisfaction interviews with both the employer of record and employees, including timely processing of timesheets, timely resolution to customer service calls and complaints, and assistance in completing enrollment packets; and
  - o A review of the FMS contract.

3. Based on referrals, the Medicaid Program Integrity Unit reviews claims paid to providers through the following processes:
- Reviewing claims paid to the FMS contractor and supporting documentation to verify that the documentation supports the billing and payment for services.
- Recovering funds paid to the FMS contractor for claims that are not sufficiently documented.

DHCF conducts an annual review of the FMS contractor business practices to verify all required IRS regulations, as well as state unemployment and worker's compensation regulations, are addressed. A copy of the contractor annual audit is requested and reviewed. If concerns are found through any of these processes, the FMS contractor is required to address the concerns within a specified time period and, when applicable, to pay corresponding penalties and fees. The FMS contract includes clauses for termination of contract if serious concerns are identified. A summary of review findings are forwarded to the State Medicaid Agent or designee.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	☒	☐
Waiver enrollment managed against approved limits	☒	☐
Waiver expenditures managed against approved levels	☒	☐
Level of care evaluation	☒	☒
Review of Participant service plans	☒	☐
Prior authorization of waiver services	☒	☒
Utilization management	☒	☒
Qualified provider enrollment	☒	☒
Execution of Medicaid provider agreements	☒	☒
Establishment of a statewide rate methodology	☒	☐
Rules, policies, procedures and information development governing the waiver program	☒	☐
Quality assurance and quality improvement activities	☒	☒

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. **Methods for Discovery: Administrative Authority**
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. **Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
A.i.a - Percentage of contract deliverables met for all contracted functions of the MMIS contract (# of contract deliverables met / # of contract deliverables)

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.i.b - Percentage of contract deliverables met for all contracted functions of the Utilization Review and Quality Assurance contract (# of contract deliverables met / # of contract deliverables)

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.i.c - Percentage of contract deliverables met for all contracted functions of the ICAP Assessment contract (# of contract deliverables met / # of contract deliverables)

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.i.d - Percentage of contract deliverables met for all contracted functions of the Medical Evaluation contract (# of contract deliverables met / # of contract deliverables)

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.i.e - Percentage of contract deliverables met for all contracted functions of the Financial Management Services contract (# of contract deliverables met / # of contract deliverables)

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Methods for remediation with contractors shall include notification to the contractor about any concerns the State has with performance as soon as they are identified, education and guidance provided to the Contractor regarding the State's expectations for performance under the contract, and modification to the language in the contract to more clearly articulate the expectations of the State. If contract performance does not improve, payment shall be withheld until a solution is reached. The contract can also be terminated.

The Wyoming Attorney General requires the inclusion of a termination clause for all state contracts. At a minimum, the following language must be included: "This Contract may be terminated, without cause, by the Agency upon thirty (30) days written notice. This Contract may be terminated by the Agency immediately for cause if the Contractor fails to perform in accordance with the terms of this Contract."

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ Aged or Disabled, or Both - General					
	☐	Aged			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
☒ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☒	Brain Injury	21		☒
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☒ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☒	Developmental Disability	0		☒
	☒	Intellectual Disability	0		☒
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

b. Additional Criteria. The state further specifies its target group(s) as follows:

In order to be eligible for the DD Waivers, an applicant must meet the eligibility criteria outlined in Chapter 46, Section 4 of the Department of Health's Medicaid Rules.

The psychological evaluation provides verification that the individual meets the qualifying diagnosis for a developmental or intellectual disability. The neuropsychological evaluation provides verification that an individual meets the qualifying diagnosis for an acquired brain injury.

Diagnoses and assessments used to meet initial clinical eligibility must be accurate and no more than five (5) years old. Any assessment or reassessment for eligibility is subject to review by DHCF before acceptance, and may require additional evidence or verification.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

◉ **Not applicable. There is no maximum age limit**

○ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

○ **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

○ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

The limit specified by the state is *(select one)*

○ **A level higher than 100% of the institutional average.**

Specify the percentage:

○ **Other**

Specify:

○ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

◉ **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The individual cost limit for the Comprehensive Waiver is $264,430.42, which is the weighted average of the per person annual forecasted SFY2019 cost at the state's only ICF-IID ($280,665.50) and state funded nursing home costs ($40,183.34). The current average plan amount for participants on the Comprehesive Waiver is $47,513 per year. Based on current and historical plan costs, the $264,430.42 has been determined sufficient to assure the health and welfare of waiver participants.

The cost limit specified by the state is *(select one)*:

◉ **The following dollar amount:**

Specify dollar amount: 264430

The dollar amount *(select one)*

○ **Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

◉ **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**

○ **The following percentage that is less than 100% of the institutional average:**

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

If a person's assessed needs indicate a budget amount in excess of the cost limit on the Comprehensive waiver, the budget may be approved by the ECC. DHCF will also work with the participant's team on other treatment, behavior, or medical support services to improve the person's condition and lower the cost of services over time.

Any applicant denied entrance onto the Comprehensive Waiver is offered the opportunity to request a Fair Hearing, as provided in Appendix F-1.

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☒ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

If the plan of care team identifies that a participant requires services that are in excess of the individual cost limit, the case manager must submit an ECC request to DHCF for review.

If the assessed need for services above the individual cost limit is verified by DHCF, then the individual's IBA may be temporarily increased above the individual cost limit. The increase will be reviewed on an annual basis to ensure ongoing appropriateness. The case manager and plan of care team will work toward transitioning the person into less expensive services, which still meet the person's needs, over time. Referrals to other appropriate services or state programs for which they are eligible and assure the person's health and safety will also be investigated.

If significant changes in the health or welfare needs of a participant require a permanent or long term increase in funding above the individual cost limit, the IBA may be approved by the ECC.

Notification of budget reductions includes a referral to other state services or waivers for which the participant is likely eligible. The participant is also offered the opportunity to request a Fair Hearing, as provided in Appendix F-1.

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	2150
Year 2	2150
Year 3	2116
Year 4	2082
Year 5	2048

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)*:

○ **The state does not limit the number of participants that it serves at any point in time during a waiver year.**

◉ **The state limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	1911
Year 2	1911
Year 3	1877
Year 4	1843
Year 5	1809

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

○ **Not applicable. The state does not reserve capacity.**

◉ **The state reserves capacity for the following purpose(s).**

Purpose(s) the state reserves capacity for:

Purposes	
Eligible Dependents of Qualified Military Service Members	
Emergency Cases	
Transitions from a state-funded institution	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Eligible Dependents of Qualified Military Service Members

Purpose *(describe):*

Per Wyoming House Enrolled Act 60 (2017 HEA 0060) and Chapter 46, Section 13 of the Department of Health's Medicaid Rules, the State reserves capacity for seven (7) people annually for dependents of qualified military service members who claim Wyoming residency on their leave and earnings statements while serving in the military. Upon receiving military orders to serve in Wyoming, or upon receiving retirement or separation orders, dependents who left the state for military reasons shall, upon their return to the state, be placed in a state identical to where they would be if they had not left the state.

Describe how the amount of reserved capacity was determined:

Information was derived from the Wyoming Military Department.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	7
Year 2	7
Year 3	7
Year 4	7
Year 5	7

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Emergency Cases

Purpose *(describe):*

The State annually reserves capacity for twenty-five (25) people who meet the criteria for an emergency case, as outlined in Chapter 46, Section 14 of the Department of Health's Medicaid Rules.

Describe how the amount of reserved capacity was determined:

DHCF reviewed data on the number of emergency placement requests that have been submitted to DHCF , which have or would result in a person receiving funding before other people waiting for services.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	25
Year 2	25
Year 3	25
Year 4	25
Year 5	25

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Transitions from a state-funded institution

Purpose *(describe):*

Pursuant to Chapter 46, Section 13 of the Department of Health's Medicaid Rules, the State annually reserves capacity for twenty-five (25) people who are transitioning out of state funded institutions such as the state ICF/IID, nursing home, psychiatric residential treatment facility, BOCES, residential treatment facility, or an inpatient psychiatric hospital and have been:

- In residence at a state funded institution; or
- On a DD Waiver wait list; or
- A previous participant on a DD waiver prior to becoming a resident at a state funded institution.

Describe how the amount of reserved capacity was determined:

DHCF reviewed data on the number of transition requests from institutions that have been submitted to DHCF, which have or would result in a person receiving funding before other people waiting for services.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	25
Year 2	25
Year 3	25
Year 4	25
Year 5	25

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

◉ **The waiver is not subject to a phase-in or a phase-out schedule.**

○ **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

◉ **Waiver capacity is allocated/managed on a statewide basis.**

○ **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

DHCF will allow applicant onto the Comprehensive Waiver up to the approved point in time limit, based on the following priorities:

1. Emergency cases approved by the ECC;
2. Participants on the Supports Waiver who choose to be on the Comprehensive Waiver.

Reserved capacity slots will be funded as requests are presented and approved by DHCF.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. **1. State Classification.** The state is a *(select one)*:

- (●) **§1634 State**
- ( ) **SSI Criteria State**
- ( ) **209(b) State**

2. Miller Trust State.
Indicate whether the state is a Miller Trust State *(select one)*:

- ( ) **No**
- (●) **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- [ ] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [ ] **Optional state supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

  - ( ) **100% of the Federal poverty level (FPL)**
  - ( ) **% of FPL, which is lower than 100% of FPL.**

  Specify percentage: [ ]

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [x] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility**

group as provided in §1902(e)(3) of the Act)

☐ **Medically needy in 209(b) States (42 CFR §435.330)**

☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

☒ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Any aged, blind or disabled individual who loses eligibility for SSI due to an increase in income, but who would be eligible for SSI if the Cost of Living Adjustments (COLA) received since the SSI termination were disregarded, as specified in 42 C.F.R. 435.135.

Individuals who lose SSI benefits due to the entitlement of SSA widow/widower benefits, as specified in Section 1634(d) of the Social Security Act.

Populations outlined at 42 CFR 435.110, 435.116, and 435.118.

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

○ **No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*

◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

☒ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The state uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who

is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

○ **The following standard included under the state plan**

Select one:

○ **SSI standard**
○ **Optional state supplement standard**
○ **Medically needy income standard**
○ **The special income level for institutionalized persons**

(*select one*):

○ **300% of the SSI Federal Benefit Rate (FBR)**
○ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

○ **A dollar amount which is less than 300%.**

Specify dollar amount:

○ **A percentage of the Federal poverty level**

Specify percentage:

○ **Other standard included under the state Plan**

Specify:

○ **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

◉ **The following formula is used to determine the needs allowance:**

Specify:

The maintenance needs allowance is equal to the individual's total income as determined under the posteligibility process which includes income that is placed in a Miller trust.

○ **Other**

Specify:

ii. Allowance for the spouse only (*select one*):

◉ **Not Applicable**

○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

○ **SSI standard**
○ **Optional state supplement standard**
○ **Medically needy income standard**
○ **The following dollar amount:**

Specify dollar amount: [ ] If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

◉ **Not Applicable (see instructions)**
○ **AFDC need standard**
○ **Medically needy income standard**
○ **The following dollar amount:**

Specify dollar amount: [ ] The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

○ **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's

Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- (●) **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ( ) **The state does not establish reasonable limits.**
- ( ) **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ( ) **SSI standard**
- ( ) **Optional state supplement standard**
- ( ) **Medically needy income standard**
- ( ) **The special income level for institutionalized persons**
- ( ) **A percentage of the Federal poverty level**

  Specify percentage:

- ( ) **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised

- (●) **The following formula is used to determine the needs allowance:**

  Specify formula:

The maintenance needs allowance is equal to the individual's total income as determined under the posteligibility process which includes income that is placed in a Miller trust.

○ **Other**

Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

◉ **Allowance is the same**

○ **Allowance is different.**

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

◉ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

○ **The state does not establish reasonable limits.**

○ **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The state requires (select one):

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- (●) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- ( ) **By a government agency under contract with the Medicaid agency.**

Specify the entity:

○ **Other**
Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

DHCF staff perform the initial Level of Care (LOC) evaluation for waiver applicants with a diagnosis of an intellectual or developmental disability, and are required to have the training and experience equivalent to a bachelor's degree in business or public administration, social services, psychology, counseling or education, PLUS two years of professional work experience in training, counseling, or planning, or administering services for persons in a developmental disability or acquired brain injury.

LOC evaluations for waiver applicants with a an ABI are performed by a registered nurse employed by a State of Wyoming Public Health Office, with a current good standing license from the Wyoming State Board of Nursing, who has received training and a guidance manual to conduct medical necessity evaluations

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

ICF/IID Level of Care Evaluation
The LT-104 form gathers information on the individual’s conditions that indicate the person may have an intellectual or developmental disability, according to the Wyoming definition, and is used to determine that an individual meets the ICF/IID LOC. The LT-104 is performed annually to reevaluate ongoing need for the ICF/IID LOC.

Nursing Facility Level of Care Evaluation
The LT-101 tool is administered by Public Health Registered Nurse to determine nursing facility LOC. The assessment documents functional status and level of assistance needed to complete activities of daily living (ADLs) and instrumental activities of daily living (IADLs). The Wyoming Department of Health Medicaid Rules, Chapter 22 Nursing Facility/Long Term Care-Home and Community Based Services Evaluation of Medical Necessity specify the criteria for meeting Medicaid nursing facility level of care.

The cost of these assessments is covered as an administrative expense.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

◉ **The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**

○ **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The reevaluation process includes the annual LOC assessment using the LT-104 or LT-101, which verifies that the person continues to meet the level of care for the demographic.

Because a participant's condition and limitations do not change frequently with a DD/ID diagnosis, subsequent psychological evaluations are only required if a drastic change in the person's condition occurs. For people with an ABI, a neuropsychological evaluation is completed every five years.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**
  Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**
  Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care *(specify):*

DHCF requires an annual submission of the LT-104 or LT-101 LOC assessment from the individual's case manager or a public health nurse, respectively, before the IPC is approved.

DHCF reviews the LOC assessment, and any subsequent psychological evaluation or neuropsychological evaluation to assure the participant meets the eligibility requirements as detailed in B.6.f. and to ensure the LOC determination has been completed within the required timeframe.

To ensure timeliness, the case manager and public health nurse receive notification that the LOC assessment is due 90 days prior to the expiration of the current LOC assessment. No IPC can be approved without an approved LOC assessment.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The case manager and DHCF are required to maintain all evaluation and reevaluation records for a minimum of six (6) years.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
B.i - Percentage of initial applicants who had a level of care assessment prior to eligibility determination (# of initial applicants with LOC assessment completed within 30 days of choosing a case manager / # of LOC assessments completed)

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
Electronic Medicaid Waiver System (EMWS, or its successor

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or

sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. *Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
B.ii - Percentage of annual level of care assessments conducted for each eligible participant in accordance with DHCF standards and the approved waiver (# of eligible participants with an LOC assessment conducted in accordance with DHCF standards and the approved waiver / # of all eligible participants)

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
EMWS, or its successor

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The anticipated outcome for this data collection is ensuring that participants receive an accurate level of care based on processes and instruments implemented by the State. The state will review the performance measure data for this assurance on a quarterly basis. If, during a quarterly review, there are areas that do not meet anticipated outcomes, DHCF will ensure that issues caused by failure to follow process or policy are remedied through technical assistance and re-education at an individual level and, where possible, through statewide case manager training. DHCF will continue to study the data collected from this measurement and make recommendations to the Medicaid agent regarding adjustments to policy, procedure, or systems as necessary in order to improve the efficacy with which the waiver is administered.

On a quarterly basis, DHCF will review performance measures. However, EMWS generates a monthly level of care report that identifies any LOC assessment that is incomplete, late, or inaccurate. If late submissions become habitual for a specific case manager, then a corrective action plan is issued.

Original source data is stored on EMWS or its successor

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DHCF provides the applicant and legally authorized representative, if applicable, information on waivers and institutional services available, so the applicant can make an informed choice of institutional or community-based services. The application guide also includes written information on the applicant's choice of waiver or institutional services. The applicant selects his/her choice and signs the application, indicating s/he understands the choice of institutional or community based services.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

DHCF maintains all applications for a minimum of six (6) years.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

DHCF utilizes an interpreter service provider, which is used by the State Medicaid Agent for other Medicaid beneficiaries. If needed, the case manager submits a request for interpreter services indicating 1) the language needed, 2) the materials that need translation, and 3) if the translation is needed in written form, verbally, or both. The IPC or other waiver materials shall be translated into another language upon request. If a significant number of beneficiaries request written materials in a language other than English, DHCF will ensure materials are available in that language as a normal course of business.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	**Adult Day Services**		
Statutory Service	**Case Management**		
Statutory Service	**Community Living Services**		
Statutory Service	**Community Support Services**		
Statutory Service	**Homemaker**		
Statutory Service	**Personal Care**		
Statutory Service	**Respite**		
Statutory Service	**Supported Employment**		
Extended State Plan Service	**Dietician Services**		
Extended State Plan Service	**Occupational Therapy**		
Extended State Plan Service	**Physical Therapy**		
Extended State Plan Service	**Skilled Nursing**		

Service Type	Service		
Extended State Plan Service	**Speech, Hearing and Language Services**		
Other Service	**Behavioral Support Services**		
Other Service	**Child Habilitation Services**		
Other Service	**Cognitive Retraining**		
Other Service	**Companion Services**		
Other Service	**Crisis Intervention Support**		
Other Service	**Environmental Modification**		
Other Service	**Individual Habilitation Training**		
Other Service	**Special Family Habilitation Home**		
Other Service	**Specialized Equipment**		
Other Service	**Transportation**		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Services

HCBS Taxonomy:

Category 1: 04 Day Services

Sub-Category 1: 04060 adult day services (social model)

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Adult day services consist of meaningful daytime activities that maximize or maintain skills and abilities; keep participants engaged in their environment and community through optimal care and support; actively stimulate, encourage, develop, and maintain personal skills; introduce new leisure pursuits; establish new relationships; improve or maintain flexibility, mobility, and strength; or build on previously learned skills. Adult day services provide active, person-centered supports which foster independence as identified in the participant's IPC.

Adult day services include personal care, protective oversight, and health maintenance activities such as medication assistance and routine activities that may be provided by unlicensed, DHCF certified direct support professionals identified in the IPC. Personal care services shall not exceed 20% of the provided service.

Adult day services may be provided in the participant's home if the participant/guardian and the plan of care team decides the home is a more appropriate place to receive the service and the approved plan of care supports the medical, behavioral, or other reason for the service to be provided in the person's home. The participant and guardian must have a choice in where the service will be received. IPC documentation shall demonstrate that the opportunity for community integration, support for employment, and social interactions is still incorporated in the IPC. Transportation is a component of adult day services and is included in the rate to providers.

Adult day services is billed as a 15 minute or daily rate.

A participant receives a tiered service approved in the IPC based upon need, according to the following tier descriptions:

Basic Level of Care
A participant with a Level 1 or 2 Level of Service (LOS) score will generally be in this tier. This service tier requires limited staff supports for, and personal attention to, a participant daily due to a moderately high level of independence and functioning. Behavioral needs, if any, can be met with medication or informal direction by staff. The person may have periods of time with indirect staff supervision where staff are onsite and available through hearing distance of a request.

Intermediate Level of Care
A participant with a Level 3 or 4 LOS will generally be in this tier. Service tier requires full-time heightened supervision with staff available as indicated in the IPC due to significant functional limitations, medical or behavioral needs. Behavioral and medical supports are not generally intense and can be provided in a shared staffing environment. Regular personal attention is given throughout the day for personal care, reinforcement, community, or social activities.

High Level of Care
A participant with a Level 5 or 6 LOS will generally be in this tier. Service tier requires full-time supervision with staff available within close proximity and as indicated in the IPC. Frequent staff interaction and personal attention for significant functional limitations and medical or behavioral needs shall be provided. Support and supervision needs are moderately intense, but can still generally be provided in a shared staffing environment unless otherwise specified in the IPC. Frequent personal attention shall be given throughout the day for reinforcement, positive behavior support, personal care, community, or social activities.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Adult day services are available to individuals who are 21 years of age or older. This is not a habilitation service.

Approved units will be based on individual level of support need and must fit within the assigned budget. A minimum of six (6) hours per day must be provided in order for the daily rate to be billed. A 15 minute unit and daily rate shall not be billed on the same day.

A relative provider (defined as a biological, adoptive, or step parent) may provide this service subject to compliance with Chapter 45, Section 31 of the Department of Health's Medicaid Rules. Adult day services shall not be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the State Medicaid Agency.

Support with personal care needs, including medication assistance, is a component of the service, but shall not comprise the entirety of the service. Personal care services shall not be billed at the same time as this service. Individuals in this adult day services shall not be paid for work activities performed during this service.

A participant's IPC may include two or more types of non-residential services as long as service times do not overlap. Services shall not exceed an average weekly amount of 35 hours if the individual receives level 3-6 community living services, The daily rate shall not be billed if the participant receives level 3-6 of community living services and receives other non-residential services during the day.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency certified by DHCF to provide service

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Adult Day Services

Provider Category:

Agency

Provider Type:

Agency certified by DHCF to provide service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider, including a sole proprietor, of this service is required to attain and maintain a certification for this service from the DHCF. If a provider meets the criteria outlined in Section 25 of Chapter 45 of the Department of Health's Medicaid Rules, it shall attain and maintain accreditation by a nationally recognized accreditation entity for human services as specified.

Other Standard *(specify):*

A provider of this service shall meet the requirements in Chapter 45 of the Department of Health's Medicaid Rules. Requirements for providers and provider direct care staff include, but are not limited to: a successful criminal history background screening; a current CPR and First Aid certification; a current Medication Assistance certification for direct care staff assisting participants with medications; a current crisis intervention and restraint usage certification, if applicable; and a current driver's license and automobile insurance, if providing transportation. Direct care staff shall complete participant specific training prior to providing services to the participant. In addition to Chapter 45 requirements, providers shall adhere to the standards and requirements of all applicable Medicaid rules and regulations specified in the Provider Manual and Provider Agreement.

A provider shall ensure that services occur in settings that are community based and facilitate opportunities for participants to access the community and community resources to the same degree as people who do not have a disability. A participant shall have choice in with whom s/he wants to spend time, the activities and events in which s/he wants to be involved, and from whom s/he'd like to receive assistance and support. S/he shall have choice and decision making authority over how s/he budgets, manages, and spends money. S/he shall be treated with dignity and respect by waiver providers, have his or her privacy respected to the extent possible for health and safety, and be free from coercion and restraint. Any restriction of rights shall meet federal requirements and include an assessed need and a restoration plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

DHCF shall initially certify a new agency providing this service for one year. Renewal of that certification, including an on-site visit, shall be conducted at least once every three (3) years. Providers that do not provide services in a setting that is owned, leased or controlled by the provider shall not be subject to an on-site visit. DHCF has the authority to conduct an on-site visit when a concern is identified during a complaint, incident report, internal referral, or at the agency's discretion.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	**Sub-Category 4:**

Case management is a required service to assist participants in gaining access to needed waiver and other Medicaid State Plan services, as well as medical, social, educational and other services, regardless of the funding source.

Case managers shall be responsible for conducting the following functions:
- Assessing and/or reassessing the need for waiver services;
- Initiating the level of care evaluation or re-evaluation process;
- Linking waiver participants to other federal, state, and local programs;
- Providing choice of services and providers;
- Developing person centered IPCs in accordance with DHCF policies and procedures;
- Coordinating multiple services and providers;
- Ongoing monitoring of the implementation of the plans of care in accordance with Chapter 45 and 46 of the Department of Health's Medicaid Rules;
- Ongoing monitoring of the IBA to assure that services are provided within the IBA, and addressing identified concerns;
- Ongoing monitoring of participants' health and welfare and addressing identified concerns;
- Responding to participant crises;
- Quarterly service observation for each habilitation service received.

Monthly requirements:
- Maintain direct contact with participant and legally authorized representative (if applicable), which may include the visit to the participant's place of residence, service observations, telephone or person to person contact with participant or legally authorized representative to complete follow up on concerns identified through incident reports, complaints, or other means.
- Follow-up on concerns or questions raised by the participant, legally authorized representative, or plan of care team, or identified through incident reports, complaints, or service observations.
- Review service utilization and documentation of traditional and self-directed services to assure the amount, frequency, and duration of services is appropriate.
- Monitor and evaluate the positive behavior support plan, as applicable, and complete follow-up on concerns.
- Evaluate the use of restraints and complete follow-up on concerns.
- When a participant chooses to self-direct services, complete referral form and submit with all required information to the Financial Management Services Agent (FMS).
- Interact with FMS to assist participants with enrollment in self-direction.
- Assist the employer of record (EOR) in completing employee paperwork, and address questions or issues that arise when participating in self-directed services.
- Use the FMS portal to review provider time sheets, determine budget usage, and provide ongoing monitoring of the participant's budget. Report improper budget usage to the assigned DHCF staff member.

Billable activities includes:
A billable case management activity is any task or function defined by DHCF as an activity that only the case manager or case management agency can provide to, or on behalf of, the participant or legally authorized representative. Billable time may be cumulative during the span in which a case manager bills. The monthly case management review must be completed prior to billing for services, and must be submitted within 60 calendar days of the service being provided.

Billable case management services include:
- Plan development;
- Plan monitoring and follow-up, including documentation review;
- Second-line medication monitoring;
- Service observation;
- Visit to the participant's place of residence;
- Team meetings;
- Participant specific training;
- Face to face meeting with participants, legally authorized representatives, and family;
- Advocacy and referral;
- Crisis intervention and management;
- Coordination of natural supports;
- Offering and discussing choice;
- Completing monthly responsibilities;

- Quarterly service observations and interviews;
- DHCF required reporting;
- Quarterly meetings with back-up case manager.

Non-billable activities include:
- Ancillary activities, such as mailing, copying, filing, faxing, drive time, or supervisory/ administrative activities are not billable. The administrative costs of these activities and other normal and customary business overhead costs have been included in the reimbursement rate for billable activities.
- Time spent with the participant or guardian for social reasons are not considered billable time, unless billable case management activities are also occurring. Incidental contact and social exchanges are part of conducting and building a business and offering customer service, and are not considered a case management service by the Centers for Medicare and Medicaid Services (CMS).
- Time spent acquiring continuing education units.
- Travel time, which has already been included as part of the rate for the service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Case management is available as a 15 minute unit or a monthly unit. Monthly and 15 minute units shall not be billed for the same participant in the same month.

Monthly Unit
The monthly unit shall be billed on or after the last day of the month. A minimum of two hours of billable services shall be documented in order to bill, but all billable services shall be documented each month.
- A monthly visit to the participant's place of residence, with the participant present, is required to monitor the participant's health and welfare, as well as to discuss satisfaction with services and needed changes to the IPC.
- At least one hour of person to person contact with the participant or legally authorized representative is required to bill a monthly unit.

15 Minute Unit
The rate for the 15 minute unit is based on the same methodology as the monthly, and allows for an average of 4.5 hours per month of case management to be billed.
- One unit a month of case management shall be provided each month to discuss participant satisfaction and address any needs or concerns.
- Case managers shall use units based on the needs of the participant or legally authorized representative, up to the amount approved in the IPC.
- The number of units on a plan may not exceed 224 units annually.
- Monthly visits to the participant's place of residence shall be required if a participant receives community living services. The participant shall be present during the visit.
- Quarterly visits to the participant's place of residence shall be required if a participant does not receive community living services. The participant shall be present during the visit. Monthly home visits may be completed if desired.
- The case manager may complete additional visits to the participant's place of residence during times of crisis or when requested by the participant or legally authorized representative.

Conflict Free Case Management
In order for a case manager to have the authority to develop, implement, and monitor plans of care in the best interest of the participant, the case manager shall not have a conflict of interest. To address conflicts of interest, DHCF has implemented exclusions for case managers, which are outlined in Chapter 45 of the Department of Health's Medicaid Rules. Relatives (defined as biological parents, step parents, or adoptive parents) and legally authorized representatives, shall not provide case management services. Additionally, case managers shall not serve participants to whom they are related by blood or marriage within the third degree. Relationships within the third degree include the spouse; mother, father, sister, or brother in-law; children (including step and adoptive); siblings; grand and great grandparents; and aunts, uncles, nieces or nephews.

DHCF may establish caseload limits to ensure the case manager effectively coordinates services with all participants on his or her caseload.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency certified BY DHCF to provide service
Individual	Individual certified to provide service

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

Agency certified BY DHCF to provide service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider of this service is required to attain and maintain a certification for this service from the DHCF. If a provider meets the criteria outlined in Section 25 of Chapter 45 of the Department of Health's Medicaid Rules, it shall attain and maintain accreditation by a nationally recognized accreditation entity for human services as specified.

Other Standard *(specify):*

A provider of this service shall meet the requirements in Chapter 45 of the Department of Health's Medicaid Rules. Requirements for case managers employed by a case management agency include, but are not limited to: a successful criminal history background screening; a current CPR and First Aid certification; a current Medication Assistance certification for case managers assisting participants with medications; and a current driver's license and automobile insurance, if providing transportation. Additionally, case managers employed by an agency shall have one (1) of the following:

(a) A Master's degree from an accredited college or university in one (1) of the following related human service fields:
- Counseling;
- Education;
- Gerontology;
- Human Services;
- Nursing;
- Psychology;
- Rehabilitation;
- Social Work;
- Sociology; or
- A related degree, as approved by the Division; or

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

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

A case manager shall obtain and maintain a National Provider Identifier (NPI) number for case management services through the Medicaid enrollment process, and 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.

A provider agency certified to provide case management services shall identify a back-up case manager from the list of DHCF 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.

A provider agency certified to provide case management services shall document on the IPC that they have no conflict of interest with the participant or family, and shall meet the following conflict of interest requirements:
- 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;
- The case management agency may be certified in other waiver services, but shall not provide case management services to any participant for whom they are providing any other waiver services, including self-directed services;
- The owner, operator, or managing employee of a case management agency shall not be related 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;
- An employee of a guardianship agency shall not provide case management to any participant who is receiving any services from the guardianship agency; and
- The case management agency shall not:

o Employ case managers that are related to the participant served by the agency, the participant's guardian, or a legally authorized representative. 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 served by the agency;

o 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
o 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.

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 another case manager is not 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.

No sub-contracting for case management shall be allowed.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

DHCF shall initially certify a new agency providing this service for one year. Renewal of that certification shall be conducted at least once every three (3) years. DHCF has the authority to conduct an on-site visit when a concern is identified during a complaint, incident report, internal referral, or at DHCFs discretion.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Individual

Provider Type:

Individual certified to provide service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider of this service is required to attain and maintain a certification for this service from the DHCF. If a provider meets the criteria outlined in Section 25 of Chapter 45 of the Department of Health's Medicaid Rules, it shall attain and maintain accreditation by a nationally recognized accreditation entity for human services as specified.

Other Standard *(specify):*

A provider of this service shall meet the requirements in Chapter 45 of the Department of Health's Medicaid Rules. Requirements for case managers include, but are not limited to: a successful criminal history background screening; a current CPR and First Aid certification; a current Medication Assistance certification if assisting participants with medications; and a current driver's license and automobile insurance, if providing transportation. Additionally, a case manager shall have one (1) of the following:

(a) A Master's degree from an accredited college or university in one (1) of the following related human service fields:
- Counseling;
- Education;
- Gerontology;
- Human Services;
- Nursing;
- Psychology;
- Rehabilitation;
- Social Work;
- Sociology; or
- A related degree, as approved by DHCF; or

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

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

A case manager shall obtain and maintain a National Provider Identifier (NPI) number for case management services through the Medicaid enrollment process, and 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.

A case manager shall identify a back-up case manager from the list of DHCF certified case managers for each participant, and have policies and procedures for backup case management, 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.

A case manager shall document on the IPC that they have no conflict of interest with the participant or family, and meet the following conflict of interest requirements:
- The case manager 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;
- The case manager may be certified in other waiver services, but shall not provide case management services to any participant for whom they are providing any other waiver services, including self-directed services;
- The case manager shall not be related 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;
- An employee of a guardianship agency shall not provide case management to any participant who is receiving any services from the guardianship agency; and
- The case manager shall not:
  - Be related to the participant, the participant's guardian, or a legally authorized representative;
  - Make financial or health-related decisions on behalf of the participant, including but not limited to a guardian, representative payee, power of attorney, or conservator; or
  - 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.

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 DHCFconfirms that another case manager is not 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.

No sub-contracting for case management shall be allowed.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

DHCF shall initially certify a new agency providing this service for one year. Renewal of that certification shall be conducted at least once every three (3) years. DHCF has the authority to conduct an on-site visit when a concern is identified during a complaint, incident report, internal referral, or at DHCFs discretion.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

Community Living Services

HCBS Taxonomy:

Category	Sub-Category
Category 1: 02 Round-the-Clock Services	**Sub-Category 1:** 02011 group living, residential habilitation
Category 2: 02 Round-the-Clock Services	**Sub-Category 2:** 02021 shared living, residential habilitation
Category 3: 02 Round-the-Clock Services	**Sub-Category 3:** 02031 in-home residential habilitation
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Community living services are individually-tailored supports that assist the participant with the acquisition, retention, or improvement of skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living including medication assistance, light housekeeping, community inclusion, transportation, adult educational supports, and social and leisure skill development that assist the participant to reside in the most integrated setting appropriate for his/her needs. Community living includes personal care, protective oversight, and supervision as indicated in the IPC.

- Community living services are reimbursed based on the Level of Service (LOS) score of the participant, and include some level of ongoing 24 hour support (i.e., 24 hour on-call support) by a provider, as defined in the level of service and outlined in the IPC.
- Community living services may be furnished in a setting owned or leased by a provider, participant, or the participant's family. Basic community living services may be provided in the family home.
- Community living services may be delivered through self-direction.
- Provider owned or leased settings where community living services are furnished shall be fully accessible to the individuals living in that setting.
- Participant's receiving community living services shall have one primary residence.
- Transportation between the participant's place of residence, other service sites, or places in the community is included in the rate.
- Community living is a habilitation service. Training on objectives is expected as part of the provision of services, and progress shall be documented and made available to the participant, guardian, and case manager each month.
- Remote support, as specifically defined and implemented by DHCF, may be utilized for supervision based on an individual risk assessment and protocol, and as outlined in the IPC.
- Family visits and trips are encouraged. The provider shall be reimbursed on the days the participant leaves for and returns from a trip.
- Health related services may be provided after staff are trained by the appropriate trainer or medical professional, and documentation of training is evident.

Host home services consist of participant specific, individually designed and coordinated services within a family (other than biological, step or adoptive parents) host home environment. Host homes differ from other community living settings by featuring one sponsor working with one participant living together in the sponsor's home. A sponsor is defined as an individual who is an independent certified provider to one person in their home. The sponsor is the only residential provider for the participant, the sponsor does not employ any staff, nor is a subcontractor. This service is not open to new participants without going through the ECC approval process for an out of home placement. The provider is the primary caregiver and assumes 24-hour care of the individual. Relative providers (defined as biological, step, or adoptive parents) shall not provide this service. Host home services shall not be self-directed.

Tiered Levels
A Participant receives a tiered service approved in the IPC based upon need, according to the following tiers descriptions. Tier levels for this service align with the assessed LOS for the participant and the expectations of the service as specified in the definition. All supervision and supports delivered shall align with the participant's IPC.

Basic Level –Due to a high to moderately high level of independence and functioning, and few significant behavioral or medical issues that require minimal staff support, monitoring, or personal care, this tier requires periodic staff availability on-site and meeting periodically with the participant during awake hours on each day billed to provide general supervision, support, monitoring, and training. On-call 24 hour support is not required for this tier level, but a contingency plan for emergency situations must be outlined in the IPC. Personal care shall not esceed 20% of the provided service.

Level 3- Due to moderate functional limitations in activities of daily living, and possible behavioral support needs, this tier requires regular staff availability on-site within hearing distance of the participant and meeting periodically with the participant on each day billed for general supervision, support, personal care, positive behavior support, monitoring, and training. Staff support shall be available through the night, and overnight expectations shall be stipulated in the IPC.

Level 4- Due to significant functional limitations and medical or behavioral support needs, this tier requires full -

time staff to be on-site when the person is in this service, with regular personal attention given throughout the day for training, personal care, reinforcement, positive behavior support, and community or social activities. Behavioral and medical supports are not generally intense and may be provided in a shared staffing setting. There shall be staff support through the night as indicated in the IPC.

Level 5- Due to significant and somewhat intensive functional limitations and medical or behavioral support needs, this tier requires 1 or more full-time staff support to be on-site and in close proximity during most awake hours when the person is in this service, with frequent personal attention given throughout the day for training, personal care, reinforcement, and community or social activities. Behavioral and medical supports or personal care may be somewhat intense but service may be provided in a smaller shared staffing setting. There shall be staff support in the residence through the night, as indicated in the IPC.

Level 6-Due to the high medical, behavioral or personal care needs, this tier requires frequent personal support and supervision with full-time staff on-site and within immediate proximity during most awake hours. The expectation is that the participant shall receive the personal attention of at least one staff person unless otherwise outlined in the IPC and approved by DHCF. Occasional 2:1 support is included in this rate, and shall be specified in the IPC. There shall be staff support in the residence through the night, as indicated in the IPC.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

With the exception of current participants receiving special family habilitation home services, participants shall be at least 18 years old to receive community living services. Services shall not duplicate or replace services covered under IDEA or through Department of Family Services programs.

Community living is a 24 hour service. The following requirement shall be met in order for payment to be allowed:
- Basic daily rate – a minimum of 4 hours of documented service per calendar day.
- Levels 3-6 daily rate – a minimum of 8 hours of documented staff support, in the residence during awake and asleep hours, in a 24 hour period (from 12:00am-11:59pm).

Community living basic services can be billed as a 15 minute unit for a minimum of 4,745 units per plan year for individuals services, or for a maximum of 5,475 per plan year for group services. The 15 minute unit and daily rate shall not be billed for a participant on the same day.

Participants who choose remote monitoring as a supervision option shall complete a risk assessment prior to utilization. Additional standards shall apply to providers that implement remote monitoring practices.

Support with personal care needs is a component of community living services, so service times for community living services and personal care services shall not overlap.

Payment shall not be made for the cost of room and board, including the cost of building maintenance, upkeep, and improvement. The method by which the costs of room and board are excluded from payment for Community Living Services is specified in Appendix I-5 of the waiver application.

A relative provider (defined as the biological, adoptive, or step parent of a participant) may provide all components of this service as defined, but shall form a Limited Liability Company (LLC) or a corporation, be a certified provider or an employee of a certified provider, and shall not reside in the same residence as the participant.

Targeting Criteria to Receive this Service
Levels 3 – 6 of this service are not open to new participants without going through the Extraordinary Care Committee (ECC) approval process for an out of home placement. Waiver participants not receiving 24-hour community living services who are at significant risk due to extraordinary needs that cannot be met in their current living arrangement, may request 24-hour community living services if the participant meets one of the following targeting criteria:
- A substantial threat to a person's life or health caused by homelessness or abuse/neglect that is either substantiated by Department of Family Services or corroborated by DHCF or Protection & Advocacy System, Inc.;
- A situation in which a person's condition poses a substantial threat to a person's life or health, and is documented in writing by a physician;
- A situation in which a person has caused serious physical harm to him or herself or someone else in the home, or the person's condition presents a substantial risk of physical threat to him or herself or others in the home;
- A situation in which there are significant and frequently occurring behavior challenges resulting in danger to the person's health and safety, or the health and safety of others in the home;
- A situation in which the person's critical medical condition requires ongoing 24-hour support and supervision to maintain the person's health and safety; or
- Loss of primary caregiver due to caregiver's death, incapacitation, critical medical condition, or inability to provide continuous care.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency certified by DHCF to provide service
Individual	Individual hired by the participant for service

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Living Services

Provider Category:

Agency

Provider Type:

Agency certified by DHCF to provide service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider, including a sole proprietor, of this service is required to attain and maintain a certification for this service from the DHCF. If a provider meets the criteria outlined in Section 25 of Chapter 45 of the Department of Health's Medicaid Rules, it shall attain and maintain accreditation by a nationally recognized accreditation entity for human services as specified.

Other Standard *(specify):*

A provider of this service shall meet the requirements in Chapter 45 of the Department of Health's Medicaid Rules. Requirements for providers and provider direct care staff include, but are not limited to: a successful criminal history background screening; a current CPR and First Aid certification; a current Medication Assistance certification for direct care staff assisting participants with medications; a current crisis intervention and restraint usage certification, if applicable; and a current driver's license and automobile insurance, if providing transportation. Direct care staff shall complete participant specific training prior to providing services to the participant. In addition to Chapter 45 requirements, providers shall adhere to the standards and requirements of all applicable Medicaid rules and regulations specified in the Provider Manual and Provider Agreement.

A provider shall ensure that services occur in settings that are community based and facilitate opportunities for participants to access the community and community resources to the same degree as people who do not have a disability. A participant shall have choice in where s/he wants to live, with whom s/he wants to spend time, the activities and events in which s/he wants to be involved, and from whom s/he'd like to receive assistance and support. S/he shall have choice and decision making authority over how s/he budgets, manages, and spends money. S/he shall be treated with dignity and respect by waiver providers, have his or her privacy respected to the extent possible for health and safety, and be free from coercion and restraint. Any restriction of rights shall meet federal requirements and include an assessed need and a restoration plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

DHCF shall initially certify a new agency providing this service for one year. Renewal of that certification, including an on-site visit, shall be conducted at least once every three (3) years. Providers that do not provide services in a setting that is owned, leased or controlled by the provider shall not be subject to an on-site visit. DHCF has the authority to conduct an on-site visit when a concern is identified during a complaint, incident report, internal referral, or at the agency's discretion.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Living Services

Provider Category:
Individual
Provider Type:

Individual hired by the participant for service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Prior to providing services, and individual being hired by the participant shall:
- Be at least 18 years of age;
- Successfully pass a criminal history background screening;
- Be able to effectively communicate with the participant and other stakeholders;
- Be able to complete record keeping as required by the employer;
- Hold a current driver's license and automobile insurance, if providing transportation during the provision of services;
- Hold a current CPR and First Aid certification;
- Hold a current Medications Assistance Training certification, if applicable; and
- Hold a certificate in crisis intervention and restraint usage (CPI, Mandt), if applicable for the participant's needs.

The participant or legally authorized representative, with assistance as needed from the case manager, shall verify that, prior to working alone with the participant, the individual being hired has received training on the participant's IPC and has received training on the following DHCF policies and procedures:

- Participant choice;
- Recognizing abuse and neglect;
- Incident reporting;
- Participant rights and confidentiality;
- Emergency drills and situations; and
- Documentation standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent- Financial Management Service

Frequency of Verification:

The Fiscal Employer Agent shall conduct an initial and quarterly review on a random sample of files to ensure that all required documents are submitted and logged correctly in its system. The Agency shall provide a weekly status report to case managers and the participant or legally authorized representative regarding provider certifications, paperwork, status of trainings, and whether or not the provider has met all requirements to work for a participant.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

Community Support Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04070 community integration
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Community support services offer assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills. Services include activities designed to keep participants engaged in their environment, develop and maintain relationships, and build on previously learned skills. Services shall be furnished consistent with the participant's IPC and include full access to the community to the same degree as community members who do not receive Medicaid home and community based services. Adult educational supports shall be an approved activity of this service.

Community support services shall be scheduled in settings separate from the participant's private residence. Services shall be furnished in a variety of settings in the community and shall not be limited to only fixed-site or congregate settings. Activities and environments shall foster the acquisition of skills, appropriate behavior, greater independence, community networking, and personal choice. Transportation is a component of community support services and is included in the rate to providers.

Community support services shall focus on enabling the participant to attain or maintain his or her maximum functional level and shall serve to reinforce skills or lessons taught in other settings, including skills learned during therapy services. Participants shall not be paid for work activities performed during this service.

Community support is a habilitation service. Training on objectives is expected as part of the provision of services, and progress shall be documented and made available to the participant, legally authorized representative, and case manager each month.

Community support services is reimbursed as a 15 minute or daily rate.

A participant receives a tiered service approved in the IPC based upon need, according to the following tier descriptions:

Basic Level of Care
A participant with a Level 1 or 2 Level of Service (LOS) score will generally be in this tier. This service tier requires limited staff supports for, and personal attention to, a participant daily due to a moderately high level of independence and functioning. Behavioral needs, if any, can be met with medication or informal direction by staff. The person may have periods of time with indirect staff supervision where staff are onsite and available through hearing distance of a request.

Intermediate Level of Care
A participant with a Level 3 or 4 LOS will generally be in this tier. Service tier requires full-time heightened supervision with staff available as indicated in the IPC due to significant functional limitations, medical and/or behavioral needs. Behavioral and medical supports are not generally intense and can be provided in a shared staffing setting. Regular personal attention is given throughout the day for personal care, reinforcement, community, or social activities.

High Level of Care
A participant with a Level 5 or 6 LOS will generally be in this tier. Service tier requires full-time supervision with staff available within close proximity and as indicated in the IPC. Frequent staff interaction and personal attention for significant functional limitations and medical or behavioral needs shall be provided. Support and supervision needs are moderately intense, but can still generally be provided in a shared setting unless otherwise specified in the IPC. Frequent personal attention shall be given throughout the day for reinforcement, positive behavior support, personal care, community, or social activities.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Community support services shall be available for participants ages 18 and older. Services shall not duplicate or replace services covered under IDEA. Evidence demonstrating that school district services have been exhausted must be submitted for participants under the age of 21.

Approved units shall be based on individual level of support need and shall fit within the person's assigned budget. A minimum of six (6) hours per day must be provided in order to bill the daily rate. The 15 minute and daily rate shall not be billed on the same day.

The high level of care tiered rate for community support services shall be available to participants who want help building meaningful relationships and social connections in the community with a more individualized approach from the provider. A participant with any LOS score may add the high level of care rate for this service to the IPC for individual services with up to one other waiver participant where the entire time is spent solely in the community and not in a provider setting.

A relative provider (defined as a biological, adoptive, or step parent) may provide this service subject to compliance with Chapter 45, Section 31 of the Department of Health's Medicaid Rules. Community Support Services shall not be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the State Medicaid Agency.

Support with personal care needs, including medication assistance, is a component of the service, but shall not comprise more than 20% of the service. Personal care services shall not be billed at the same time as this service.

A participant's IPC may include two or more types of non-residential services as long as service times do not overlap. Services shall not exceed an average weekly amount of 35 hours if the individual receives level 3-6 community living services, The daily rate shall not be billed if the participant receives level 3-6 of community living services and is receiving other non-residential services during the day.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency certified by DHCF to provide service

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Support Services

Provider Category:

Agency

Provider Type:

Agency certified by DHCF to provide service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider, including a sole proprietor, of this service is required to attain and maintain a certification for this service from the DHCF. If a provider meets the criteria outlined in Section 25 of Chapter 45 of the Department of Health's Medicaid Rules, it shall attain and maintain accreditation by a nationally recognized accreditation entity for human services as specified.

Other Standard *(specify):*

A provider of this service shall meet the requirements in Chapter 45 of the Department of Health's Medicaid Rules. Requirements for providers and provider direct care staff include, but are not limited to: a successful criminal history background screening; a current CPR and First Aid certification; a current Medication Assistance certification for direct care staff assisting participants with medications; a current crisis intervention and restraint usage certification, if applicable; and a current driver's license and automobile insurance, if providing transportation. Direct care staff shall complete participant specific training prior to providing services to the participant. In addition to Chapter 45 requirements, providers shall adhere to the standards and requirements of all applicable Medicaid rules and regulations specified in the Provider Manual and Provider Agreement.

A provider shall ensure that services occur in settings that are community based and facilitate opportunities for participants to access the community and community resources to the same degree as people who do not have a disability. A participant shall have choice in with whom s/he wants to spend time, the activities and events in which s/he wants to be involved, and from whom s/he'd like to receive assistance and support. S/he shall have choice and decision making authority over how s/he budgets, manages, and spends money. S/he shall be treated with dignity and respect by waiver providers, have his or her privacy respected to the extent possible for health and safety, and be free from coercion and restraint. Any restriction of rights shall meet federal requirements and include an assessed need and a restoration plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

DHCF shall initially certify a new agency providing this service for one year. Renewal of that certification, including an on-site visit, shall be conducted at least once every three (3) years. Providers that do not provide services in a setting that is owned, leased or controlled by the provider shall not be subject to an on-site visit. DHCF has the authority to conduct an on-site visit when a concern is identified during a complaint, incident report, internal referral, or at the agency's discretion.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08050 homemaker
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Homemaker services consist of chore-type activities such as meal preparation and routine household care. Services shall be available when the individual who is regularly responsible for these activities is temporarily unavailable or unable to manage the home and care for him or herself or others in the home. Homemaker is not a direct care service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A maximum of three (3) hours per week per household (624 units per year) is allowed. Service is not available to participants who receive levels 3-6 of community living services. Relative providers (defined as biological, adoptive, and step parents) shall not provide this service.

This service is not available to participants who receive special family habilitation home, host home, or CLS level 3 – 6 services.

A provider of homemaker services shall not bill for two participants during the same time frame.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency certified by DHCF to provide service
Individual	Individual hired by the participant

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:
Agency
Provider Type:

Agency certified by DHCF to provide service

Provider Qualifications
License *(specify):*

If the agency is a Home Health Agency, it shall be fully licensed in the State of Wyoming.

Certificate *(specify):*

A provider, including a sole proprietor, of this service is required to attain and maintain a certification for this service from the DHCF

Other Standard *(specify):*

A provider of this service shall meet the requirements in Chapter 45 of the Department of Health's Medicaid Rules. In addition to Chapter 45 requirements, providers shall adhere to the standards and requirements of all applicable Medicaid rules and regulations specified in the Provider Manual and Provider Agreement.

Verification of Provider Qualifications
Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

DHCF shall initially certify a new agency providing this service for one year. Renewal of that certification shall be conducted at least once every three (3) years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:
Individual
Provider Type:

Individual hired by the participant

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Prior to providing services, and individual being hired by the participant shall:
- Be at least 18 years of age;
- Successfully pass a criminal history background screening;
- Be able to effectively communicate with the participant and other stakeholders;
- Be able to complete record keeping as required by the employer

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent- Financial Management Service

Frequency of Verification:

The Fiscal Employer Agent shall conduct an initial and quarterly review on a random sample of files to ensure that all required documents are submitted and logged correctly in its system. The Agency shall provide a weekly status report to case managers and the participant or legally authorized representative regarding provider certifications, paperwork, status of trainings, and whether or not the provider has met all requirements to work for a participant.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Personal care services consist of a range of assistance to enable participants to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may include hands-on assistance or prompting the participant to perform a task. Personal care services may be provided on an episodic or on a continuing basis. Health-related services that may be provided include care relating to medical or health protocols, medication assistance or administration, and range of motion exercises. Health related services may be provided after staff are trained by the appropriate trainer or medical professional, and documentation of training is evident. Personal care services may include assistance in performing activities of daily living (i.e., bathing dressing, personal hygiene, bathroom assistance, transferring, maintaining continence) and more complex instrumental activities of daily living on the person's property (i.e., light housework, laundry, meal preparation exclusive of the cost of the meal, medication and money management).
The participant shall be physically present during this service. Personal care services shall be provided in the participant's home or on their property. Personal care services shall be essential to the health and welfare of the participant rather than that participant’s family. If the individual providing this service is not employed and supervised by an agency, then the participant is responsible for supervising the individual and may coordinate monitoring of the service with his/her case manager.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is available to all ages and is a 1:1 service. The number of personal care service units authorized by DHCF will be based upon individual extraordinary care needs as specified in the IPC and other assessments, and shall not exceed 7,280 units.

Personal care services are included in adult day services, companion, child habilitation, community support services, prevocational, supported employment, and community living services, and cannot be billed during the same time frame as these services, which is subject to audit by the Program Integrity Unit within the Single State Medicaid Agency. Personal care services shall not be provided on the same IPC as special family habilitation home or host home services.

Personal care services through the Medicaid State Plan can only be provided through a home health agency. Being a rural state, many Wyoming communities do not have home health providers to serve their community. Those that do often do not have enough employees to meet the extensive needs of some waiver participants. Waiver participants who need personal care services shall utilize providers that can provide the type, amount, and flexible hours of services deemed most appropriate for them. This waiver service allows the team to find and utilize providers who can best meet the participant's needs.

A relative provider (defined as a biological, adoptive, or step parent) may provide this service with certain restrictions:
- A relative shall only provide this service if they are either a certified provider and form a limited liability company (LLC) or other corporation, or they work for a certified provider.
- The number of units approved for a relative provider will depend on the individual needs of the participant and shall not exceed four (4) hours per day or 5,840 units per year. The number of service units shall be justified in the IPC.
- If the participant is under 18 years of age, the provision of personal care services by a relative shall only be authorized for assessed extraordinary care services as documented in the IPC.

Extraordinary care cases shall meet the following criteria:
1. The participant's Adaptive Behavior Quotient is 0.35 or lower on the Inventory for Client and Agency Planning (ICAP) assessment; and
2. The participant needs assistance with Activities of Daily living (ADLs) or Instrumental Activities of Daily Living (IADLs) exceeding the range of expected activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant, and which will avoid institutionalization. (Example: a 12 year old needing assistance with dressing and bathing, whereas the average 12 year old does not.); or
3. The participant requires care from a person with specialized medical skills relating to the participant's diagnosis or medical condition as determined appropriate by the participant's medical professional and the Behavioral Health Division.

A legally authorized representative of a person under the age of 18 may provide personal care services to their ward if they meet the restrictions noted above. A legally authorized representative shall not be authorized to provide personal care services to an individual 18 years of age or older.
If a legally authorized representative is providing personal care services to his/her minor ward, the IPC shall be developed and monitored by a case manager without a conflict of interest to ensure the provision of services is in the best interest of the participant.

Relative providers and legally authorized representatives shall not provide this service through self-direction.

The IPC shall state that services do not duplicate similar services, natural supports, or services otherwise available to the participant.

Transportation costs are not included as part of this service.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☒ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual hired by the participant
Agency	Agency certified by DHCF to provide service

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:

Individual

Provider Type:

Individual hired by the participant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Prior to providing services, and individual being hired by the participant shall:
- Be at least 18 years of age;
- Successfully pass a criminal history background screening;
- Be able to effectively communicate with the participant and other stakeholders;
- Be able to complete record keeping as required by the employer;
- Hold a current driver's license and automobile insurance, if providing transportation during the provision of services;
- Hold a current CPR and First Aid certification;
- Hold a current Medications Assistance Training certification, if applicable; and
- Hold a certificate in crisis intervention and restraint usage (CPI, Mandt), if applicable for the participant's needs.

The participant or legally authorized representative, with assistance as needed from the case manager, shall verify that, prior to working alone with the participant, the individual being hired has received training on the participant's IPC and has received training on the following DHCF policies and procedures:

- Participant choice;
- Recognizing abuse and neglect;
- Incident reporting;
- Participant rights and confidentiality;
- Emergency drills and situations; and
- Documentation standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent- Financial Management Service

Frequency of Verification:

The Fiscal Employer Agent shall conduct an initial and quarterly review on a random sample of files to ensure that all required documents are submitted and logged correctly in its system. The Agency shall provide a weekly status report to case managers and the participant or legally authorized representative regarding provider certifications, paperwork, status of trainings, and whether or not the provider has met all requirements to work for a participant. The FMS submits a report to the SMA on a representative sample of employee files annually.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:

Agency

Provider Type:

Agency certified by DHCF to provide service

Provider Qualifications

License *(specify):*

If the agency is a Home Health Agency, it shall be fully licensed in the State of Wyoming.

Certificate *(specify):*

A provider, including a sole proprietor, of this service is required to attain and maintain a certification for this service from the DHCF.

Other Standard *(specify):*

A provider of this service shall meet the requirements in Chapter 45 of the Department of Health's Medicaid Rules. Requirements for providers and provider direct care staff include, but are not limited to: a successful criminal history background screening; a current CPR and First Aid certification; a current Medication Assistance certification for direct care staff assisting participants with medications; a current crisis intervention and restraint usage certification, if applicable; and a current driver's license and automobile insurance, if providing transportation. Direct care staff shall complete participant specific training prior to providing services to the participant. In addition to Chapter 45 requirements, providers shall adhere to the standards and requirements of all applicable Medicaid rules and regulations specified in the Provider Manual and Provider Agreement.

A provider shall ensure that services occur in settings that are community based and facilitate opportunities for participants to access the community and community resources to the same degree as people who do not have a disability. A participant shall have choice in with whom s/he wants to spend time, the activities and events in which s/he wants to be involved, and from whom s/he'd like to receive assistance and support. S/he shall be treated with dignity and respect by waiver providers, have his or her privacy respected to the extent possible for health and safety, and be free from coercion and restraint. Any restriction of rights shall meet federal requirements and include an assessed need and a restoration plan

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

DHCF shall initially certify a new agency providing this service for one year. Renewal of that certification, including an on-site visit, shall be conducted at least once every three (3) years. Providers that do not provide services in a setting that is owned, leased or controlled by the provider shall not be subject to an on-site visit. DHCF has the authority to conduct an on-site visit when a concern is identified during a complaint, incident report, internal referral, or at the agency's discretion.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: 09 Caregiver Support

Sub-Category 1: 09011 respite, out-of-home

Category 2: 09 Caregiver Support

Sub-Category 2: 09012 respite, in-home

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Respite services are intended to be utilized on a short-term, temporary basis to provide relief for an unpaid caregiver from the daily burdens of care. Respite is also available to non-accredited providers of community living services. Respite includes assistance with ADLs, medication assistance if needed, and supervision. Respite shall not be used to substitute for care while the primary caregiver is at work, or during services otherwise available through public education programs including education activities, after school supervision, daytime services when the school is not in session, or services to preschool age children. The participant may choose to receive a more appropriate service, such as child habilitation or companion services, for supports and supervision while their primary caregiver is working. Respite shall not replace residential or day services.

Respite may be provided in the caregiver's home, the provider's home, or in community settings. The respite setting and services shall support the identified needs of the participant and family. Respite shall only be provided for up to two people at the same time. Three people may be supported in this service if they are family members, live in the same household, and can be safely supported by one provider.

A provider of respite services may also provide supervision to other children under the age of 12 or other individuals requiring support and supervision, but shall limit the total combined number of persons to whom they are providing services to no more than three people unless approved by DHCF. The provider shall adhere to the supervision levels identified in each participant's IPC.

Respite shall not be provided to individuals under the age of 18 and individuals 18 and older at the same time. In exceptional cases, such as when participants are members of the same family, respite may be provided to adults and children at the same time with DHCF approval.

Routine transportation is included in the service rate.

Respite is reimbursed as a 15-minute unit or a daily rate.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

On the Comprehensive Waiver, there is an annual cap of 5,616 individual 15-minute units. Each daily unit counts as 48 units against the 5,616 individual 15-minute units.

- Any use of respite over nine (9) hours a day must be billed as a daily unit.
- Approved service units are based upon the participant's need and budget limit
- Relative providers (defined as biological, adoptive, or step parents) shall not provide this service.
- Respite services shall not be provided during the same time period as other waiver services, which is subject to audit by Medicaid.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency certified by DHCF to provide service
Individual	Individual hired by the participant

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Agency certified by DHCF to provide service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider, including a sole proprietor, of this service is required to attain and maintain a certification for this service from the DHCF.

Other Standard *(specify):*

A provider of this service shall meet the requirements in Chapter 45 of the Department of Health's Medicaid Rules. Requirements for providers and provider direct care staff include, but are not limited to: a successful criminal history background screening; a current CPR and First Aid certification; a current Medication Assistance certification for direct care staff assisting participants with medications; a current crisis intervention and restraint usage certification, if applicable; and a current driver's license and automobile insurance, if providing transportation. Direct care staff shall complete participant specific training prior to providing services to the participant. In addition to Chapter 45 requirements, providers shall adhere to the standards and requirements of all applicable Medicaid rules and regulations specified in the Provider Manual and Provider Agreement.

A provider shall ensure that services occur in settings that are community based and facilitate opportunities for participants to access the community and community resources to the same degree as people who do not have a disability. A participant shall have choice in with whom s/he wants to spend time, the activities and events in which s/he wants to be involved, and from whom s/he'd like to receive assistance and support. S/he shall be treated with dignity and respect by waiver providers, have his or her privacy respected to the extent possible for health and safety, and be free from coercion and restraint. Any restriction of rights shall meet federal requirements and include an assessed need and a restoration plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

DHCF shall initially certify a new agency providing this service for one year. Renewal of that certification, including an on-site visit, shall be conducted at least once every three (3) years. Providers that do not provide services in a setting that is owned, leased or controlled by the provider shall not be subject to an on-site visit. DHCF has the authority to conduct an on-site visit when a concern is identified during a complaint, incident report, internal referral, or at the agency's discretion.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Individual hired by the participant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Prior to providing services, and individual being hired by the participant shall:
- Be at least 18 years of age;
- Successfully pass a criminal history background screening;
- Be able to effectively communicate with the participant and other stakeholders;
- Be able to complete record keeping as required by the employer;
- Hold a current driver's license and automobile insurance, if providing transportation during the provision of services;
- Hold a current CPR and First Aid certification;
- Hold a current Medications Assistance Training certification, if applicable; and
- Hold a certificate in crisis intervention and restraint usage (CPI, Mandt), if applicable for the participant's needs.

The participant or legally authorized representative, with assistance as needed from the case manager, shall verify that, prior to working alone with the participant, the individual being hired has received training on the participant's IPC and has received training on the following DHCF policies and procedures:

- Participant choice;
- Recognizing abuse and neglect;
- Incident reporting;
- Participant rights and confidentiality;
- Emergency drills and situations; and
- Documentation standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent- Financial Management Service

Frequency of Verification:

The Fiscal Employer Agent shall conduct an initial and quarterly review on a random sample of files to ensure that all required documents are submitted and logged correctly in its system. The Agency shall provide a weekly status report to case managers and the participant or legally authorized representative regarding provider certifications, paperwork, status of trainings, and whether or not the provider has met all requirements to work for a participant.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03010 job development
Category 2:	**Sub-Category 2:**
03 Supported Employment	03021 ongoing supported employment, individual
Category 3:	**Sub-Category 3:**
03 Supported Employment	03022 ongoing supported employment, group
Category 4:	**Sub-Category 4:**
03 Supported Employment	03030 career planning

Service Definition *(Scope):*

The outcome of using employment services is to help a participant find and maintain a job that meets personal and career goals. Supported Employment Services offer a variety of supports to assist a participant age 18 or older who, because of their disability, needs intensive support to find and maintain self-employment or a job in a competitive, integrated work setting for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by an individual without a disability.

Services are conducted in a variety of settings, particularly work sites where people without disabilities are employed. Services include activities needed in order for a participant to sustain paid work, including supervision and training. Payment is made only for the adaptations, supervision, and training required by participants as a result of their disabilities, but does not include payment for the supervisory activities rendered as a normal part of doing business.

Consistent with the Olmstead decision and with person-centered planning, a participant's IPC shall be developed in a manner that reflects individual choice and goals relating to employment, and ensures provision of services in the most integrated setting appropriate. Objectives that support the need for continued job coaching with a plan to lessen the job coaching over time, if possible, shall be identified in the participant's IPC.

Small Group Supported Employment
Small group supported employment shall be provided under a group rate for groups ranging from 2 to 8 persons, and include mobile work crews or enclaves. Group employment for groups larger than 8 people shall not be reimbursed by the waiver.

The job coach shall be in the immediate vicinity and available for immediate intervention and support. Services shall ideally be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities in these workplaces. Small group supported employment may include employment in community businesses or businesses that are part of a provider organization.

Individual Supported Employment
Individual supported employment services are 1:1 supports available to a participant, and include customized and self-employment. Individual supported employment also includes 1:1 career planning and discovery support services that focus on individualized determination of the strengths, needs, and interests of the participant, and are designed to meet the specific needs of the employee and employer relationship. These services include employment developed through job carving, self-employment or entrepreneurial initiatives, or other job development or restructuring strategies that result in job responsibilities being customized and individually negotiated to fit the needs of participants. These services presume the provision of reasonable accommodations and supports necessary to perform functions of a job that is individually negotiated and developed.

A final component of individual supported employment is a direct follow along service, which enables a participant who is paid at or above minimum wage to maintain employment in an integrated community employment setting. This service is provided for a participant through job support and communication with the participant's supervisor or manager, while the participant is present. Reimbursable activities include teaching job tasks and monitoring performance to ascertain the success of the job placement, support services not specifically related to job skill training that enable the participant to be successful in integrating into the job setting, and time spent at the participant's work site conducting observation and supervision of the participant.

Individual supported employment shall be provided in a community employment setting, unless the support is to address issues necessary to maintain a current job, or to develop customized employment, self-employment, or home-based employment (subject to prior approval of DHCF).

Supported Employment Follow Along
Supported employment follow along (SEFA) services enable a participant, who is paid at or above the federal minimum wage, to maintain employment in an integrated community employment setting. SEFA is intended to be an indirect service, meaning the service is provided for, or on behalf of, a participant through intermittent and occasional job support and communication with the participant's supervisor or manager, while the participant is not present. However, this definition does not preclude the participant from being present during the provision of this service. SEFA may include phone calls between support staff and the participant's managerial staff. SEFA reimburses up to 100 units annually; approved units are based upon individual need in order to maintain

employment. SEFA services shall be specifically outlined in the IPC.

SEFA reimbursable activities include:
- Regular contact and/or follow-up with the employer in order to reinforce and stabilize the job placement
- Facilitation of natural supports at the work site
- Individual program development, writing tasks analyses, monthly reviews, termination reviews and behavioral intervention programs
- Advocacy on behalf of the participant, but only with persons at the employment site (i.e., employers, co-workers, customers) and only for purposes directly related to employment
- Staff time to travel to and from a work site

SEFA non-reimbursable activities include:
- Transportation of an individual participant
- Observations of activities taking place in a group, i.e., work crews or enclaves
- Public relations
- Community education
- In-service meetings, department meetings, individual staff development
- Sheltered work observation

Approved services shall be directly related to a participant's employment needs and fit within the person's assigned budget.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Documentation that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 (Vocational Rehabilitation or Workforce Services) or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) shall be maintained in the case manager and provider file. Services shall not be provided during the same timeframes that an individual is receiving services through an Individualized Educational Plan (IEP). A third party liability form may be required by DHCF unless the participant is using the first 100 units of this service to help access assistance from the Division of Vocational Rehabilitation (DVR), to complete a career planning assessment tool, or for indirect SEFA services.

This service shall not be used to fund incentive payments including:
1. Payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for training that is not directly related to a participant's supported employment program.

Relative providers (defined as a biological, adoptive, or step parent), spouses, and legally authorized representatives shall not provide these services.

Transportation is included in the reimbursement rates for a direct service, but shall not be used for SEFA services or solely for the purpose of transporting a participant to and from work.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency certified BY DHCF to provide service
Individual	Individual hired by the participant

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

Agency certified BY DHCF to provide service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider, including a sole proprietor, of this service is required to attain and maintain a certification for this service from the DHCF. If a provider meets the criteria outlined in Section 25 of Chapter 45 of the Department of Health's Medicaid Rules, it shall attain and maintain accreditation by a nationally recognized accreditation entity for human services as specified.

Other Standard *(specify):*

A provider of this service shall meet the requirements in Chapter 45 of the Department of Health's Medicaid Rules. Requirements for providers and provider direct care staff include, but are not limited to: a successful criminal history background screening; a current CPR and First Aid certification; a current Medication Assistance certification for direct care staff assisting participants with medications; a current crisis intervention and restraint usage certification, if applicable; and a current driver's license and automobile insurance, if providing transportation. Direct care staff shall complete participant specific training prior to providing services to the participant. In addition to Chapter 45 requirements, providers shall adhere to the standards and requirements of all applicable Medicaid rules and regulations specified in the Provider Manual and Provider Agreement.

Agencies providing this service shall have procedures in place to assure participants are involved in making informed employment-related decisions, participants are linked to services and community resources that enable them to achieve their employment objectives, participants are given information on local job opportunities, and participants' satisfaction with employment services is assessed on a regular basis.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

DHCF shall initially certify a new agency providing this service for one year. Renewal of that certification, including an on-site visit, shall be conducted at least once every three (3) years. Providers that do not provide services in a setting that is owned, leased or controlled by the provider shall not be subject to an on-site visit. DHCF has the authority to conduct an on-site visit when a concern is identified during a complaint, incident report, internal referral, or at the agency's discretion.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Individual
Provider Type:

Individual hired by the participant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Prior to providing services, and individual being hired by the participant shall:
- Be at least 18 years of age;
- Successfully pass a criminal history background screening;
- Be able to effectively communicate with the participant and other stakeholders;
- Be able to complete record keeping as required by the employer;
- Hold a current driver's license and automobile insurance, if providing transportation during the provision of services;
- Hold a current CPR and First Aid certification;
- Hold a current Medications Assistance Training certification, if applicable; and
- Hold a certificate in crisis intervention and restraint usage (CPI, Mandt), if applicable for the participant's needs.

The participant or legally authorized representative, with assistance as needed from the case manager, shall verify that, prior to working alone with the participant, the individual being hired has received training on the participant's IPC and has received training on the following DHCF policies and procedures:

- Participant choice;
- Recognizing abuse and neglect;
- Incident reporting;
- Participant rights and confidentiality;
- Emergency drills and situations; and
- Documentation standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent – Financial Management Service

Frequency of Verification:

The Fiscal Employer Agent shall conduct an initial and quarterly review on a random sample of files to ensure that all required documents are submitted and logged correctly in its system. The Agency shall provide a weekly status report to case managers and the participant or legally authorized representative regarding provider certifications, paperwork, status of trainings, and whether or not the provider has met all requirements to work for a participant.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Dietician Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11040 nutrition consultation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Dietician services shall be provided by a registered dietician, and include services such as menu planning, consultation with and training for caregivers, and education for the individual served. The service does not include the cost of meals. This service shall be cost effective and necessary to prevent institutionalization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Dietician services are available for participants who are 21 and older. Participants under the age of 21 can access this service through Early Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

Dietician services are available on the Medicaid State Plan; therefore, the waiver service shall not be used unless the state plan services are exhausted. Dietician services shall be designated in the participant's IPC, supported by a formal assessment completed by a registered dietician, and ordered by a licensed medical professional. Both referrals and any claims billed for this service shall include the referring entity's NPI number. A third party liability form shall be required.

Relative providers (defined as biological, adoptive, and step parents) shall not provide this service.

At least 30 minutes of service shall be provided per session in order to bill.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency certified by DHCF to provide service

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Dietician Services

Provider Category:

Agency

Provider Type:

Agency certified by DHCF to provide service

Provider Qualifications

License *(specify):*

If the agency is a Home Health Agency, it shall be fully licensed in the State of Wyoming. Staff providing dietician services shall have a current license to practice from the Commission on Dietetic Registration.

Certificate *(specify):*

A provider of this service is required to attain and maintain a certification for this service from the DHCF.

Other Standard *(specify):*

A provider of this service shall meet the requirements in Chapter 45 of the Department of Health's Medicaid Rules. Requirements for providers and provider direct care staff include, but are not limited to: a successful criminal history background screening; a current CPR and First Aid certification; and a current driver's license and automobile insurance, if providing transportation. Direct care staff shall complete participant specific training prior to providing services to the participant. In addition to Chapter 45 requirements, providers shall adhere to the standards and requirements of all applicable Medicaid rules and regulations specified in the Provider Manual and Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

DHCF shall initially certify a new agency providing this service for one year. Renewal of that certification shall be conducted at least once every three (3) years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Occupational Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11080 occupational therapy
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Occupational therapy services consist of the full range of activities provided by a licensed occupational therapist. Services include assessing needs, developing a treatment plan, determining therapeutic intervention, and training and assisting with adaptive aids. Occupational therapy services through the waiver may be used for maintenance and the prevention of regression of skills.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Occupational therapy services are available for participants who are 21 and older. Participants under the age of 21 can access this service through Early Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

Units shall be subject to prior authorization and require a prescription and treatment letter or recommendation from a licensed medical professional. The referral and any claims billed for this service must include the referring entity's NPI number. Restorative services are available on the Medicaid State Plan. Maintenance therapy shall be provided under the waiver, and shall be supported with a third party liability form. State plan restorative therapy and waiver maintenance therapy shall not be billed on the same day.

Relative providers (defined as biological, adoptive, or step parents) shall not provide this service.

Services are available as an individual 15 minute unit or as a group session unit which requires a minimum of 30 minutes in service in order to bill.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency certified by DHCF to provide service

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:

Agency

Provider Type:

Agency certified by DHCF to provide service

Provider Qualifications

License *(specify):*

If the agency is a Home Health Agency, it shall be fully licensed in the State of Wyoming. Staff providing Occupational Therapy Services shall have a current license to practice from the Wyoming Board of Occupational Therapy.

Certificate *(specify):*

A provider of this service is required to attain and maintain a certification for this service from the DHCF.

Other Standard *(specify):*

A provider of this service shall meet the requirements in Chapter 45 of the Department of Health's Medicaid Rules. Requirements for providers and provider direct care staff include, but are not limited to: a successful criminal history background screening; a current CPR and First Aid certification; and a current driver's license and automobile insurance, if providing transportation. Direct care staff shall complete participant specific training prior to providing services to the participant. In addition to Chapter 45 requirements, providers shall adhere to the standards and requirements of all applicable Medicaid rules and regulations specified in the Provider Manual and Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

DHCF shall initially certify a new agency providing this service for one year. Renewal of that certification shall be conducted at least once every three (3) years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Physical Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11090 physical therapy
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Physical therapy services consist of the full range of activities provided by a licensed physical therapist. This service assists individuals to preserve and improve their abilities for independent function such as range of motion, strength, tolerance, and coordination. It may also prevent, insofar as possible, progressive disabilities through the use of assistive and adaptive devices, positioning, and sensory stimulation.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Physical therapy services are available for participants who are 21 and older. Participants under the age of 21 can access this service through Early Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

Units shall be subject to prior authorization and require a prescription and treatment letter or recommendation from a licensed medical professional. The referral and any claims billed for this service must include the referring entity's NPI number. Restorative services are available on the Medicaid State Plan. Maintenance therapy shall be provided under the waiver, and shall be supported with a third party liability form. State plan restorative therapy and waiver maintenance therapy shall not be billed on the same day.

Relative providers (defined as biological, adoptive, or step parents) shall not provide this service.

Services are available as an individual 15 minute unit or as a group session unit which requires a minimum of 30 minutes in service in order to bill.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency certified by DHCF to provide service

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Physical Therapy

Provider Category:

Agency

Provider Type:

Agency certified by DHCF to provide service

Provider Qualifications

License *(specify):*

If the agency is a Home Health Agency, it shall be fully licensed in the State of Wyoming. Staff providing Physical Therapy Services shall have a current license to practice from the Wyoming Board of Physical Therapy.

Certificate *(specify):*

A provider of this service is required to attain and maintain a certification for this service from the DHCF.

Other Standard *(specify):*

A provider of this service shall meet the requirements in Chapter 45 of the Department of Health's Medicaid Rules. Requirements for providers and provider direct care staff include, but are not limited to: a successful criminal history background screening; a current CPR and First Aid certification; and a current driver's license and automobile insurance, if providing transportation. Direct care staff shall complete participant specific training prior to providing services to the participant. In addition to Chapter 45 requirements, providers shall adhere to the standards and requirements of all applicable Medicaid rules and regulations specified in the Provider Manual and Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

DHCF shall initially certify a new agency providing this service for one year. Renewal of that certification shall be conducted at least once every three (3) years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Skilled Nursing

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05020 skilled nursing
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Skilled nursing services are medical care services delivered on an intermittent or part time basis to individuals with complex chronic medical conditions, which are performed within the Nurses' scope of practice as defined by Wyoming's Nurse Practice Act, and includes:

- The application of the nursing process including assessment, diagnosis, planning, intervention and evaluation;
- The administration, teaching, counseling, supervision, delegation, and evaluation of nursing practice; and
- The execution of the medical regimen.

Services must require a level of expertise that is undeliverable by non-medically trained individuals. Services must be supported by an order from a licensed medical professional. The referral and any claims billed for this service shall include the referring entity's NPI number. A Request for Prior Authorization of Skilled Nursing Services form must be submitted to the Division contractor that approves skilled nursing services, and prior authorization must be obtained before services can be added to the plan of care.

One skilled nursing assessment per plan year is allowed. An in-person assessment of the individual's skilled nursing needs is required as part of the assessment, and a Request for Prior Authorization of Skilled Nursing Services form, which includes a plan to address the identified needs, must be submitted in order to bill for the assessment or request prior authorization of skilled nursing services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Skilled nursing services are available for participants who are 21 and older. Participants under the age of 21 can access this service through Early Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

Skilled nursing services are an extension of the Medicaid State Plan. Skilled nursing services may be used when the Medicaid State Plan services have been exhausted, are not available in the person's area, or the hours of need for the service are not available by the home health provider. Services approved in the IPC must be within the scope of the State's Nurse Practice Act.

- Skilled nursing shall not be used if trained provider staff are able to provide the service, such as medication assistance or support for a medical appointment.
- A billable skilled nursing service unit is considered to be a service that is provided up to 15 minutes and that involves one-on-one direct participant care.
- Providers cannot be reimbursed for skilled nursing services that do not include direct participant care or services that do not include skilled nursing duties. For example, skilled nursing providers cannot be reimbursed for participant supervision, transportation to and from doctor appointments, time spent in waiting room with participant, or time spent charting or completing paperwork.
- Relative providers (defined as biological, adoptive, or step parents) shall not provide this service.
- Certified Nursing Assistants and other non-licensed individuals shall not provide this service.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency certified by DHCF to provide service

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Skilled Nursing

Provider Category:

Agency

Provider Type:

Agency certified by DHCF to provide service

Provider Qualifications

License *(specify):*

If the agency is a Home Health Agency, it shall be fully licensed in the State of Wyoming. Staff providing skilled nursing services shall have a current license to practice nursing from the Wyoming State Board of Nursing.

Certificate *(specify):*

A provider of this service is required to attain and maintain a certification for this service from the DHCF.

Other Standard *(specify):*

A provider of this service shall meet the requirements in Chapter 45 of the Department of Health's Medicaid Rules. Requirements for providers and provider direct care staff include, but are not limited to: a successful criminal history background screening; a current Basic Life Support Training certification; and a current driver's license and automobile insurance, if providing transportation. Direct care staff shall complete participant specific training prior to providing services to the participant. In addition to Chapter 45 requirements, providers shall adhere to the standards and requirements of all applicable Medicaid rules and regulations specified in the Provider Manual and Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

DHCF shall initially certify a new agency providing this service for one year. Renewal of that certification shall be conducted at least once every three (3) years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Speech, Hearing and Language Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
11 Other Health and Therapeutic Services	11100 speech, hearing, and language therapy
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Speech, hearing, and language services consist of the full range of activities provided by a licensed speech therapist. Services include screening and evaluation of participants with respect to speech function; development of therapeutic treatment plans; direct therapeutic intervention; selection, assistance, and training with augmentative communication devices, and the provision of ongoing therapy.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Speech, hearing and language services are available for participants who are 21 and older. Participants under the age of 21 can access this service through Early Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

Units shall be subject to prior authorization and require a prescription and treatment letter or recommendation from a licensed medical professional. The referral and any claims billed for this service must include the referring entity's NPI number. Restorative services are available on the Medicaid State Plan. Maintenance therapy shall be provided under the waiver, and shall be supported with a third party liability form. State plan restorative therapy and waiver maintenance therapy shall not be billed on the same day.

Relative providers (defined as biological, adoptive, or step parents) shall not provide this service.

Services are available as an individual or group session unit, which requires a minimum of 30 minutes in service in order to bill.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency certified by DHCF to provide service

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Speech, Hearing and Language Services

Provider Category:

Agency

Provider Type:

Agency certified by DHCF to provide service

Provider Qualifications

License *(specify):*

If the agency is a Home Health Agency, it shall be fully licensed in the State of Wyoming. Staff providing Speech Therapy Services shall have a current license to practice from the Wyoming Board of Speech Pathology and Audiology.

Certificate *(specify):*

A provider of this service is required to attain and maintain a certification for this service from the DHCF.

Other Standard *(specify):*

A provider of this service shall meet the requirements in Chapter 45 of the Department of Health's Medicaid Rules. Requirements for providers and provider direct care staff include, but are not limited to: a successful criminal history background screening; a current CPR and First Aid certification; and a current driver's license and automobile insurance, if providing transportation. Direct care staff shall complete participant specific training prior to providing services to the participant. In addition to Chapter 45 requirements, providers shall adhere to the standards and requirements of all applicable Medicaid rules and regulations specified in the Provider Manual and Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

DHCF shall initially certify a new agency providing this service for one year. Renewal of that certification shall be conducted at least once every three (3) years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Behavioral Support Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
10 Other Mental Health and Behavioral Services	10040 behavior support
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Behavioral support services are used to develop and implement individualized behavior plans based on behavioral sciences that focus on positive behaviors and identified challenges to improve a variety of well-defined skills. This service includes development of a functional behavior analysis, positive behavior support plan, training in appropriate expression of emotions and desires through the implementation of positive behavior support, and interventions to increase adaptive replacement behaviors. Behavioral support services can also be accessed for the purpose of reducing the use of restrictions and restraints within a participant's current IPC.

Activities required for reimbursement:

- Direct contact and observation with the participant (and collaterals as necessary) for the purposes of baseline determinations and positive behavior support plan (PBSP) development, which must comply with Chapter 45, Section 17 of the Department of Health's Medicaid Rules.
- Completing a functional behavior analysis and developing a behavioral support plan and subsequent revisions utilizing positive behavior supports and interventions.
- Conducting participant training to support effective implementation of an individual's desired outcomes through comprehensive Positive Behavior Support.
- Creating templates and providing training and technical assistance with primary caregiver(s) on the implementation of the participant's support plan.
- Documenting work completed, including case notes on training provided to primary caregivers and participants.
- Regularly reviewing the effectiveness of the plan with the participant and team.
- Generating summary documents to include baseline data regarding the behaviors, any progress has been made, intervention strategies have been implemented, and identified barriers that may inhibit progress.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Behavioral support services are available for participants who are 21 and older. Participants under the age of 21 can access this service through early education programs, school programs, and the Medicaid State Plan (for individuals with an Autism diagnosis).

Behavioral support services shall require a service request form, shall be subject to prior authorization by the Division, and shall not be covered under any billable service through the Medicaid State Plan.

A maximum of 120 units per plan year are available at the BCBA/BCaBA levels for initial assessment, completion of a functional behavior analysis, and positive behavior support plan development. A maximum of 960 units per year are available at the RBT level for measurement assessment, skill acquisition, behavior reduction, and documentation and reporting.

Documentation must be submitted to substantiate the need for continued behavioral support services on subsequent plans as this service isn't meant to be a continuous long term service.

Activities that are not allowed under this service:
- Aversive techniques – Any technique not approved by the individual's person centered planning team and the provider's human rights committee, if applicable.
- Restrictive interventions described in Chapter 45 of the Department of Health's Medicaid Rules.
- Direct care services.
- Counseling, therapy, or other services covered under the Medicaid State Plan.

Relative providers (defined as biological, step, or adoptive parents) shall not provide this service.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency certified by DHCF to provide service
Individual	Individual certified by DHCF to provide service

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Support Services

Provider Category:

Agency

Provider Type:

Agency certified by DHCF to provide service

Provider Qualifications

License *(specify):*

Agencies offering this service shall ensure that the practicing provider of behavioral support services follows the requirements and certifications established by the Board of Certified Behavior Analysts, per https://www.bacb.com. Each individual providing this service must meet the certification standards for the service that is being provided.

Certificate *(specify):*

A provider of this service is required to attain and maintain a certification for this service from the DHCF.

Other Standard *(specify):*

A provider of this service shall meet the requirements in Chapter 45 of the Department of Health's Medicaid Rules. Requirements for providers and provider direct care staff include, but are not limited to: a successful criminal history background screening; a current CPR and First Aid certification; and a current driver's license and automobile insurance, if providing transportation. Direct care staff shall complete participant specific training prior to providing services to the participant. In addition to Chapter 45 requirements, providers shall adhere to the standards and requirements of all applicable Medicaid rules and regulations specified in the Provider Manual and Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

DHCF shall initially certify a new agency providing this service for one year. Renewal of that certification shall be conducted at least once every three (3) years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Support Services

Provider Category:

Individual

Provider Type:

Individual certified by DHCF to provide service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider of behavioral support services shall follow the requirements and certifications established by the Board of Certified Behavior Analysts, per https://www.bacb.com, in order to provide behavioral support services. Each individual providing this service must meet the certification standards for the service that is being provided.

Other Standard *(specify):*

A provider of this service shall meet the requirements in Chapter 45 of the Department of Health's Medicaid Rules. Requirements for providers and provider direct care staff include, but are not limited to: a successful criminal history background screening; a current CPR and First Aid certification; and a current driver's license and automobile insurance, if providing transportation. Provider shall complete participant specific training prior to providing services to the participant. In addition to Chapter 45 requirements, providers shall adhere to the standards and requirements of all applicable Medicaid rules and regulations specified in the Provider Manual and Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

DHCF shall initially certify a provider this service for one year. Renewal of that certification shall be conducted at least once every three (3) years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Child Habilitation Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Child habilitation services provide regularly scheduled activities and supervision to children for a portion of their day. Services include training, coordination, and intervention directed at skill development and maintenance, physical health promotion and maintenance, language development, cognitive development, socialization, social and community integration, and domestic and economic management. This includes services not otherwise available through public education programs in the participant's local school district, including after school supervision, daytime services when school is not in session, and services to preschool age children. This service shall exclude any services available through public education programs funded under the Individuals with Disabilities Education Act (IDEA).

Services may be provided at various times of the day in multiple settings, when other waiver services would not be more appropriate, such as respite or personal care. Service may occur in a single physical environment or in multiple environments, including settings in the community.

For children ages 0-12, this service includes the provision of supplementary staffing necessary to meet the child's exceptional care needs in a daycare setting. This service does not include the basic cost of child care, which is the rate charged by and paid to a child care center or worker for children who do not have special needs.

For children ages 13-17, this service is available for the cost of child care, which is no longer required after age 12.

Transportation is included in the reimbursement rate.

This is a habilitation service. Training on objectives is expected as part of the provision of services, and progress shall be documented and made available to the participant, guardian, and case manager each month.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is limited to children under age 18. Services approved shall be based on assessed need and fit within the person's assigned budget.

A provider of child habilitation services may receive reimbursement for up to two (2) participants at one time, but shall limit the total combined number of persons to whom they are providing services to no more than three people unless approved by DHCF. The provider shall adhere to the supervision levels identified in each participant's IPC.

A relative provider (defined as a biological, adoptive, or step parent) shall not provide this service. Child habilitation services shall not be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the State Medicaid Agency.

Support with personal care needs, including medication assistance, is a component of the service, but may not comprise more than 20% of the service. Personal care services shall not be billed at the same time as child habilitation services.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency certified by DHCF to provide service
Individual	Individual hired by the participant

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Child Habilitation Services

Provider Category:

Agency

Provider Type:

Agency certified by DHCF to provide service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider, including a sole proprietor, of this service is required to attain and maintain a certification for this service from the DJCF.

Other Standard *(specify):*

A provider of this service shall meet the requirements in Chapter 45 of the Department of Health's Medicaid Rules. Requirements for providers and provider direct care staff include, but are not limited to: a successful criminal history background screening; a current CPR and First Aid certification; a current Medication Assistance certification for direct care staff assisting participants with medications; a current crisis intervention and restraint usage certification, if applicable; and a current driver's license and automobile insurance, if providing transportation. Direct care staff shall complete participant specific training prior to providing services to the participant. In addition to Chapter 45 requirements, providers shall adhere to the standards and requirements of all applicable Medicaid rules and regulations specified in the Provider Manual and Provider Agreement.

A provider shall ensure that services occur in settings that are community based and facilitate opportunities for participants to access the community and community resources to the same degree as people who do not have a disability. A participant shall have choice in with whom s/he wants to spend time, the activities and events in which s/he wants to be involved, and from whom s/he'd like to receive assistance and support. S/he shall be treated with dignity and respect by waiver providers, have his or her privacy respected to the extent possible for health and safety, and be free from coercion and restraint. Any restriction of rights shall meet federal requirements and include an assessed need and a restoration plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

DHCF shall initially certify a new agency providing this service for one year. Renewal of that certification, including an on-site visit, shall be conducted at least once every three (3) years. Providers that do not provide services in a setting that is owned, leased or controlled by the provider shall not be subject to an on-site visit. DHCF has the authority to conduct an on-site visit when a concern is identified during a complaint, incident report, internal referral, or at the agency's discretion.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Child Habilitation Services

Provider Category:
Individual
Provider Type:

Individual hired by the participant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Prior to providing services, and individual being hired by the participant shall:
- Be at least 18 years of age;
- Successfully pass a criminal history background screening;
- Be able to effectively communicate with the participant and other stakeholders;
- Be able to complete record keeping as required by the employer;
- Hold a current driver's license and automobile insurance, if providing transportation during the provision of services;
- Hold a current CPR and First Aid certification;
- Hold a current Medications Assistance Training certification, if applicable; and
- Hold a certificate in crisis intervention and restraint usage (CPI, Mandt), if applicable for the participant's needs.

The participant or legally authorized representative, with assistance as needed from the case manager, shall verify that, prior to working alone with the participant, the individual being hired has received training on the participant's IPC and has received training on the following DHCF policies and procedures:

- Participant choice;
- Recognizing abuse and neglect;
- Incident reporting;
- Participant rights and confidentiality;
- Emergency drills and situations; and
- Documentation standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent- Financial Management Service

Frequency of Verification:

The Fiscal Employer Agent shall conduct an initial and quarterly review on a random sample of files to ensure that all required documents are submitted and logged correctly in its system. The Agency shall provide a weekly status report to case managers and the participant or legally authorized representative regarding provider certifications, paperwork, status of trainings, and whether or not the provider has met all requirements to work for a participant.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Cognitive Retraining

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
11 Other Health and Therapeutic Services	11120 cognitive rehabilitative therapy
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Cognitive retraining provides training and rehabilitation services to the person served and family members that will assist in the restoration of cognitive function (e.g. ability/skills for learning, analysis, memory, attention, concentration, orientation, and information processing) in accordance with the IPC.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Agency certified by DHCF to provide service

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Cognitive Retraining

Provider Category:

Individual

Provider Type:

Agency certified by DHCF to provide service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider, including a sole proprietor, of this service is required to attain and maintain a certification for this service from the DHCF. Agencies are required to verify that the staff member providing the service is certified in cognitive retraining from an accredited institution of higher learning, is a certified Brain Injury Specialist through the Brain Injury Association of America, is a licensed professional with one year of acquired brain injury training, or has a Bachelor's degree in a related field and three (3) years of experience in working with people with acquired brain injuries.

Other Standard *(specify):*

A provider of this service shall meet the requirements in Chapter 45 of the Department of Health's Medicaid Rules. Requirements for providers and provider direct care staff include, but are not limited to: a successful criminal history background screening; a current CPR and First Aid certification; and a current driver's license and automobile insurance, if providing transportation. Direct care staff shall complete participant specific training prior to providing services to the participant. In addition to Chapter 45 requirements, providers shall adhere to the standards and requirements of all applicable Medicaid rules and regulations specified in the Provider Manual and Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

DHCF shall initially certify a new agency providing this service for one year. Renewal of that certification shall be conducted at least once every three (3) years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Companion Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08040 companion
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Companion services include supervision, socialization, and assistance for a participant to maintain safety in the home and community, and to enhance independence. Companions may assist or supervise the individual with tasks such as meal preparation, laundry, and shopping, but do not perform these activities as discrete services. Companions may also perform light housekeeping tasks that are incidental to the care and supervision of the participant. The provision of companion services does not entail hands-on nursing care, but does include personal care, such as medication assistance, and assistance with activities of daily living, as needed, during the provision of services. Routine transportation is included in the reimbursement rate.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is available to participants ages 18 and up. It is reimbursed at a 15-minute unit and is available as a 1:1 service or as a group rate serving 2 or 3 people. Service shall be provided for no more than nine (9) hours a day except for special events or out of town trips. This service shall not be used in conjunction with community living services, so services times shall not overlap. This service shall not be used to provide monitoring while a participant sleeps.

Companion services provided to participants ages 18 through 21 shall not duplicate or replace services that are covered under IDEA. Providers shall not serve children and adults at the same time unless authorized in advance by DHCF. Services shall not be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit.

Relative providers (defined as biological, adoptive, or step parents) shall not provide this service.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency certified by DHCF to provide service
Individual	Individual hired by the participant

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Companion Services

Provider Category:

Agency

Provider Type:

Agency certified by DHCF to provide service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider, including a sole proprietor, of this service is required to attain and maintain a certification for this service from the DHCF. If a provider meets the criteria outlined in Section 25 of Chapter 45 of the Department of Health's Medicaid Rules, it shall attain and maintain accreditation by a nationally recognized accreditation entity for human services as specified.

Other Standard *(specify):*

A provider of this service shall meet the requirements in Chapter 45 of the Department of Health's Medicaid Rules. Requirements for providers and provider direct care staff include, but are not limited to: a successful criminal history background screening; a current CPR and First Aid certification; a current Medication Assistance certification for direct care staff assisting participants with medications; a current crisis intervention and restraint usage certification, if applicable; and a current driver's license and automobile insurance, if providing transportation. Direct care staff shall complete participant specific training prior to providing services to the participant. In addition to Chapter 45 requirements, providers shall adhere to the standards and requirements of all applicable Medicaid rules and regulations specified in the Provider Manual and Provider Agreement.

A provider shall ensure that services occur in settings that are community based and facilitate opportunities for participants to access the community and community resources to the same degree as people who do not have a disability. A participant shall have choice in with whom s/he wants to spend time, the activities and events in which s/he wants to be involved, and from whom s/he'd like to receive assistance and support. S/he shall have choice and decision making authority over how s/he budgets, manages, and spends money. S/he shall be treated with dignity and respect by waiver providers, have his or her privacy respected to the extent possible for health and safety, and be free from coercion and restraint. Any restriction of rights shall meet federal requirements and include an assessed need and a restoration plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

DHCF shall initially certify a new agency providing this service for one year. Renewal of that certification, including an on-site visit, shall be conducted at least once every three (3) years. Providers that do not provide services in a setting that is owned, leased or controlled by the provider shall not be subject to an on-site visit. DHCF has the authority to conduct an on-site visit when a concern is identified during a complaint, incident report, internal referral, or at the agency's discretion.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Companion Services

Provider Category:

Individual

Provider Type:

Individual hired by the participant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Prior to providing services, and individual being hired by the participant shall:
- Be at least 18 years of age;
- Successfully pass a criminal history background screening;
- Be able to effectively communicate with the participant and other stakeholders;
- Be able to complete record keeping as required by the employer;
- Hold a current driver's license and automobile insurance, if providing transportation during the provision of services;
- Hold a current CPR and First Aid certification;
- Hold a current Medications Assistance Training certification, if applicable; and
- Hold a certificate in crisis intervention and restraint usage (CPI, Mandt), if applicable for the participant's needs.

The participant or legally authorized representative, with assistance as needed from the case manager, shall verify that, prior to working alone with the participant, the individual being hired has received training on the participant's IPC and has received training on the following DHCF policies and procedures:

- Participant choice;
- Recognizing abuse and neglect;
- Incident reporting;
- Participant rights and confidentiality;
- Emergency drills and situations; and
- Documentation standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent- Financial Management Service

Frequency of Verification:

The Fiscal Employer Agent shall conduct an initial and quarterly review on a random sample of files to ensure that all required documents are submitted and logged correctly in its system. The Agency shall provide a weekly status report to case managers and the participant or legally authorized representative regarding provider certifications, paperwork, status of trainings, and whether or not the provider has met all requirements to work for a participant.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Crisis Intervention Support

HCBS Taxonomy:

Category 1: 10 Other Mental Health and Behavioral Services

Sub-Category 1: 10030 crisis intervention

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Crisis intervention services are available for situations in which a participant's tier level may not provide sufficient support for specific activities, medical conditions or occurrences of behaviors or crisis, but extensive supervision is not needed at all times. The service shall only be provided to a participant age 18 years or older in habilitative day services. Crisis intervention provides funding for extra staff support in order to supervise a participant during times of periodic behavioral episodes where the person is a danger to him/herself or others, or if the participant has an occasional or temporary medically fragile situation and is at risk of imminent harm without the extra staff support. Intervention for behavioral purposes is not intended for monitoring the person should the behavior occur, but for the purpose of supporting the participant when the need arises, using positive behavior supports and interventions outlined in the IPC to de-escalate a situation, teach appropriate behaviors, and keep the participant safe until the participant is stable.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The service shall only be provided to a participant age 18 years or older in community living services levels 3 – 5 or habilitation day services. Due to the expectation that participants in level 6 community living services shall receive the attention of at least one to two staff members as specified in the plan of care, this level of service is not eligible for crisis invention.

Crisis intervention units are approved by the ECC and shall be based on verified need and evidence of the diagnosis or condition requiring this service. Documentation of progress and data on behaviors and outcome of the intervention services must be submitted to the case manager and DHCF at the frequency specified in the IPC.

Relatives (defined as biological, adoptive, or step parents) shall not provide this service.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency certified by DHCF to provide service

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Crisis Intervention Support

Provider Category:

Agency

Provider Type:

Agency certified by DHCF to provide service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider of this service is required to attain and maintain a certification for this service from the DHCF.

Other Standard *(specify):*

A provider of this service shall meet the requirements in Chapter 45 of the Department of Health's Medicaid Rules. Requirements for providers and provider direct care staff include, but are not limited to: a successful criminal history background screening; a current CPR and First Aid certification; a current Medication Assistance certification for direct care staff assisting participants with medications; a current crisis intervention and restraint usage certification, if applicable; and a current driver's license and automobile insurance, if providing transportation. Direct care staff shall complete participant specific training prior to providing services to the participant. In addition to Chapter 45 requirements, providers shall adhere to the standards and requirements of all applicable Medicaid rules and regulations specified in the Provider Manual and Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

DHCF shall initially certify a new agency providing this service for one year. Renewal of that certification, including an on-site visit, shall be conducted at least once every three (3) years. Providers that do not provide services in a setting that is owned, leased or controlled by the provider shall not be subject to an on-site visit. DHCF has the authority to conduct an on-site visit when a concern is identified during a complaint, incident report, internal referral, or at the agency's discretion.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Modification

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Environmental modifications include functionally necessary physical adaptations to the private residence of the participant or the participant's family, as outlined in the participant's IPC, that are necessary to ensure the health, welfare, and safety of the participant or that enable the participant to function with greater independence in the home. Adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant.

All services shall be provided in accordance with applicable State or local building codes.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A lifetime cap of $20,000 per family per any current or previous DHCF waiver will be calculated for purchases made after July 1, 2013. A request that addresses a critical health or safety need and exceeds the lifetime cap is subject to available funding and approval by ECC.

Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). Adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant are excluded.

Modifications of rented or leased homes shall be extraordinary alterations that are uniquely needed by the individual, and for which the property owner would not ordinarily be responsible.

Adaptations that are covered by the Medicaid state plan, a state independent living center, or vocational rehabilitation are excluded. Providers of environmental modification services are required to contact Wyoming Medicaid to determine if the requested modification is covered under the Medicaid State Plan. The provider must then sign a third party verification form indicating that the Comprehensive Waiver is the payor of last resort. Home accessibility adaptations shall not be furnished to modify settings that are owned or leased by providers of waiver services.

Pursuant to Chapter 44 of the Department of Health's Medicaid Rules, the case manager shall not obtain quotes until the overall scope of the project is approved by DHCF.

DHCF may use a third party to conduct an on-site visit to assess the proposed modification and need for the modification to ensure cost effectiveness.

Sale of environmental modifications shall not profit the participant or family.

Relative providers (defined as biological, adoptive, or step parents) may provide this service in accordance with Chapter 45 of the Department of Health's Medicaid Rules, adhering to the following requirements:

- They are a certified Medicaid Waiver Environmental Modification Provider; and
- DHCF receives at least one other bid from another provider to ensure cost effectiveness.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency certified by DHCF to provide service

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modification

Provider Category:

Agency

Provider Type:

Agency certified by DHCF to provide service

Provider Qualifications

License *(specify):*

Provider staff shall have the applicable building, electrical, plumbing, or contractor's license, as required by local or state regulations.

Certificate *(specify):*

A provider, including a sole proprietor, of this service is required to attain and maintain a certification for this service from the DHCF.

Other Standard *(specify):*

A provider of this service shall meet the requirements in Chapter 45 of the Department of Health's Medicaid Rules. Staff shall complete training on incident reporting, HIPAA, and confidentiality requirements. In addition to Chapter 45 requirements, providers shall adhere to the standards and requirements of all applicable Medicaid rules and regulations specified in the Provider Manual and Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

DHCF shall initially certify a new agency providing this service for one year. Renewal of that certification shall be conducted at least once every three (3) years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Individual Habilitation Training

HCBS Taxonomy:

Category 1:	Sub-Category 1:
13 Participant Training	13010 participant training
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Individual habilitation training is a specialized 1:1 intensive training service to assist a participant with the acquisition or improvement in skills not yet mastered that will lead to more independence and a higher level of functioning. Individual habilitation training services are available for participants who live with unpaid caregivers or who need less than 24-hour paid supervision and support.

- Training objectives are required, must be meaningful to the participant, and may include: adaptive skill development; assistance and training on activities of daily living; transportation safety and navigation; building social capital and connections; and hobby skill development for work on fine or gross motor skills.
- Objectives must be specific and measureable, and data must be tracked and analyzed for trends. Summary reports on progress or lack of progress must be provided to the case manager and participant or guardian monthly. Objectives shall be revised as needed when skills are acquired or the objective is not yielding any progress.
- Services may be provided in the person's home or in the community.
- Supports may include facilitation of inclusion of the individual within a community group or volunteer organization; opportunities for the participant to join associations and community groups; opportunities for inclusion in a broad range of community activities including opportunities to pursue social and cultural interests, choice making, and volunteer time.
- Transportation relating to the participant's training objective shall be provided by the service provider and is included in the rate for the service.
- This service includes services not otherwise available through IDEA or other public education programs in the participant's local school district, including after school supervision, daytime services when school is not in session, and services to preschool age children.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

- Individual habilitation training is an intensive training service; therefore, it is expected that training is occurring at all times this service is being provided. If the participant is unable to sustain intensive training, the IPC shall identify an alternate service to be used during times in which supervision is provided but training is not conducted.
- Individual Habilitation Training is a 1:1 service. It is available to participant's ages 0 through 20, and shall be approved based upon the participant's needs and budget limit. Individual habilitation training is limited to 4 hour a day.
- Relative providers (defined as a biological, adoptive, or step parent) shall not provide this service.
- Individual habilitation training shall not be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the State Medicaid Agency.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency certified by DHCF to provide service
Individual	Individual hired by the participant

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Individual Habilitation Training

Provider Category:

Agency

Provider Type:

Agency certified by DHCF to provide service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider, including a sole proprietor, of this service is required to attain and maintain a certification for this service from the DHCF.

Other Standard *(specify):*

A provider of this service shall meet the requirements in Chapter 45 of the Department of Health's Medicaid Rules. Requirements for providers and provider direct care staff include, but are not limited to: a successful criminal history background screening; a current CPR and First Aid certification; a current Medication Assistance certification for direct care staff assisting participants with medications; a current crisis intervention and restraint usage certification, if applicable; and a current driver's license and automobile insurance, if providing transportation. Direct care staff shall complete participant specific training prior to providing services to the participant. In addition to Chapter 45 requirements, providers shall adhere to the standards and requirements of all applicable Medicaid rules and regulations specified in the Provider Manual and Provider Agreement.

A provider shall ensure that services occur in settings that are community based and facilitate opportunities for participants to access the community and community resources to the same degree as people who do not have a disability. A participant shall have choice in with whom s/he wants to spend time, the activities and events in which s/he wants to be involved, and from whom s/he'd like to receive assistance and support. S/he shall be treated with dignity and respect by waiver providers, have his or her privacy respected to the extent possible for health and safety, and be free from coercion and restraint. Any restriction of rights shall meet federal requirements and include an assessed need and a restoration plan.

Within a year of being certified in this service, and annually thereafter, the provider or staff providing the service must 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 s/he serves, writing measurable objectives, gathering and using data to develop better training programs, or training modules posted by the Division.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

DHCF shall initially certify a new agency providing this service for one year. Renewal of that certification, including an on-site visit, shall be conducted at least once every three (3) years. Providers that do not provide services in a setting that is owned, leased or controlled by the provider shall not be subject to an on-site visit. DHCF has the authority to conduct an on-site visit when a concern is identified during a complaint, incident report, internal referral, or at the agency's discretion.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Individual Habilitation Training

Provider Category:

Individual

Provider Type:

Individual hired by the participant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Prior to providing services, and individual being hired by the participant shall:
- Be at least 18 years of age;
- Successfully pass a criminal history background screening;
- Be able to effectively communicate with the participant and other stakeholders;
- Be able to complete record keeping as required by the employer;
- Hold a current driver's license and automobile insurance, if providing transportation during the provision of services;
- Hold a current CPR and First Aid certification;
- Hold a current Medications Assistance Training certification, if applicable; and
- Hold a certificate in crisis intervention and restraint usage (CPI, Mandt), if applicable for the participant's needs.

The participant or legally authorized representative, with assistance as needed from the case manager, shall verify that, prior to working alone with the participant, the individual being hired has received training on the participant's IPC and has received training on the following DHCF policies and procedures:

- Participant choice;
- Recognizing abuse and neglect;
- Incident reporting;
- Participant rights and confidentiality;
- Emergency drills and situations; and
- Documentation standards.

Within a year of being certified in this service, and annually thereafter, the provider or staff providing the service must 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 s/he serves, writing measurable objectives, gathering and using data to develop better training programs, or training modules posted by the Division.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent- Financial Management Service

Frequency of Verification:

The Fiscal Employer Agent shall conduct an initial and quarterly review on a random sample of files to ensure that all required documents are submitted and logged correctly in its system. The Agency shall provide a weekly status report to case managers and the participant or legally authorized representative regarding provider certifications, paperwork, status of trainings, and whether or not the provider has met all requirements to work for a participant.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Special Family Habilitation Home

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
02 Round-the-Clock Services	02031 in-home residential habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Special family habilitation home (SFHH) services consist of participant specific, individually designed and coordinated services within a family (other than biological, step, or adoptive parents) host home environment. Services are only available to children ages 0 – 17.

Special family habilitation home services are available until another residential option is available to the child, subject to involvement from the Department of Family Services, Department of Education, Office of the Attorney General, and the Wyoming Department of Health. DHCF will work with the Department of Family Services and the Department of Education in order to help the child receive residential services if they are determined to be the last resort for the minor child. When a child on this service turns 18, s/he may transition to the appropriate community living service.

- Transportation between the participant's place of residence, other service sites, or places in the community is included in the rate.
- Providers are responsible for both formal and informal training opportunities. Participant schedules must be individualized and objectives must be meaningful. Training on objectives is expected as part of the provision of services, and progress shall be documented and made available to the participant, legally authorized representative, and case manager each month.
- The SFHH provider is the primary caregiver and assumes 24-hour care of the individual. The provider must be in the participant's residence, providing services during both awake and sleeping time for a minimum of eight (8) hours in a twenty-four (24) hour period (from 12:00am – 11:59pm), in order to be reimbursed.
- Family visits and trips are encouraged. The provider shall be reimbursed on the days the participant leaves for and returns from a trip.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

- This service is not open to new participants without going through the Extraordinary Care Committee (ECC) approval process for an out of home placement.
- This service cannot be used in conjunction with individual habilitation training services.
- SFHH services include personal care needs, so IPCs with both SFHH and personal care services will not be approved.
- Relative providers (defined as biological, step, or adoptive parents) shall not provide this service.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency certified by DHCF to provide service

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Special Family Habilitation Home

Provider Category:

Agency

Provider Type:

Agency certified by DHCF to provide service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider, including a sole proprietor, of this service is required to attain and maintain a certification for this service from the DHCF. If a provider meets the criteria outlined in Section 25 of Chapter 45 of the Department of Health's Medicaid Rules, it shall attain and maintain accreditation by a nationally recognized accreditation entity for human services as specified.

Other Standard *(specify):*

A provider of this service shall meet the requirements in Chapter 45 of the Department of Health's Medicaid Rules. Requirements for providers and provider direct care staff include, but are not limited to: a successful criminal history background screening; a current CPR and First Aid certification; a current Medication Assistance certification for direct care staff assisting participants with medications; a current crisis intervention and restraint usage certification, if applicable; and a current driver's license and automobile insurance, if providing transportation. Direct care staff shall complete participant specific training prior to providing services to the participant. In addition to Chapter 45 requirements, providers shall adhere to the standards and requirements of all applicable Medicaid rules and regulations specified in the Provider Manual and Provider Agreement.

A provider shall ensure that services occur in settings that are community based and facilitate opportunities for participants to access the community and community resources to the same degree as people who do not have a disability. A participant shall have choice in where s/he wants to live, with whom s/he wants to spend time, the activities and events in which s/he wants to be involved, and from whom s/he'd like to receive assistance and support. S/he shall have choice and decision making authority over how s/he budgets, manages, and spends money. S/he shall be treated with dignity and respect by waiver providers, have his or her privacy respected to the extent possible for health and safety, and be free from coercion and restraint. Any restriction of rights shall meet federal requirements and include an assessed need and a restoration plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

DHCF shall initially certify a new agency providing this service for one year. Renewal of that certification, including an on-site visit, shall be conducted at least once every three (3) years. Providers that do not provide services in a setting that is owned, leased or controlled by the provider shall not be subject to an on-site visit. DHCF has the authority to conduct an on-site visit when a concern is identified during a complaint, incident report, internal referral, or at the agency's discretion.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Specialized Equipment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Specialized equipment includes:
1. Devices, controls, or appliances that enable participants to increase their ability to perform activities of daily living;
2. Devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment or community in which they live;
3. Items necessary for life support or to address physical conditions, including ancillary supplies and equipment necessary for the proper functioning of such items;
4. Other durable and non-durable medical equipment not available under the Medicaid State Plan or IEP that is necessary to address participant functional limitations; and,
5. Necessary medical supplies not available under the Medicaid State Plan or other insurance held by the participant. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the Medicaid State Plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.

The IPC shall reflect the need for equipment, how the equipment addresses health, safety, or accessibility needs of the participant or allows them to function with greater independence, and specific information on how often and where the equipment is used. Criteria for approval, allowable items, and limitations of this service are outlined in Chapter 44 of the Department of Health's Medicaid Rules. The case manager shall check with Medicaid, Medicare, and/or a participant's other insurance carrier to see if the requested equipment is covered under their plans. Waiver funds are a payer of last resort.

If the participant has an Individualized Education Plan or Individualized Family Service Plan, the case manager will be required to submit a copy of that document, along with documentation as to why the equipment is not available through those services.

Specialized equipment shall be functionally necessary and meet at least two of the following criteria and is subject to DHCF approval:
1. Be necessary to increase the participant's ability to perform activities of daily living or to perceive control, or communicate with the environment in which the person lives;
2. Be necessary to enable the participant to function with greater independence and without which the person would require institutionalization; or
3. Be necessary to ensure the person's health, welfare, and safety.

Relative providers (defined as biological, adoptive, and step parents) may provide this service with the following requirements:
- They are a certified Medicaid Waiver Specialized Equipment Provider; and
- Do not impose a mark-up to the total cost of the equipment when providing this service to their relative (unless they operate a non-profit corporation); and
- Receive at least one other bid from another provider to ensure cost effectiveness.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Specialized equipment has a $2,000 annual limit and is subject to prior authorization through DHCF. If a needed item exceeds $2,000, the team may request an exception through the Extraordinary Care Committee (ECC). The Division may require an assessment by a Certified Specialized Equipment (CSE) professional prior to an equipment purchase. The cost of the assessment must be funded as a part of the $2,000 cap.

Providers of specialized equipment services are required to contact Wyoming Medicaid to determine if the requested equipment is covered under the Medicaid State Plan. The provider must then sign a third party verification form indicating that the Comprehensive Waiver is the payor of last resort.

The purchase of electronic technology devices shall be allowed once every five (5) years, and like items shall not be purchased during those five (5) years unless the device is used as a primary means for communication and the request is accompanied by a letter of necessity from a Speech Language Pathologist. The Division shall limit the purchase of general items (i.e., iPad, electronic tablet), and shall require a written recommendation by a CSE professional before such an item is approved.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency certified by DHCF to provide service

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Equipment

Provider Category:

Agency

Provider Type:

Agency certified by DHCF to provide service

Provider Qualifications

License *(specify):*

Provider staff shall have the applicable building, electrical, plumbing, or contractor's license, as required by local or state regulations.

Certificate *(specify):*

A provider, including a sole proprietor, of this service is required to attain and maintain a certification for this service from the DHCF.

Other Standard *(specify):*

A provider of this service shall meet the requirements in Chapter 45 of the Department of Health's Medicaid Rules. Requirements for provider staff include, but are not limited to a successful criminal history background screening. Staff shall complete training on incident reporting, HIPAA, and confidentiality requirements. In addition to Chapter 45 requirements, providers shall adhere to the standards and requirements of all applicable Medicaid rules and regulations specified in the Provider Manual and Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

DHCF shall initially certify a new agency providing this service for one year. Renewal of that certification shall be conducted at least once every three (3) years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transportation

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
15 Non-Medical Transportation	15010 non-medical transportation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Transportation is a gap service that enables participants to gain access to employment sites, community services, activities, and resources as specified in the IPC, when a service provider is not needed at the event. Service is not intended to replace formal or informal transportation options, such as the use of natural supports, city transportation services, and travel vouchers. Transportation services under the waiver shall be offered in accordance with an individual's IPC, and only when family, neighbors, friends, or community agencies are unable to provide transportation alternatives.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service does not include transportation to medical appointments required under 42 CFR 431.53, or transportation services available under the Medicaid State Plan.

Service will be reimbursed by trip. A trip may be rounded up to 5 miles if at least 2 miles are traveled. A trip may be rounded up to 10 miles if at least 7 miles are traveled. Service is capped at $2,000 per year.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency certified by DHCF to provide services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Agency certified by DHCF to provide services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider of this service is required to attain and maintain a certification for this service from the DHCF.

Other Standard *(specify):*

A provider, including a sole proprietor, of this service shall meet the requirements in Chapter 45 of the Department of Health's Medicaid Rules. Requirements for providers and provider direct care staff include, but are not limited to: a successful criminal history background screening; a current CPR and First Aid certification; and a current driver's license and automobile insurance, if providing transportation. Direct care staff shall complete participant specific training prior to providing services to the participant. In addition to Chapter 45 requirements, providers shall adhere to the standards and requirements of all applicable Medicaid rules and regulations specified in the Provider Manual and Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

DHCF shall initially certify a new agency providing this service for one year. Renewal of that certification shall be conducted at least once every three (3) years.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.

◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.
Check each that applies:

☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*

☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

☐ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

☐ **As an administrative activity.** *Complete item C-1-c.*

☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

○ **No. Criminal history and/or background investigations are not required.**

◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Providers and provider staff members who deliver direct 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 Health and Human Services Office of Inspector General (OIG) Exclusion Database screening, a Federal Bureau of Investigation (FBI) fingerprint background check, and State of Wyoming Division of Criminal Investigation (DCI) fingerprint background check per Chapter 45, Section 14 of the Department of Health's Medicaid rules. The only exceptions are waiver providers certified to provide environmental modifications or specialized equipment, which are not direct services.

DHCF requires the provider and all staff members to submit a background screening before waiver services can be provided. When a participant self-directing a service, or his/her representative, hires a new employee, the Financial Management Service shall assure the background screening is submitted before the employee can receive reimbursement for working for the participant.

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 18 years or older following the submission of a 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 a successful background screening.

The background check must verify the provider, provider staff, or employee of a self-directing participant has not been convicted, plead guilty, no contest to, or does not have a pending deferred prosecution for:

An Offense Against the Person, including:
- Homicide (W.S. 6-2-10)
- Kidnapping (W.S. 6-2-201)
- Sexual assault (W.S. 6-2-301)
- Robbery and blackmail (W.S. 6-2-401),
- Assault and battery (W.S. 6-2-501), and
- Human trafficking (W.S. 6-2-701), or
- Similar laws of any other state or the United States relating to these crimes.

An Offense Against Morals, Decency and Family including:
- Bigamy (W.S. 6-4-401)
- Incest (W.S. 6-4-402)
- Abandoning or endangering children (W.S. 6-4-403)
- Violation of order of protection (W.S. 6-4-404), and
- Endangering children; controlled substances (W.S. 6-4-405), or
- Similar laws of any other state or the United States relating to these crimes.

DHCF requires a full subsequent background screening every 5 years. Additionally, 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 OIG screenings.

Providers are responsible for ensuring results of background screenings are maintained in the provider or staff file. DHCF completes a staff file review of provider agencies during the provider certification renewal process to assure background checks have been completed and to verify that staff meet the background check requirements to provide waiver services. DHCF also oversees the Financial Management Service provider to assure background checks are completed before employees of participants who are self-directing services begin working with the participant.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

○ **No. The state does not conduct abuse registry screening.**

◉ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been

conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Wyoming Department of Family Services (DFS) maintains the Central Registry of child and disabled adult protection cases, as authorized in Wyoming State Statute W.S. §7-19-201. All providers and provider staff members who provide direct 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 submit a Central Registry Disclosure Form for screening by DFS to ensure they are not listed on the DFS central registry, per Chapter 45 of the Department of Health's Medicaid Rules.

Providers are responsible for ensuring results of the DFS central registry screening are maintained in the provider or staff file. DHCF completes a staff file review of provider agencies during the provider certification renewal process to assure central registry screenings have been completed and to verify that staff meet the requirements to provide waiver services. DHCF also oversees the Financial Management Service provider to assure central registry screenings are completed before employees of participants who are self-directing services begin working with the participant.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- ◉ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- ○ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- ○ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ◉ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

Wyoming State Statute 42-4-102(a)(ii) provides the statutory authority to allow payments to legally responsible individuals as described in this section.

1. Children under the age of 18 may receive personal care services from a legally responsible individual for services that are deemed extraordinary care, if the legally responsible individual is the biological, adoptive, or step parent of a minor child, or the legally authorized representative of a minor child.
2. The legally responsible individual(s) shall be a certified Medicaid provider, establish a Limited Liability Company or a Corporation, and meet the qualifications as specified in Chapter 45 of the Department of Health's Medicaid Rules.
3. The need for personal care services shall meet the service definition for personal care as described in Appendix C-1/C-3. Criteria for extraordinary care shall meet the requirements specified below, and shall be documented in the participant's IPC;
a. The participant's Adaptive Behavior Quotient is 0.35 or lower on the ICAP assessment; and
b. The participant needs assistance with ADLs or IADLs exceeding the range of expected activities that a legally responsible individual would ordinarily perform in the household on behalf of a person of the same age without a disability or chronic illness, and which are necessary to assure the health and welfare of the participant and avoid institutionalization. (Example: a 12 year old needing assistance with dressing and bathing, whereas a typical 12 year old does not.); or
c. The participant requires care from a person with specialized medical skills relating to the participant's diagnosis or medical condition as determined appropriate by the participant's licensed medical professional and DHCF.
4. Personal care services for extraordinary care paid to a legally responsible individual shall not exceed four (4) hours per day per participant. Additional units needed beyond 4 hours a day shall only be approved by the Extraordinary Care Committee (ECC).
5. A spouse may receive reimbursement only if he/she presents DHCF with a certified court order establishing another party as the legally authorized representative of a participant.
6. To ensure the provision of services is in the best interest of the participant, the IPC shall be developed and monitored by a case manager without a conflict of interest. The IPC shall document that services do not duplicate similar services, natural supports, or services otherwise available to the participant.
7. Personal care services shall be subject to prior authorization by DHCF and be based upon individual extraordinary care needs as specified in the IPC and other assessments. Documentation of services provided are reviewed by the case manager on a monthly basis to verify that services delivered align with the approved IPC.

☐ **Self-directed**

☒ **Agency-operated**

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

○ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**

○ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

◉ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

DHCF recognizes that there are certain circumstances in which paying a relative to provide essential waiver services is the most efficient, cost effective, and beneficial to participants. These circumstances may include:
- A lack of available non-related staff persons in remote geographic regions, who can furnish services at necessary times and places;
- A participant's extraordinary care needs; or
- The need for specialized medical skills acquired by relatives.

However, it is important to ensure that there are systems in place to guard against conflicts of interest, inadvertent limits on participant choice, and potential fraud.

1. A relative is defined as a biological, adoptive, or step parent who:
a. Has established a LLC or other corporation;
b. Is a certified Medicaid provider, or an employee of a certified Medicaid provider, and meets the qualifications specified in Chapter 45 of the Department of Health's Medicaid Rules; and
c. Is not the spouse or legally authorized representative of the participant.
2. Relatives may furnish certain services: community living, community support, personal care, environmental modification, and specialized equipment.
a. Specific limitations for relatives providing these services are outlined in Appendix C1.
3. Documentation of services provided shall be reviewed by the case manager on a monthly basis to verify that services delivered align with the approved IPC.
4. Relatives paid to provide services as outlined above shall meet the same requirements and qualifications as other providers and provider staff, and are subject to the same oversight levels as outlined in the waiver and applicable regulations and policies. All claims are subject to post-payment validation.
5. Relatives shall not provide services through self-direction.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Continuous open enrollment is available for potential providers of DD Waiver services. Information on how to become a DD Waiver provider is available on the DHCF website, and DHCF staff members are available to review the process and requirements of becoming a DD Waiver provider. The on-line provider enrollment process can be through the DHCF website.

DHCF works with the applicant throughout the enrollment process and is available to answer questions. After all requirements of certification have been met, a provider number is generated. All DD Waiver providers are required to have a provider number and a current provider agreement with the SMA before the provision of services can be reimbursed.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
C.i.a - Percentage of waiver providers that initially met all state certification requirements (# of waiver providers initially certified that met all the requirements / # of providers initially certified to provide waiver services)

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
Information Management for Providers (IMPROV) system, or its successor

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
C.i.b - Percentage of waiver providers that obtained certification renewal prior to certification expiration (# of providers that obtained certification renewal by certification expiration date / # of providers recertified)

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
IMPROV, or its successor

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid**	☐ **Weekly**	☒ **100% Review**

Agency		
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
C.ii - Percentage of non-certified self-directed employees who met minimum requirements outlined in Wyoming rule and regulation (# of self-directed employees who met requirements / # self-directed employees).

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
C.iii - Percentage of enrolled providers that met Wyoming training requirements (# of enrolled providers that met training requirements / # of providers).

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
IMPROV, or its successor

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The anticipated outcome for this data collection is ensuring that the state has designed and implemented an adequate system for assuring that qualified providers deliver waiver services to participants. The state will review the performance measure data for this assurance on a quarterly basis. If, during a quarterly review, there are areas that do not meet anticipated outcomes, DHCF will ensure that issues caused by failure to follow process or policy are remedied through technical assistance and re-education at an individual level, and, where possible, through statewide training. Individual remediation activity requires follow up from DHCF to determine that the provider successfully completed the required corrective action. Corrective action plans, sanctions, and decertification may occur if a provider fails to meet remediation efforts. Remediation strategies include training, revision of administrative processes and procedures, administrative rule revisions, and waiver amendments. These strategies will be used based on the results of the discovery and analysis of the related performance measure. If compliance with the performance measure falls below 86%, a request for a corrective action plan, including activities and time lines for completion and follow-up, will be required. Follow-up will include a discovery process using a valid random sample.

On a quarterly basis, DHCF will review performance measures, corrective action, and other meaningful data listed above. Processes for such review will be studied, and possibly adjusted on an annual basis.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

○ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

◉ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the

amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☒ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

A. The waiver services to which the limit applies:

The Individual Budget Amount (IBA) assigned to a participant applies to any of the waiver services he/she chooses to have on the IPC. Levels 3 - 6 of community living services are not open to new participants without going through the ECC approval process for an out of home placement.

B. The basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject:

DHCF uses a methodology for assessing need and determining budgets which provides a stable and equitable foundation on which to build a stronger, more person-centered waiver system that promotes greater community integration, employment support, and independence.

The IBA methodology uses the nationally recognized Inventory for Client and Agency Planning (ICAP) to determine budgets based on a participant's assessed needs. The ICAP has been applied to each applicant and participant of Wyoming DD Waiver services for over 25 years. The ICAP assessment determines an individual's level of functioning for broad independence and general maladaptive factors. The sub-scores of the ICAP also measure a person's functioning in the areas of social and communication skills, personal living skills, motor skills, and community living skills.

A participant's IBA is determined by three (3) factors:

1. Level of Service score (LOS) (continuous scale between 1 – 6), assigned to a person based on independent assessments of need, including their ICAP scores, supplemental assessments, and prior service utilization;
2. Living Situation: family home, independently or semi-independently, or in community living services; and
3. Age: over 21 or under 21 and in school.

Assessing the Level of Service Need
For each individual on the Comprehensive Waiver, the IBA algorithm will use three (3) separate 'passes' to assess the level of need on a continuous scale between 1 and 6.

The first pass determines a level based on the overall ICAP service score alone. The second pass considers the ICAP sub-scores corresponding most closely to overall behavioral and medical needs (general maladaptive score and personal living domain score, respectively). The highest of the first and second passes is chosen. The third pass, based on generated flags, considers other independent assessment information on the person, based on specific assessment questions and prior service utilization. These flags may result in an adjustment of the final LOS, necessitating an adjusted budget in order to properly reflect the person's assessed needs.

C. How the limit will be adjusted over the course of the waiver period:
DHCF will review the methodology and algorithm used to set budgets each year to determine if the IBAs assigned are reflective of the assessed service needs of the waiver participants. DHCF will also review the IBA adjustments requests that have been submitted (whether approved or denied) in order to analyze the reasons for adjustment requests and determine whether a factor in the model is missing or incorrectly weighted.

D. Provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state:
If a participant's plan of care team believes a participant's budget for the Comprehensive Waiver does not reflect his or her assessed needs, they may request a review by the Extraordinary Care Committee (ECC). The request must accompany additional information on other assessed needs the plan of care team believes are inaccurately captured in the ICAP. The ECC process is outlined in Chapter 46, Section 15 of the Department of Health's Medicaid Rules.

If a person needs a budget in excess of the cost limit for the Comprehensive Waiver, the budget will be approved by the ECC. DHCF will also work with the participant's team on other treatment, behavior or medical support services, and other service options to try to improve the person's condition and lower the cost of services over time.

E. The safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs:
DHCF reserves a portion of the waiver budget for emergency increases to an IBA. If the IBA increase needed would exceed the cost limit for the waiver, the participant and his/her plan of care team may receive an increased IBA for a period of one (1) to two (2) years, and may also be notified of other waiver options and programs in the state for which they are possibly eligible, in order to meet the person's health and safety needs.

Funding requests, which are modified or denied, are eligible for a fair hearing, and the participant is notified of this right. After approving additional funding, DHCF may complete follow-up monitoring to assure the funds are being utilized appropriately and the assessed need continues to exist for the participant.

F. How participants are notified of the amount of the limit:
Upon initial placement on the waiver, and prior to each annual plan of care renewal, the case manager is notified of the assigned budget and the case manager communicates the budget to the participant and legally authorized representative in order to plan services. Any adjustments to budgets based on legislative decisions or other factors will go through the same notification process.

The IBA Methodology is available for review on the DHCF website.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Per the Wyoming Statewide Transition Plan, which received final approval on June 29, 2018, all settings have been assessed and are considered to be in full compliance with home and community based standards. Settings are regularly reviewed to assure ongoing compliance with federal rule.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Individualized Plan of Care

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- ☐ **Registered nurse, licensed to practice in the state**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☒ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
  Specify qualifications:

☐ **Social Worker**
Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

○ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

◉ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Except for extraordinary circumstances, the Case Manager shall be conflict free. Case managers shall only provide other direct waiver services when it is documented that no other willing and qualified provider is available. If the case manager is the only provider available to provide other services to a participant, then the Division will review the case and determine the appropriateness of the exception. Case documentation shall include other options to secure case management or direct care services that were tried and failed.

The provider manual and Chapter 45 of the Department of Health's Medicaid Rules require the case manager to review the participant's choice of providers and services, risks, and goals without any undue influence from other providers or parties. The case manager is required to fully disclose any conflicts to the participant, and who they can contact if there is a concern, including the process for filing a grievance or complaint with the state in order to get DHCF involvement in the case. A DHCF representative will be assigned to any case with a conflict to ensure that the participant has been supported in exercising his or her right to choose waiver providers and choose services from the full range of waiver services offered through DD Waivers.

In cases where there is evidence of unethical conduct or non-performance of duties, a referral shall be made to DHCF to investigate the complaint. If the complaint is substantiated, the case manager shall be required to complete a corrective action plan addressing the non-compliance with case management requirements.

DHCF provides specific safeguards to assure that the planning process includes: 1) participant free choice of providers; 2) participant control of the content of the plan; 3) participant input and agreement on the frequency and duration of services; and 4) participant notification of rights. These elements are documented on the IPC verification form before the plan is signed by the participant and legally authorized representative. Case managers shall follow team meeting procedures to ensure choice in providers, services, institutional care, and service delivery options are reviewed with the participant and legally authorized representative annually. If a case manager with a conflict of interest is approved on an IPC, the case manager shall submit the process for how the plan of care process will be separated from direct care services, including the procedures the participant or legally authorized representative may follow to report a complaint.

If a participant or legally authorized representative disputes DHCFs decision to allow a case manager with a conflict to provide services on the IPC, they may request that the decision be overturned and provide an alternative to the case manager with a conflict.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

DHCF requires and promotes a person-centered approach to services. DHCF staff meets with the applicant, provides the necessary application, explains the waiver application process, and walks them through the application guide. During this time, staff provides information on home and community-based and institutional services. This information includes DHCFs policy on home and community-based settings and the rights of each participant outlined in Chapter 45 of the Department of Health's Medicaid Rules. This process helps ensure applicants can make an informed choice between institutional or home and community-based services. During this initial application review, DHCF staff explains the option to self-direct services, applicant choice in providers, and the process for developing and implementing an IPC.

The participant is responsible for selecting a case manager to provide targeted case management while waiting for services. After receiving a funding opportunity, the case manager will help them find providers and develop the IPC.

The case manager shall review the array of services available on the waiver, including the option and rights and responsibilities of self-directing services. If the participant chooses to receive traditional services, the case manager shall work with the participant to review his/her choice of providers in the community s/he prefers.

The participant and legally authorized representative shall inform the case manager of the people they would like included on the plan of care team. This team will collaborate with the case manager, participant, and legally authorized representative to develop the participant's IPC, which shall include natural supports and waiver services needed to assist the person in achieving his or her personal goals.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The IPC is generated by CCMS. The logic and prompts within CCMS, in addition to a team meeting checklist utilized by case managers during each team meeting, promote a person centered planning approach which is in compliance with 42 CFR §441.301(c)(2) and Chapter 45 of the Department of Health's Medicaid Rules.

A participant's IPC is developed by the case manager, with input from the participant, legally authorized representative (if applicable), and the plan of care team. The plan of care team is comprised of representatives from each service provider and other stakeholders the participant or legally authorized representative chooses to involve, including therapists, employers, family members, friends, or other people important in the participant's life. The IPC is renewed annually, and all sections of the IPC are formally reviewed at least once every six (6) months. Plan of care meetings are scheduled at a place and time that is convenient for the participant or the legally authorized representative. Plan of care team members are typically notified at least twenty (20) days prior to the meeting date.

During the development of the IPC, the plan of care team identifies the provider responsible for implementing the specific sections of the plan, including the frequency and number of service units to be provided. This information is outlined on the Service Authorization page.

A current LT-104 or LT-101 form, which assesses presumed clinical eligibility, shall be on file before an IPC can be renewed. The ICAP shall be conducted every five (5) years, but may be administered sooner should there be a significant change in a participant's condition.

CCMS is designed to collect information specific to a participant's preferences, support needs, goals, and health status.
- The Individual Preferences section requires that questions regarding a participant's desired accomplishments for the coming year, personal preferences, and important things to know about the participant be addressed.
- The Needs and Risks section lists the areas of need that should be addressed (i.e., communication, mobility, personal care), and includes a space for any necessary protocols to be uploaded into the system and included in the IPC document.
- The Circle of Supports section identifies non-waiver services that are available to the participant.
- The Medical section is a comprehensive compilation of medical information including medical appointments (dental, vision, counseling, specialists), allergies, medical conditions and protocols, and how to assist the participant while at an appointment.

The Comprehensive and Supports Waiver Service Index, which shall be found at https://health.wyo.gov/healthcarefin/dd/comprehensive-support-waivers/, is an extensive list of services available on the DD Waivers, and is available to participants, legally authorized representatives, plan of care team members, and case managers. The case manager shall review the services available with the participant and legally authorized representative prior to the IPC meeting. If the participant or legally authorized representative requests a change in services, the case manager shall work with them to identify providers that offer the service using the provider list maintained by DHCF, and schedule provider interviews, if requested. Changes shall be documented in team meeting or case management notes. A change in services or providers can be made at any time during the plan year.

The case manager has specific monitoring responsibilities to ensure the IPC is implemented appropriately and to identify possible changes needed in the plan. Responsibilities include:
- Monthly – A home visit, with the participant present, to monitor the participant's health and welfare, as well as assess participant satisfaction with both waiver and non-waiver services.
- Monthly – A review of critical incidents to identify trends and concerns.
- Monthly – A review of goal progress.
- Monthly – A review of restraint usage.
- Monthly – A review of service utilization and documentation.
- Monthly – A review of documentation and progress on all self-directed services, if applicable.
- Quarterly – Observation, with participant present, of all services delivered.
- Quarterly – A review of health information to identify possible changes in health status.

If the case manager identifies concerns with plan implementation, the case manager is responsible for collaborating with the participant, legally authorized representative, and plan of care team to address the concerns and revise the IPC, if needed.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The IPC is developed in collaboration with the participant's team, and must include input from the participant and legally authorized representative to determine risks and develop mitigation plans. Mitigation of risk factors is addressed by the participant and team. Training and goals related to the mitigation of risk is given a very high priority during the planning process.

The needs and risk section of the IPC addresses areas of potential risk. In this section, the type of support needed, a description of what the support should look like, and a space for relevant protocols is included. Per the IPC meeting checklist, these areas must be addressed, at a minimum, during the annual IPC meeting and the 6 month plan review meeting. The IPC is revised when necessitated by changes in the participant's health, wellness, or other risk factors.

The individual preferences section of the plan outlines the participant's preference and any additional support s/he may need. During the IPC meeting, the case manager shall facilitate the conversation to address unhealthy habits, risky behavior, and important changes the participant wants to make in his/her life. To further expand on the input from the participant, legally authorized representative, and team members, the medical and behavioral support sections of the IPC address risk in these specific areas.

Risks that result in a rights restriction must be noted in the IPC and address the eight areas specified in CFR 441.301, including a restoration plan that includes the specific strategies that the participant will use to build the skills necessary to reinstate the right over time.

The circle of supports section of the plan addresses the specific back up supports the participant needs. This includes emergency contacts, back up case management services, and other supports in the person life. This section also identifies the main contact people for the participant's routine activities and environments, in case an incident arises. For individuals who live more independently, a more detailed action plan for on call or emergency situations will be developed. All providers of community living services are expected to address or provide 24 hour emergency support.

All provider staff are mandatory reporters of suspected abuse, neglect, and exploitation.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Waiver participants and legally authorized representatives shall have free choice of providers and may request a change of providers at any time during the plan year.

DHCF reviews information on institutional and community services available, provider choice, and self-direction options when the person first applies for services. A case manager list is provided, as well as tips and tools for interviewing and selecting a case manager. Once a case manager is selected, eligibility is determined, and a funding opportunity is available, the case manager shall review the choice of services and providers available for the services selected, shall assist with scheduling interviews or visits, and shall convene the plan of care team based on the participant's choices.

Services and provider choice shall be formally reviewed at the 6 month review and annual plan of care meetings. The Participant and Legally Authorized Representative Verification Form shall be signed, indicating that the participant and legally authorized representative had choice in service providers.

Satisfaction with current providers and services is reviewed during home visits. A provider list, searchable by service and location, is available on the DHCF website and can be accessed at any time. The case manager shall be responsible for providing this information if it is requested by the participant or legally authorized representative.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The IPC is generated within CCMS. The logic and prompts within CCMS ensure the IPC is developed in accordance with DHCF requirements. In accordance with the IPC Review Process, IPC review is conducted through a process flow outlined in CCMS that utilizes a defined set of criteria to identify IPCs in need of manual review performed by DHCF staff. Other IPCs do not receive manual review.

In order to assure that the quality of the IPC is maintained, a random sampling of IPCs are reviewed by DHCF each month. The review methodology utilized can be found in the Quality Assurance Operations Manual and Quality Improvement Review Process.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

☒ **Medicaid agency**

☒ **Operating agency**

☒ **Case manager**

☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The case manager is responsible for monitoring the implementation of the IPC and participant health and welfare. Monitoring activities include:

- Monthly home visit, with the participant present, to monitor the participant's health and welfare, discuss satisfaction with both waiver and non-waiver services, and identify changes needed in the IPC.
- Quarterly service observations.
- Monthly review of critical incidents, goal progress, and backup plans to identify trends and concerns.
- Monthly review of the implementation and effectiveness of the positive behavior support plan and restraint usage, and conducting follow-up as needed.
- Monthly review of utilization of services, and documentation of service delivery.
- Quarterly review of specific health information to identify possible changes in health status.

Per Chapter 45 of the Department of Health's Medicaid Rules, case managers are required to report concerns with IPC implementation and participant health and safety to DHCF each quarter, using the incident reporting or complaint process. The case manager is required to report significant concerns to DHCF immediately.

b. Monitoring Safeguards. *Select one:*

○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**

◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Case managers are typically prohibited from providing other services to a participant for whom they provide case management. However, if a rural area of the State does not have a case manager without a conflict of interest, the participant or legally authorized representative may request to have a case manager with a conflict. If DHCF 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 DHCF representative 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. Further information may be found in Appendix D 1b.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.i - Percentage of IPCs with participant and/or legally authorized representative signature verifying they participated in the development of the plan and that the plan met the participant's assessed needs and goals (# of plans with signature affixed / # of plans)

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
Electronic Medicaid Waiver System (EMWS), or its successor

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.ii.a - Percentage of IPCs that were updated/revised every 12 months (# of IPCs that were updated or revised every 12 months / # of IPCs).

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
EMWS or its successor

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.ii.b - Percentage of IPCs that were revised to address changing needs (# of IPCs revised to address changing needs / # of IPCs requiring a revision due to a change in participant's needs).

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
EMWS or its successor

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.iii - Percentage of services delivered in accordance with the IPC, including the type, scope, amount, duration and frequency (# of services delivered in accordance with the IPC, including the type, scope, amount, duration, and frequency / # services delivered)

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
EMWS, or its successor, and COGNOS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.iv.a - Percentage of IPCs stating participants/legally authorized representatives were given a choice of providers (# of IPCs containing verified choice of providers in the plan of care documentation / # of plans approved)

Data Source (Select one):
Record reviews, off-site

If 'Other' is selected, specify:
EMWS, or its successor

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other**	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.iv.b - Percentage of IPCs stating participants/legally authorized representatives were given a choice of services (# of IPCs containing verified choice of services in the plan of care documentation / # of plans approved)

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
EMWS, or its successor

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The anticipated outcome for this data collection is ensuring that the state has designed and implemented an adequate system for assuring that participants receive services in accordance with their plan. The state will review the performance measure data for this assurance on a quarterly basis. If, during a quarterly review, there are areas that do not meet anticipated outcomes, DHCF will ensure that issues caused by failure to follow process or policy are remedied through technical assistance and re-education at an individual level and, where possible, through statewide training. Individual remediation activity requires follow up from DHCF to determine that the party in need of remediation (case manager etc.) successfully completed the required corrective action. Remediation strategies include training, revision of administrative processes and procedures, administrative rule revisions, and waiver amendments. These strategies will be used based on the results of the discovery and analysis of the related performance measure. If compliance with the performance measure falls below 86%, a request for a corrective action plan, including activities and time lines for completion and follow-up, will be required.

DHCF will, on a quarterly basis, review performance measures, corrective action, and other meaningful data listed above. Processes for such review will be studied, and possibly adjusted on an annual basis.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- ◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- ◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Waiver participants have the option to receive support services provided by qualified HCB Medicaid waiver providers certified by DHCF, support services through participant self-direction, or a combination of both self-directed and traditional support services.

If self-directing one or more of their services, participants or their legally authorized representative act as the employer of record. This option gives participants the authority and responsibility to recruit, hire, schedule, evaluate, and supervise their workers, and gives the participant budgetary authority.

Participants choosing to be the employer of record will receive assistance with the self-direction process from the Fiscal/Employer agent (FMS) and case manager.

The FMS, which is funded as an administrative activity and does not come out of a participant's budget, assures all federal, state and local employment tax, labor and workers' compensation insurance rules and other requirements are followed. The FMS makes financial transactions on behalf of participants.

The case manager will assist the participant with the self-direction process, and is responsible for the following:
- Completing and submitting the referral form and other required documents to the FMS
- Submitting the IPC
- Monitoring implementation of, and conducting follow up on concerns found with the implementation of the IPC
- Assisting the EOR with completing employment paperwork
- Conducting ongoing monitoring of the participant's budget

These services/supports have responsibility to provide protection and safeguards to participants self-directing services.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**

☒ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**

☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

○ **Waiver is designed to support only individuals who want to direct their services.**

◉ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The case manager is responsible for providing initial information on self-directed services, which includes:
1) An overview of self-determination and self-directing services, including the principles of self-determination (Freedom, Authority, Support, Responsibility, and Confirmation).
2) The benefits of self-directing, including enhanced choice and control over services and how the budget is spent.
3) The responsibilities involved in self-directing services, including hiring, training, and firing workers, managing the budget, and approving workers' timecards.
4) The potential liabilities of self-directing services, including liabilities that may occur as the common law employer when hiring or firing staff, managing the budget, and approving timecards.

Once the participant chooses self-direction, the FMS provides information on the role of the FMS, the employer of record, and the direct support worker. The participant and legally authorized representative can contact the case manager or FMS for questions related to self-directed services.
DHCF staff located throughout the state also serve as ongoing resources if questions or concerns arise about self-directing services.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☐ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Homemaker	☒	☒
Individual Habilitation Training	☒	☒
Child Habilitation Services	☒	☒
Community Living Services	☒	☒
Respite	☒	☒
Companion Services	☒	☒
Supported Employment	☒	☒

Waiver Service	Employer Authority	Budget Authority
Personal Care	☒	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Financial Management Services are provided by a contractor using the Fiscal/Employer Agent Model. Every three (3) to five (5) years the SMA undergoes a Request for Proposal (RFP) of any Financial Management entities that might be interested in contracting to be the state's FMS. Entities that submit an RFP include a per member per month (PMPM) rate. The SMA selects a contractor utilizing the Wyoming procurement process.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The FMS is compensated for administrative activities based upon a PMPM reimbursement method.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☒ **Assist participant in verifying support worker citizenship status**

☒ **Collect and process timesheets of support workers**

☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-**

related taxes and insurance

☐ **Other**

Specify:

Supports furnished when the participant exercises budget authority:

☒ **Maintain a separate account for each participant's participant-directed budget**

☒ **Track and report participant funds, disbursements and the balance of participant funds**

☒ **Process and pay invoices for goods and services approved in the service plan**

☒ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other services and supports**

Specify:

Additional functions/activities:

☐ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**

☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**

☒ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

State Medicaid Agency and DHCF Policy for Monitoring the FMS:

DHCF monitors the performance of the FMS. The primary function of the FMS in relation to participant-directed services, as outlined in the waivers, is to address federal, state, and local employment tax, labor, and workers compensation insurance rules and other requirements that apply when the participant functions as the employer of workers.

The SMAs contract with the FMS vendor outlines the requirements of the FMS to act as agent for the employer/participant in gathering and maintaining relevant employee information; maintaining employer and employee files with necessary tax, IRS, and payroll information; and provide a system for payment of services rendered (payroll to direct support worker) that takes into account any Department of Employment and waiver specific restrictions as applicable (e.g.: overlapping services, waiver-identified service caps, excess of 40 hours/week, over identified budget) and verifies submitted timesheets against these expectations.

Policy Provisions:
DHCF issues policy, procedure manuals, memorandums, instructions, and other correspondence to interpret and implement the approved waivers, including information on the roles and responsibilities of the FMS, responsibilities of the case manager in the monthly monitoring of services provided by the FMS, and monitoring responsibilities of DHCF and the Medicaid Program Integrity Unit (PI).

DHCF conducts annual on-site monitoring of the FMS that includes a convenience sample file review. DHCF monitors call center reports from the FMS each quarter. The reports are reviewed for timeliness of response, numbers of calls received, and other trends relating to call data. DHCF completes a review of the FMS contract biennially or as needed if concerns arise.

DHCF conducts an annual review of the FMS complaint policy and complaints filed to ensure:
• Adequate written information regarding how to file a formal complaint with the FMS is conveyed to the participant or their legally authorized representative, and to employees of the participant
• All complaints are reviewed in a timely manner and addressed appropriately

The FMS is required to develop and complete a correction action plan, as specified in the remediation section of this policy, if complaints are not reviewed in a timely manner or are left unresolved.

The contract includes clauses for termination of the contract if serious concerns are identified. The FMS shall submit a corrective action plan as outlined in Chapter 45 of the Department of Health's Medicaid Rules for each area of non-compliance identified in the participant file review. DHCF and PI review and approve the corrective action plan according to Medicaid Rules, and monitor implementation of the corrective action plan to assure areas of non-compliance are adequately addressed.

PI completes the recovery of funds if documentation of services does not support the billing and payment for services. PI completes the required process to assure CMS is reimbursed for the federal portions of payments when recovery of funds occurs.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

The case manager provides information to participants or legally authorized representatives on traditional service delivery and self-direction.

Case managers provide assistance in support of self-direction at the time an applicant receives a funding opportunity, twice a year during home visits or team meetings, or as requested or needed.

The case manager will assist the participant with the self-direction process, and is responsible for the following:
- Completing and submitting the referral form and other required documents to the FMS
- Submitting the IPC
- Monitoring implementation of, and conducting follow up on concerns found with the implementation of the IPC
- Assisting the EOR with completing employment paperwork
- Conducting ongoing monitoring of the participant's budget

☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Transportation	☐
Crisis Intervention Support	☐
Cognitive Retraining	☐
Adult Day Services	☐
Homemaker	☐
Individual Habilitation Training	☐
Child Habilitation Services	☐
Case Management	☒
Community Living Services	☐
Behavioral Support Services	☐
Specialized Equipment	☐
Respite	☐
Dietician Services	☐
Speech, Hearing and Language Services	☐
Physical Therapy	☐
Special Family Habilitation Home	☐
Occupational Therapy	☐
Companion Services	☐
Environmental Modification	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Supported Employment	☐
Community Support Services	☐
Personal Care	☐
Skilled Nursing	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

◉ **No. Arrangements have not been made for independent advocacy.**

○ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

A participant may voluntarily terminate self-direction at any time during their plan year. When a participant voluntarily terminates self-direction, s/he works with the case manager who follows the DHCF transition process for changing services or service providers.

The transition process includes a transition team meeting to assure the team, including all providers, has current information on the changes being made to the IPC. During the transition team meeting, the case manager revises the IPC to reflect the changes in services and service providers. The IPC is submitted to DHCF for review before the transitions occur. DHCF has seven (7) calendar days to review the revised IPC.

The case manager works with the participant or their legally authorized representative to notify the FMS of the termination of self-directed services, and assists the participant in completing any required paperwork.

DHCF has an emergency transition process in place if there are significant health and welfare concerns that may require a quicker transition out of self-directed services. This transition process requires DHCF staff to be involved in the transition process so DHCF can assure the new services and service providers meet the needs of the participant, and to assure the participant's health and welfare needs are met during the transition from self-direction. The case manager submits the revised IPC to DHCF, which can review the revised plan within one (1) business day if an emergency situation exists. Once a participant has chosen to voluntarily terminate self-direction, they cannot choose to self-direct services until their semi-annual or annual plan of care meeting, which will assure that the participant and team have an opportunity to carefully plan the transition back to self-directed services.

Voluntary termination of self-direction does not require the participant to change waivers.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Situations that may result in involuntary termination are described in Chapter 46, Section 12 of the Department of Health's Medicaid Rules.

DHCF can involuntarily terminate the use of participant direction when the following situations occur:

1) A participant or their representative is not managing the budget appropriately.
DHCF has processes in place to identify mismanagement of a budget, including budget oversight and reporting by the FMS and review of monthly budget reports by the participant's case manager. DHCF works with the participant's case manager and the FMS to provide additional training, education, and support to help the participant understand their responsibilities with managing the budget. However, if mismanagement of the budget continues, DHCF can involuntarily terminate the use of self-direction.

2) A participant's health and welfare needs are not adequately met.
DHCF has processes in place to identify when a participant's health and welfare needs are not adequately being met, including oversight by the participant's case manager, critical incident reporting, the complaint process, and oversight of self-directed services. DHCF works with the participant's case manager to provide additional training, education, and support to help the participant understand the need for the IPC and for services to meet their health and welfare needs. However, if significant concerns with the participant's health and welfare continues, BHD may involuntarily terminate the participant from self-direction.

3) Situations involving the commission of fraudulent or criminal activity associated with self-direction of services are identified.
When these situations occur, DHCF will work with the State Medicaid Agent, the Medicaid Fraud Control Unit and the Attorney General's office to identify the appropriate steps to take to remove the participant from participant direction of services pending the outcome of investigations.

Participants who are involuntarily terminated from self-direction are notified in writing of the involuntary termination and the reasons. The notification includes information on the right of the participant to request a Fair Hearing. When a participant is involuntarily terminated from self-direction, the participant works with the case manager who follows the DHCF transition process for changing services and/or service providers.

The transition process includes a transition team meeting to assure the team, including all providers, has current information on the changes being made to the IPC. During the transition team meeting the case manager revises the IPC to reflect the changes in services and service providers. The IPC is submitted to DHCF for review before the transitions occur. DHCF has seven (7) calendar days to review the revised IPC.

The case manager works with the participant or their legally authorized representative to notify the FMS of the termination of self-directed services, and assists the participant in completing any required paperwork.

DHCF has an emergency transition process in place if there are significant health and welfare concerns that may require a quicker transition out of self-directed services. This transition process requires DHCF staff to be involved in the transition process so DHCF can assure the new services and service providers meet the needs of the participant, and to assure the participant's health and welfare needs are met during the transition from self-direction. The case manager submits the revised IPC to DHCF , which can review the revised plan within one (1) business day if an emergency situation exists. Once a participant is involuntarily terminated from self-direction, they cannot choose to self-direct services until their semi-annual or annual plan of care meeting, which will assure that the participant and team have an opportunity to carefully plan the transition back to self-directed services. In addition, DHCF works with the team to assure that safeguards have been put in place as necessary to assure the previous concerns or difficulties the participant had with self-directing services have been adequately addressed.

Involuntary termination of self-direction does not require that the participant change waivers

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction

opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		339
Year 2		356
Year 3		373
Year 4		378
Year 5		383

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**
☐ **Refer staff to agency for hiring (co-employer)**
☐ **Select staff from worker registry**
☒ **Hire staff common law employer**
☒ **Verify staff qualifications**
☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

The cost of criminal history background screenings is an administrative cost absorbed by DHCF.

☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

Does not vary

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☒ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☐ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

☒ **Reallocate funds among services included in the budget**

☒ **Determine the amount paid for services within the state's established limits**

☒ **Substitute service providers**

☒ **Schedule the provision of services**

☒ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**

☒ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

☒ **Identify service providers and refer for provider enrollment**

☒ **Authorize payment for waiver goods and services**

☒ **Review and approve provider invoices for services rendered**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Budgets that will be self-directed are determined by the participant and legally authorized representative. The self-directed service budget cannot exceed the person's assigned budget level for the waiver. DHCF assigns budget amounts for each participant as described in Appendix C-4 of this application. The budget amount does not change if a person chooses to self-direct services. The participant may self-direct some or all of the budget, except for case management.

A request for a budget increase must be submitted and approved by the ECC. The ECC policy, procedure, and forms for requesting additional funds are available on the DHCF website.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

A participant is notified of his/her IBA at the time a funding opportunity is offered, and before the IPC is developed. Participants receive the same IBA if they choose to self-direct services. A participant can submit a request through his/her case managers for an increase in the IBA if the participant's team identifies that the budget allotted to a participant does not meet the services and supports needed.

A request for a budget increase must be submitted and approved by the ECC. The ECC policy, procedure and forms for requesting additional funds are available on the DHCF website.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ◉ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

During the plan year, the participant may choose to modify services included in his/her self-directed budget without prior DHCF approval as long as service costs stay within the IBA. The participant shall coordinate modifications to the self-directed service budget with his/her case manager, who will submit the change to the FMS. The case manager shall assure the assessed needs of the participant can continue to be met, then update the IPC to reflect the change in services and budget. DHCF monitors the modification process to the IPC and budget.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

DHCF and the FMS have established safeguards to prevent the premature depletion of the participant's IBA and address potential service delivery problems that may be associated with budget over- or underutilization. DHCF is responsible for ensuring the implementation of safeguards developed for participants who are self-directing services. The FMS tracks budget utilization and provides monthly reporting to participants, case managers, and DHCF.

DHCF and the FMS have developed business rules that will flag participants for possible over-utilization. For example, if the participant's claims exceed more than 20% of the expected monthly utilization, DHCF, and the participant's case manager will automatically be notified through an electronic message. Likewise, the rules flag participants if two consecutive pay periods bear no claims or claims total 20% less than expected utilization. If premature depletion of the budget or the lack of claims are noted by the FMS, DHCF, and the participant's case manager are automatically notified.

DHCF follows up with the case manager to assure that the concern is addressed and resolved according to DHCFs monitoring processes for case managers, which includes:
• Direct contact with the FMS to provide notification of concerns and collaborate to resolve the issues.
• Meeting with appropriate parties involved, including the employee of the participant who is involved in a situation and the FMS representative to work through the concerns.
• Reporting issues to DHCF if significant concerns are identified that impact health and safety, indicate potentially fraudulent activity, or if concerns are not addressed by FMS after the case manager has worked directly with them.

All issues reported to DHCF are documented and reviewed quarterly for trends, and to determine if participant education, provider re-education, or further actions are needed from DHCF or the FMS to prevent future occurrences of the same problem.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Individuals are notified and afforded the opportunity to request a fair hearing when the following occurs:
• An applicant does not meet the eligibility requirements for the waiver;
• An applicant is not provided the choice of home and community-based services as an alternative to institutional care;
• A participant is denied the service(s) of their choice or the provider(s) of their choice; or
• A participant's services are denied, suspended, reduced, or terminated.

If one of these situations occur, the applicant or participant is notified in writing. The notification outlines instructions on how to request a fair hearing in accordance with Chapter 4 of the Department of Health's Medicaid Rules, including time frames and procedures. The applicant or participant is also informed that s/he may choose to have an attorney, relative, friend, or other spokesperson represent them at the hearing.

A request for a fair hearing must be submitted to the DHCF Administrator, in writing, within thirty (30) calendar days of notification of an adverse action. The following information shall be submitted as part of the request:

1) A statement of request for an administrative hearing;
2) The reasons why the denied request should be approved or allowed; and
3) The issues to be raised at the hearing

If a request for a fair hearing concerning this action is submitted in a timely manner, DHCF will advance the request to the Office of Administrative Hearings (OAH). OAH will notify the participant or applicant of the date, time, and place of the hearing, and provide other relevant information.

Information regarding the fair hearing process is included in the Application Packet all applicants and legally authorized representatives receive when applying for waiver services, and is explained during the review of the application process. If a participant is receiving waiver services at the time of the adverse action, s/he is notified that services will not be terminated or reduced pending the results of the fair hearing, unless otherwise authorized as specified in 42 CFR §431.230. More information can be found in the Developmental Disabilities Section process for Adverse Actions, Reconsiderations, and Administrative Hearings.

Notices of adverse actions and the opportunity to request a fair hearing are kept on file for 6 years. Notices of an adverse action, which include specific information on a participant's right to request a fair hearing, are stored in the EMWS case file.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

In addition to the fair hearing process, DHCF offers participants an opportunity to request a reconsideration. The reconsideration process does not prohibit a participant or guardian from requesting a fair hearing, and can be waived if the participant chooses to proceed straight to a fair hearing.

A request for reconsideration for a specific decision may be submitted, in writing, to the DD Section Administrator if one of the following conditions is documented and supported in the request:
1) Information presented in the case was misrepresented;
2) Information was not represented to the fullest extent needed;
3) There was a misapplication of DHCF standards or policy in the case; or
4) The criteria for the case was misunderstood.

More information can be found in the Developmental Disabilities Section process for Adverse Actions, Reconsiderations, and Administrative Hearings.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

Wyoming Department of Health, Division of Healthcare Financing

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Participants, legally authorized representatives, providers, and other interested parties may file anonymous complaints with DHCF by using the web-based complaint system available on the DHCF website. Complaints regarding an imminent threat to a participant's health or welfare can also be submitted via phone, letter, or email. DHCF staff are responsible for reviewing complaints in the electronic provider management system. Complainants who identify themselves are sent a letter verifying that the complaint has been received, next steps that will be taken, and the process of notifying them once a review of the complaint is complete. The complaint process does not prohibit a participant or legally authorized representative from requesting a fair hearing.

DHCF staff review the information in the complaint to determine if there is suspicion of abuse, neglect, exploitation, intimidation, or self-neglect, which by state law must be reported to the Protective Services unit of the Department of Family Services (DFS). In these cases, DHCF will report the complaint to, and collaborate with, DFS to determine the appropriate follow-up as described in Appendix G -1 of this application. If staff believe there are significant participant health and welfare concerns, but the complaint does not identify suspected abuse, neglect, exploitation, intimidation, or self-neglect, then staff are required to contact the appropriate DHCF manager immediately to determine appropriate follow-up actions. The manager coordinates the follow-up on these complaints to assure the immediate health and welfare issues are addressed, and to oversee completion of the complaint investigation.

Complaints that involve waiver policies and procedures, waiver staff, or other specific waiver issues are referred to the appropriate DHCF manager for review and/or follow-up. Complaints that involve provider noncompliance are referred to the appropriate DHCF staff for review. Complaints that identify concerns with the overall service system are reviewed by the DHCFs management team and, when appropriate, the DD Advisory Council to determine if changes to rules, regulations, policies, or procedures need to be made.

Chapter 45, Section 21 of the Department of Health’s Medicaid rules addresses the complaint process in detail, as does the Developmental Disabilities Section Complaint Response process.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Abuse with respect to a child means inflicting or causing physical or mental injury, harm or imminent danger to the physical or mental health or welfare of a child other than by accidental means, including abandonment, excessive or unreasonable corporal punishment, malnutrition or substantial risk thereof by reason of intentional or unintentional neglect, and the commission or allowing the commission of a sexual offense against a child as defined by law (W.S. § 14-3-202.)

Per the Wyoming Adult Protective Services Act (WS 35-20-103): "Any person or agency who knows or has reasonable cause to believe that a vulnerable adult is being or has been abused, sexually abused, neglected, exploited, intimidated, abandoned or is committing self-neglect, shall report the information immediately…"

Per Chapter 45, Section 20 of the Department of Health's Medicaid Rules, all waiver providers and provider staff are required to report critical and non-critical incidents to DHCF, the case manager, the legally authorized representative, and, depending on the nature of the incident, DFS, Protection & Advocacy System Inc., and law enforcement. Critical incidents shall be filed immediately after assuring the health and safety of the participant and other individuals, and include the following categories:

- Suspected abuse as defined by Wyo. Stat. Ann. § 35-20-102 or Wyo. Stat. Ann. § 14-3-202;
- Suspected self-abuse;
- Suspected neglect as defined in Wyo. Stat. Ann. § 35-20-102 or Wyo. Stat. Ann. § 14-3-202;
- Suspected self-neglect as defined Wyo. Stat. Ann. § 35-20-102;
- Suspected abandonment as defined in Wyo. Stat. Ann. § 35-20-102;
- Suspected exploitation as defined in Wyo. Stat. Ann. § 35-20-102;
- Suspected intimidation as defined by Wyo. Stat. Ann. § 35-20-102;
- Sexual abuse as defined in Wyo. Stat. Ann. § 35-20-102; and
- Death.

Non-critical incidents shall be filed within one (1) business day and include the following categories:

- 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;
- Any use of restraint;
- Any use of seclusion;
- Injuries caused by restraints;
- Serious injury to the participant;
- Elopement; and
- Medical or behavioral admission and Emergency Room visits that are not scheduled medical visits.

Medication errors shall be filed withing three (3) business days after the error is discovered, and include:

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

Providers filing incident reports shall use DHCFs web-based system. Participants and legally authorized representatives may contact DHCF to report an incident. If appropriate, they are also encouraged to report directly to DFS or law enforcement so pertinent information can be gathered for the investigation. If the participant or legally authorized representative does not want to contact other agencies, DHCF will file the report on their behalf.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Information regarding a participant's right to be free from abuse, neglect, and exploitation, including the steps to take to notify appropriate authorities, is discussed during the annual IPC process. The case manager is responsible for reviewing this information with the participant and, as required, the legally authorized representative, either verbally or utilizing the information available on the DHCF website. Case managers also ask open ended questions during regular home and service observations, and review behavior and medical trends to detect potential abuse.

Additionally, per Chapter 45 of the Department of Health's Medicaid Rules, providers are required to implement policies and procedures to meet standards, including protection from abuse, neglect, and intimidation. Per rule, these policies and procedures shall be shared with participants and legally authorized representatives.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

As outlined in Chapter 45, Section 20 of the Department of Health's Medicaid Rule, providers shall report critical incidents involving waiver participants to DHCF, DFS, P&A, the case manager, the legally authorized representative, and law enforcement immediately after assuring the health and safety of the participant and other individuals. DHCF staff reviews incidents to assure all reporting timelines required in rule are met.

Critical incidents shall be reported using DHCFs web-based system. Daily, the Provider Support Unit shall review and evaluate all critical incident reports that are received. Based on the type of incident, which is outlined in the Incident Management Process, DHCF shall refer the incident to the appropriate authority (DFS, Medicaid Fraud Control Unit, law enforcement) for investigation. Referrals to investigating authorities must occur within 24 hours. The methods and timelines of the investigation are determined by the investigative authority. As the reporting agency, DHCF shall cooperate with the investigative authority to provide follow-up documentation and evidence, as requested.

For clinical reviews needed in specific critical incidents and mortality review cases, the State utilizes the expertise of the Utilization Management contractor. State staff and the contractor have monthly meetings to review findings, aggregated data, and track case specific remediation steps. Referrals to the Utilization Management Contractor fall into four (4) categories:
1. Death;
2. Quality of care issues beyond DHCFs scope to research (i.e. suspected medical neglect);
3. Systemic issues (i.e., repeated injury or accident with the same provider); and
4. Crisis cases (i.e., repeated restraints, behavioral health admissions).

Per Chapter 45, Section 20 of the Department of Health's Medicaid Rules, Protection and Advocacy shall be informed of specific critical and non-critical incidents. Critical incidents of which P&A must be notified immediately after assuring the health and safety of the participant and other individuals include:
- Suspected abuse as defined by Wyo. Stat. Ann. § 35-20-102 or Wyo. Stat. Ann. § 14-3-202;
- Suspected self-abuse;
- Suspected neglect as defined in Wyo. Stat. Ann. § 35-20-102 or Wyo. Stat. Ann. § 14-3-202;
- Suspected self-neglect as defined Wyo. Stat. Ann. § 35-20-102;
- Suspected abandonment as defined in Wyo. Stat. Ann. § 35-20-102;
- Suspected exploitation as defined in Wyo. Stat. Ann. § 35-20-102;
- Suspected intimidation as defined by Wyo. Stat. Ann. § 35-20-102;
- Sexual abuse as defined in Wyo. Stat. Ann. § 35-20-102; and
- Death.

Non-critical incidents of which P&A must be notified within one (1) business day include:
- 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;
- Any use of restraint;
- Any use of seclusion;
- Injuries caused by restraints;
- Serious injury to the participant;
- Elopement; and
- Medical or behavioral admission and Emergency Room visits that are not scheduled medical visits.

DHCF staff review incidents that are received within one (1) business day of receipt, and may conduct follow-up with P&A to ensure the report was made. DHCF will conduct an investigation of critical incidents to identify violation of Department of Health Medicaid Rules.

Upon completion of an investigation, DHCF shall generate a corrective action plan or impose sanctions, as outlined in Chapter 45, Sections 29 and 30 of the Department of Health's Medicaid Rules, which correspond with the investigation results. Chapter 45, Section 30 of the Department of Health's Medicaid Rules authorize DHCF to impose sanctions. Chapter 16, Sections 9 and 19 of the Department of Health's Medicaid Rules outline the specific sanctions that are available, grounds for the sanctions, notice of the sanctions, and effective dates of the sanctions. Possible sanctions, as outlined in Chapter 16, Section 19, include additional education, medical clearance from a medical specialist, restricting a provider's provision of services, denying new admissions, imposing a monitor, civil monetary penalties, suspension of payments, and provider suspension. Ultimately, the State has the authority to decertify providers.

Final detailed results of the investigation are provided to the participant by the investigative authority. Once DHCF completes the investigation of rule violation, staff send a resolution letter to the participant, and legally authorized representative if necessary, within fifteen (15) business days.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

DHCF shall conduct a daily review and evaluation of all critical incident reports that are received, as outlined in the Incident Management Process and the Investigation of Provider Incidents and Complaints Process. DHCF shall ensure the incident is reported to the appropriate authority (DFS, Medicaid Fraud Control Unit, law enforcement) for investigation. The investigative authority shall report findings of the investigation back to DHCF. DHCF shall investigate violations of rule, and develop corrective action plans or impose sanctions as needed. At the conclusion of any external investigation, oversight and follow-up efforts of resulting provider corrective action plans or sanctions are ongoing until all action items are complete, or identified issues are resolved.

DHCF shall analyze all critical incident information on a quarterly basis to identify provider trends, including number and type of critical incidents and participants and staff members involved. A root cause analysis of critical incidents will also be conducted. This information shall be used to develop targeted intervention plans for providers in order to provide technical assistance and address challenges to decrease the number of critical incidents over time.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Although the state is exploring ways to reduce or even eliminate all restraints in the future, restraints are allowed in some instances. Safeguards are in place and must be practiced by providers.

Safeguards for restraint usage are written into Wyoming State Statute 35-1-625 and 626, which mandate participants must be free from physical restraints and isolation except for emergency situations or when isolation or restraint is a part of a treatment program; and isolation or restraint of a participant may be used only when less restrictive measures are ineffective or not feasible for the welfare of the participant and shall be used for the shortest time possible.

Specific DHCF safeguards concerning the use of restraints are found in Chapter 45, Section 19 of the Department of Health's Medicaid Rules.

- A chemical restraint 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 chemical restraint shall be ordered and administered by a licensed medical professional. Standing orders for chemical restraints are prohibited, except when deemed necessary to prevent extreme recurring behavior by the participant's plan of care team and limited to one (1) month.
- A mechanical restraint 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 restraint shall only by applied under the direct supervision of a licensed medical professional for the purpose of medical treatment procedures when compliance is deemed necessary for the health of a participant, and shall not be used on individuals under the age of eighteen (18).
- A physical restraint is the application of physical force without the use of any device, for the purposes 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.
- 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 repayment of funds for waiver services and other sanctions.

DHCF has a robust incident reporting process, by which case managers, provider staff members, legally authorized representatives, community members, and other stakeholders report the use of restraints, as well as other identified incident. Additionally, the case manager, as a conflict-free, second line monitor, is responsible for reviewing provider internal incidents, and discusses participant satisfaction and concerns, behavioral changes, service delivery, and self-determination during regular service observations and home visits. This relationship and regular interaction is a critical step in identifying situations in which the unauthorized use of restraint may occur.

Restraints shall only be used in emergency circumstances and shall only be performed by individuals trained and certified in restraint usage. A positive behavior support plan shall be in place and implemented prior to the use of restraints.

Chapter 45, Section 18 (o) of the Department of Health's Medicaid Rules lists specific documentation required if a provider performs restraints. This documentation includes the tracking and analysis of each restraint, its antecedents, reason(s) for the restraint, the participant's reaction to the restraint, and actions that may make future restraints unnecessary. All available data must be regularly reviewed to work toward reducing the duration and frequency of restraint occurrences. Information must be submitted to the case manager within five (5) business days of a restraint event.

If a restraint protocol is included in the participant's IPC, the protocol must include the authority that has authorized the restraint, and demonstration that the following standards have been met:
- Identification of the specific and individualized assessed need;
- Documentation of the positive interventions and supports that have been used prior to any modifications to the IPC;
- Documentation of less intrusive methods of meeting the need that have been tried but did not work;
- A clear description of the condition that is directly proportionate to the specific assessed need;

- Regular collection and review of data to measure the ongoing effectiveness of the modification or restraint;
- Established time limits for periodic reviews to determine if the modification or restraint is still necessary or can be terminated;
- Informed consent of the individual; and
- Assurance that interventions and supports will cause no harm to the individual.

Additionally, the IPC must address how the team will work to restore any right that has been limited or denied, including those associated with restraints.

The provider and provider staff shall maintain certification and receive ongoing training in deescalation 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 DHCF.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

DHCF is responsible for overseeing the use of restraints and ensuring that safeguards concerning their use are followed.

This oversight includes a semi-annual IPC review, which incorporates a review of authorized restraints written into the IPC.

The provider certification renewal process occurs at least once every three (3) years and includes a review of required policies, procedures, and staff training related to restraints. Per Chapter 45, Section 29 of the Department of Health's Medicaid Rules, providers found to be out of compliance with rules, regulations, or policies, including the unauthorized use of restraints, are required to submit a corrective action plan.

A review of complaints and critical incidents, which includes all restraints, is conducted on an ongoing basis to identify trends and the inappropriate use of restraint.

Case managers are required to report aggregate information on restraint usage, by participant, on a quarterly basis. Quarterly, DHCF reviews aggregate data, by participant and provider, to identify systemic trends in this area, as outlined in Appendix H – Quality Improvement Strategy.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other

individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Specific DHCF safeguards concerning a restriction to a person's rights are outlined in Chapter 45, Section 4 of the Department of Health's Medicaid Rules.

DHCF has a robust incident reporting process, by which case managers, provider staff members, legally authorized representatives, community members, and other stakeholders report the use of restraints, as well as other identified incidents. Additionally, the case manager, as a conflict-free, second line monitor, is responsible for reviewing provider internal incidents, and discusses participant satisfaction and concerns, behavioral changes, service delivery, and self-determination during regular service observations and home visits. This relationship and regular interaction is a critical step in identifying situations in which the unauthorized use of restraint may occur.

Before a restrictive intervention may be employed, the IPC shall address the reason for the rights restriction, 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. The IPC shall:

- Identify the specific and individualized assessed need;
- Document the positive interventions and supports used prior to any modifications to the individualized plan of care;
- Document less intrusive methods of meeting the need that have been tried but did not work;
- Include a clear description of the condition that is directly proportionate to the specific assessed need;
- Include regular collection and review of data to measure the ongoing effectiveness of the modification;
- Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;
- Include the informed consent of the individual; and
- Include an assurance that interventions and supports will cause no harm to the individual.

In addition to the items mentioned above, the IPC shall address how the team will work to restore any right that has been limited or denied.

Personnel involved in authorization and administration of restrictive interventions must meet the training standards set forth in Chapter 45, Section 15 of the Department of Health's Medicaid Rules.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

DHCF is responsible for monitoring and overseeing the use of restrictive interventions.

This oversight includes a semi-annual IPC review, which incorporates a review of authorized restrictive interventions written into the IPC.

The provider certification renewal process occurs at least once every three (3) years and includes a review of required policies, procedures, and staff training related to restrictive interventions. Per Chapter 45, Section 29 of the Department of Health's Medicaid Rules, providers found to be out of compliance with rules, regulations, or policies, including the unauthorized use of restraints, are required to submit a corrective action plan.

A review of complaints and critical incidents is conducted on an ongoing basis to identify trends and the inappropriate use of restrictive interventions, including a root cause analysis. The case manager also conducts regular home and service observations, during which time both approved and inappropriate restrictive interventions may be detected.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

DHCF is responsible for detecting the unauthorized use of seclusion.

This oversight includes a semi-annual IPC review process, which incorporates a review of authorized restraints written into the IPC.

The provider certification renewal process occurs at least once every three (3) years and includes a review of required policies, procedures, and staff training related to restrictive interventions. Per Chapter 45, Section 29 of the Department of Health's Medicaid Rules, providers found to be out of compliance with rules, regulations, or policies, including the unauthorized use of restraints, are required to submit a corrective action plan

A review of critical incidents and complaints, including a root cause analysis, is conducted on an ongoing basis. The case manager also conducts regular home and service observations, during which time unauthorized seclusion may be detected.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

○ **No. This Appendix is not applicable** *(do not complete the remaining items)*

◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

First line monitoring:
The participant's physician, psychiatrist, or other licensed medical professional who prescribes medications to the participant shall be the first line monitor of the participant's medication regimen. The first line monitor shall conduct regular assessments of medication regimens, side effects, or concerns that arise regarding a participant's treatment plan, health condition, or potentially harmful contraindicated medications.

Second line monitoring:
Case managers shall conduct second line medication monitoring to help ensure a participant's medical needs are addressed and medication regimens are delivered in a manner that promotes the health, safety, and well-being of the participant. The case manager shall provide monitoring of, and review trends regarding, the usage of all over-the-counter and prescription medications, including vitamins, herbal remedies and psychotropic medications, through a monthly review of medication assistance records and PRN medication usage records, including behavior modifying medications. Over-the-counter medications shall be submitted for review by the licensed medical professional to mitigate the potential for medical concerns or side effects.

Use of psychotropic PRN medication requires secondary documentation, including the time the medication was taken, the purpose for the medication, and a one-hour follow up to determine the result of the medication usage. If the intent of the medication is not met, the information is sent to the prescribing authority for further evaluation.

DHCFs monitoring system is multi-faceted. The case manager reviews all Medication Assistance Records and supplemental PRN documentation. Concerns or exceptions are reported to the physician, guardian, or DHCF. Providers are required to report all medication errors through the DHCF Notification of Incident reporting system. DHCF then reviews exceptions in order to identify trends. This robust system of review offers the highest probability of detection of harmful practices, and allows opportunity on the part of the case manager and DHCF to provide timely and necessary follow-up.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Per Chapter 45 of the Department of Health's Medicaid Rules, providers shall report all instances of medication errors using DHCFs web-based system. DHCF reviews all critical incident reports as outlined in Appendix G-1-a.

DHCF is responsible for overseeing and monitoring provider compliance with the Division's medication assistance policy and standards, potentially harmful practices and the provider's own policies and procedures. DHCFs registered nurse reviews all incident reports related to medication errors to gather information on potentially harmful practices. If a concern is identified, the provider is contacted to review the incident. Based on the result of the provider contact, 1) further clarification is added to the incident report; 2) the provider is offered technical assistance; or 3) a provider corrective action is issued.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

○ **Not applicable.** *(do not complete the remaining items)*

◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Per Chapter 45 of the Department of Health's Medicaid Rules, providers, subcontractors, and provider employees shall maintain a current certificate in medication assistance training offered through DHCF if a provider is assisting with medications. Providers offering medication assistance shall develop and implement internal medication assistance policies and procedures that meet DHCF standards.

The complete Medication Assistance Policy is available upon request.

iii. Medication Error Reporting. *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

DHCF is responsible for overseeing and monitoring medication errors.

DHCF will involve DFS, Protection & Advocacy, and law enforcement if an error is reported that falls into one of the other reportable incident categories, which requires notification to other parties included in the DHCF Notification of Incident process.

(b) Specify the types of medication errors that providers are required to *record:*

Providers shall record the following medication errors:
- Wrong medication;
- Wrong dosage;
- Missed medication;
- Wrong participant;
- Wrong route; and
- Wrong Time, which is any deviation from accepted standard time frame for the medication assistance.

Providers have additional medication errors or incidents that are recorded within their organization, but not reportable to DHCF. These categories include:
- Refusals,
- Dropped medication,
- Expired or damaged medication,
- Other medication events determined to need action

(c) Specify the types of medication errors that providers must *report* to the state:

Per Chapter 45, Section 20 of the Department of Health's Medicaid Rules, providers shall report the following medication errors to DHCF using the web-based incident reporting system:

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

Medication errors shall be reported within three (3) business days of the error being discovered.

Providers are required to report exploitation of participants, including medication diversion, through the DHCF Notification of Incident process. Providers receive training on the discouragement and prevention of, as well as risk mitigation associated with, medication diversion during Medication Assistance Training, which is required for any provider assisting with medication.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

DHCF is responsible for monitoring the performance of providers in the administration of medications to waiver participants.

During provider certification renewal, a review of provider policies, procedures, and documentation is conducted to determine the adequacy of and compliance with DHCF standards. Additionally, a sample of provider staff are interviewed, and must demonstrate knowledge of procedures, incident reporting requirements, and individual medication assistance needs.

DHCF reviews all critical incident reports and complaints as outlined in Appendix G-1-a. Data is reviewed on a quarterly and as needed basis to identify trends related to:

- Provider
- Staff member
- Participant
- Time of day
- Scheduled vs. PRN medication
- New vs. existing prescriptions

If trends related to the provider, staff member, or participant are identified, targeted technical assistance is conducted for the relevant provider. Other identified trends are addressed during regularly scheduled provider support calls and other provider training, as well as DHCF Medication Assistance Training.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
G.i.a - Percentage of abuse, neglect, exploitation, and unexplained deaths reported and referred to the appropriate authority in accordance with DHCF policy and within the required timeframe (# of abuse, neglect, exploitation, and unexplained death incidents that were reported and referred in accordance with DHCF policy and within required timeframe / # of related incidents received)

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
IMPROV

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.i.b - Percentage of abuse, neglect, exploitation, and unexplained death incidents that were reviewed in accordance with DHCF policy and within the required timeframe (# of abuse/neglect/exploitation/unexplained death incidents reviewed in accordance with policy and required timeframes / # of related incidents received)

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
IMPROV

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.i.c - Percentage of substantiated abuse/neglect/exploitation/unexplained death incidents in which required/recommended follow-up was completed in accordance with DHCF policy and within the required timeframes (# of substantiated abuse/neglect/exploitation/unexplained deaths-required/recommended follow-up was completed in accordance with policy and required timeframes / # related incidents rcd)

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
IMPROV

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and**	☐ **Other**

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.i.d - Percentage of participants informed of how to identify and report incidents of abuse, neglect, and exploitation (# of IPCs containing verification of education on identifying and reporting incidents of abuse, neglect, and exploitation / # of plans approved).

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
IMPROV

Responsible Party for data collection/generation	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

(check each that applies):		
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
G.ii.a - Percentage of critical incidents in which root cause was identified (# of incidents of abuse, neglect, exploitation, and death in which root cause identified / # of incidents of abuse, neglect, exploitation, and death reviewed for root cause).

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.ii.b - Percentage of critical incident trends for which systemic intervention was implemented (# of trends identified through root cause analysis for which systemic intervention was implemented / # trends identified through root cause analysis).

Data Source (Select one):
Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
G.iii - Percentage of restraints reported to the DHCF that received appropriate follow-up action in accordance with state rules and procedures (# of restraints reported that received appropriate follow-up action in accordance with state rules and procedures / # of restraints reported).

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
EMWS, or its successor

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
G.iv - Percentage of participants who received preventive medical care according to the state standard (# of participants whose IPC includes dates for preventive medical care appointments as specified in state standards / # of plans)

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
EMWS, or its successor

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The anticipated outcome for this data collection is ensuring that the state has designed and implemented an adequate system for assuring that participants are safe and healthy. The state will review the performance measure data for this assurance on a quarterly basis. If, during a quarterly review, there are areas that do not meet anticipated outcomes, DHCF will ensure that issues caused by failure to follow process or policy are remedied through technical assistance and re-education, both at an individual level and, where possible, through statewide training. Individual remediation activity requires follow up from DHCF to determine that the provider successfully completed the required corrective action, required sanctions, or other disciplinary action Corrective action plans, sanctions, and decertification may occur if a provider fails to meet remediation efforts. Remediation strategies include training, revision of administrative processes and procedures, administrative rule revisions, and waiver amendments. These strategies will be used based on the results of the discovery and analysis of the related performance measure. If compliance with the performance measure falls below 86%, a request for a corrective action plan, including activities and time lines for completion and follow-up will be required. Follow-up will include a discovery process using a valid random sample.

DHCF will review 100% of critical incidents related to abuse, neglect, exploitation, and unexplained death on an ongoing basis. Individual provider remediation requires follow up to determine the cause of the incident and if the provider successfully completed the required corrective action, sanctions, or other disciplinary action. Corrective action plans, sanctions, and decertification may occur if a provider fails to meet remediation efforts. Performance measures, corrective action, and other meaningful data listed above. DHCF will study processes for such review, and possibly adjusted on an annual basis.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Quality Improvement Strategy (QIS) utilizes discovery, analysis, and remediation activities as the method of ensuring that services provided through the Comprehensive and Supports waivers are routinely monitored, and that necessary corrective action processes are in place. While performance measure review occurs on a quarterly basis for Comprehensive and Supports waiver services, discovery, analysis, and remediation efforts are continuous. Data informing the performance measures are reviewed and analyzed on an ongoing basis by the DD section staff in each area (outlined within each assurance). Each unit works to identify areas of deficiency, required improvement actions, and to assure completion of remediation efforts. Review and remediation activities are tracked and made accessible to appropriate DHCF and State Medicaid Agent staff for maintaining timelines, ensuring compliance, and to issue reports relating to review and remediation activities.

DHCF has a variety of processes employed to aggregate, analyze, and evaluate waiver performance, as well as to assist in the identification and remediation of problems. These processes, and the assurance categories that they encompass, are:

1. Waiver Applicant Process: Informs Level of Care. This process includes eligibility assessments and determination of eligibility. Data is collected in EMWS, or its successor.

2. Plan of Care Development: Informs Service Plan, and Health and Welfare. DHCFs Participant Support Unit provides education to applicants and families on the waiver system, and defines participants and/or guardians, and case manager roles and responsibilities.

3. Plan of Care Review: Informs Service Plan, Qualified Providers, Health and Welfare. DHCSs Participant Support Unit reviews certain IPCs to ensure accurate service plans, services are delivered by certified providers, and the health and welfare of participants. Data is collected in EMWS and IMPROV, or their successors.

4. Extraordinary Care Review: Informs Service Plan, Qualified Providers, Health and Welfare, Financial Accountability. This process allows participants, through their case managers, to request additional funding and services beyond their initial individual budget amount. The Participant Support Unit prepares documentation for a committee comprised of medical professionals, staff from Medicaid finance, and DHCF staff. The committee meets routinely to review the requesting participant's IPC for services, qualified providers, health and welfare, and financial accountability. Data is collected in Extraordinary Care Committee Google Drive.

5. Provider Certification Renewal: Informs Service Plan, Qualified Providers, Health and Welfare, Administrative Authority, Financial Accountability. DHCFs Provider Support Unit certifies qualified providers in accordance with rules, regulations, and policy. Policies and procedures are in place to identify noncompliance and remediation efforts. Data is collected in IMPROV, or its successor.

6. Complaint Process: Informs Service Plan, Qualified Providers, Health and Welfare, Financial Accountability. Complaints are reviewed and addressed in accordance with DHCF rules, regulations, and policy. Data is collected in IMPROV, or its successor.

7. Incident Reporting: Informs Service Plan, Qualified Providers, Health and Welfare, Financial Accountability. Each incident is reviewed, and addressed in accordance with Division rule, regulation, and policy. A root cause analysis is conducted on all closed critical incidents to identify trends and inform systemic change. Data is collected in IMPROV, or its successor.

8. Mortality Review: Informs Service Plan, Qualified Providers, Health and Welfare, Administrative Authority, Financial Accountability. The 1915c Committee is comprised of individuals from the Wyoming Department of Health and the contractor for utilization review. The committee meets on a routine basis to review participant cases associated with critical incidents, complaints, and participant deaths reported to DHCF. If there is a recommendation for further action, DHCF ensures that there is proper follow-up and assists providers in implementing necessary changes to internal processes to ensure participant safety. Data is collected in the Mortality Review Database.

9. Plan of Care Quality Review: Informs Service Plan, Qualified Providers, Health and Welfare, Financial Accountability. This process randomly selects and reviews IPCs approved through the EMWS system, or its successor. Data is used to target case management training and improve practices.

10. Utilization Review Process: Informs Service Plan, Financial Accountability, Qualified Providers, and Administrative Authority. This process reviews IPCs to ensure that participants are receiving services in accordance with the type, scope, amount, duration, and frequency specified. Responses to the Case Management quarterly reports are reviewed, and identified deficiencies, separated by category, are noted. If needed, DHCF staff work with case managers to ensure that IPCs are accurate and participants are receiving the services outlined in their IPCs.

11. Assurance of Proper Provider Payments: All services must be prior authorized. In order to be prior authorized, services must be included on the participant's individualized plan of care (IPC), which is created in the Electronic Waiver Management System (EMWS). Services are included in the participant's IPC in accordance with the participant's assessed needs and within the limits established by the HCBS waiver application. EMWS edits IPCs to ensure services are authorized within those established limits, and submits a prior authorization request to MMIS. MMIS validates the participant's Medicaid eligibility and verifies enrollment in the particular waiver program for which the prior authorization request is submitted. All agency claims for reimbursement for services are submitted to MMIS. MMIS edits claims for participant eligibility and for prior authorization. Claims for eligible participants are posted against the prior authorization, and MMIS allows payment only if the services included on the claim are delivered within the authorized dates and amounts.Case managers are required to conduct monthly monitoring of service plans and documentation, and conduct regular service observations to assure services are provided in accordance with the IPC, including the type, scope, amount, duration, and frequency of each service. The case manager is required to report variances on the Case Management Quarterly Report Form.

While these processes are continuous, performance measures are collected and reviewed quarterly. In addition, DHCF reviews a summary of its performance measures, remediation efforts, recommendations for system improvements, and the 372(S) report annually. The results of the review are noted on the QIS portion of the 372(S) report. Changes in indicators, new data measurement, or discontinuance of indicators due to demonstrated ongoing goal compliance is noted.

The performance measures for which the State is requesting consolidated reporting are related to administrative authority, and are as follows:
A.i.a
A.i.b
A.i.c
A.i.d
A.i.e

The Wyoming Supports and Comprehensive waivers are very similar, with the only notable difference to design being the cost limit set for participants receiving services. In accordance with the guidance issued by CMS on March 12, 2014, the two waivers are almost identical with regard to participant services, participant safeguards, and quality management, with the only notable difference to participant services being the level of community living services that are available. The quality management approach is identical across waivers, including methodology for discovering information, the manner in which individual issues are remedied, the process for identifying and analyzing patterns and trends, and performance indicators. Provider networks and oversight are the same.

The State does not intend to consolidate evidence reports given that the State collects and analyzes all data, outside of Appendix A, separately.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☒ **Other** Specify: Developmental Disability Advisory Council and Partnership Improvement Team	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

Quality review of the performance measures undertaken by DHCF may indicate the need for recommendations for system design changes. DHCF presents recommendations for such changes to the Developmental Disabilities Advisory Council (DDAC) and Partnership Improvement Team (PIT) for discussion.

Review for system-wide change occurs every two years, or as needed, based on continuous discovery and analysis efforts. Once all parties agree on recommended system design changes, DHCF and the State Medicaid Agent identify the following:

- Individuals responsible for oversight of the systems change, which depends on the assurances impacted by the change.
  - The State Medicaid Agent or designee leads the efforts on the changes impacting Administrative Authority and/or Financial Accountability
  - DHCF leads the efforts on changes impacting Level of Care, Service Plan, Qualified Providers, and Health and Welfare
- Other agencies or stakeholders who should be involved in system design changes.
- Major action steps needed to implement the change.
- The timeline for the change, including time lines for each major action step.
- Performance measures and appropriate data collection to track the results of the systems change.
- The timeline for assessing the impact of changes made.

Once a change has been implemented, DHCF, the Medicaid Waiver Liaison, and the Medicaid Program Integrity Manager review the implementation of systems changes quarterly to identify potential barriers and to make changes as needed to the action plan created during implementation of the system changes. The DDAC and PIT is updated annually, or as needed, on the implementation of the system improvements.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

DHCF presents information on the effectiveness of the quality improvement strategy annually to the DDAC and PIT. Topics include:

- Effectiveness of the performance measures;
- Processes used by DHCF to gather data;
- Changes to databases or data analysis; and
- Issues with data reliability.

The DDAC and PIT may make recommendations on changes to the quality improvement strategy related to policy changes, data collection efforts, and changes to service definitions. DHCF works with the State Medicaid Agent to identify appropriate changes based on these recommendations.

On an annual basis, the Outcomes and Evaluation Unit reviews its processes for collecting and utilizing performance measure data related to remediation efforts, trend analysis, systemic issues, and the prioritization and implementation of system improvements. This review is summarized and presented to the DDAC and PIT.

Upon completion of DHCFs analysis and review of quality assurance activity data and reports, and DHCFs own review of its operations, all relevant information is compiled into a Quality Assurance overview report and is submitted to the Medicaid State Agent. The Medicaid State Agent may offer feedback on trends and implementation of systemic quality improvement activities. A timeline is developed to implement changes that include responsible parties, action steps, and deadlines for each major step. The DDAC and PIT is updated on the progress of the changes, and the changes are reported to CMS in an annual report.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- (●) **No**
- ( ) **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ( ) **HCBS CAHPS Survey :**
- ( ) **NCI Survey :**
- ( ) **NCI AD Survey :**
- ( ) **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

(a) In accordance with 2 CFR §200.502(i), provider agencies are not subject to an independent audit as payments for services rendered are not made on a cost-reimbursement basis. Provider certification renewal occurs at least once every three (3) years.

Providers that do not provide services in a setting that is owned, leased, or controlled by the provider are not subject to an on-site visit. Other providers will be subject to an on-site visit at least once every three (3) years. DHCF utilizes a survey tool which incorporates a review of specific HCB setting components and other standards outlined in Chapter 45 of the Department of Health's Medicaid Rules, and 42 CFR 441.301(c)(4)-(5). Provider compliance with each standard is rated, and the final score determines a one (1), two (2) or three (3) year certification period.

- *A sample of participant files is reviewed during the certification renewal process. This review includes a review of service and billing documentation. Additionally, the case manager is responsible for reviewing service and billing documentation of each participant each month.*
- *A statistically significant number of claims is not reviewed. State resources do not accommodate the workload that is necessary to review that number of claims.*
- *Post payment review is conducted by Wyoming Medicaid Program Integrity through data mining and analytics, receipt of referrals from Medicaid programs, referrals from third contracted vendors, and coordination of efforts the contracted Financial Management Service agency. Analytics are conducted at the provider agency level. When anomalies are identified and the need for clinical expertise (i.e. medical necessity determinations) the PI unit will coordinate additional reviews with a third party vendor Optum to conduct these medical necessity reviews. A monthly meeting is held with Optum to review ongoing medical record reviews that have been assigned and receive results of completed reviews. These reviews are conducted randomly. The State has implemented the mandatory risk based screening requirements outlined in 42 CFR 455.434. This requirement is specifically related to ownership interest in entities designated as "high" risk provider types (i.e. Newly Enrolling: Home Health Agencies, DMEPOS). All waiver providers are reviewed and receive an onsite visit from DHCF provider certification staff prior to enrollment. Recurring onsite visits take place upon provider recertification.*
- *DHCF does not complete an audit of claims processed by the FMS. All Medicaid claims are processed through MMIS. Oversight activities of the FMS are outlined in Appendix E-1(iv).*
- *In addition, the State agency coordinates and collaboratively executes the beneficiary verifications (EOMBs) process. The data analytics personnel within Program Integrity creates an annual schedule for the mailing of EOMBs. This is done through the evaluation of category of service and expenditure. Each month a total of 400 EOMBs are submitted to beneficiaries. 300 are sent at a consistent amount every month (i.e. 90/every month to Home health, 50/every month to DD etc.). Then a targeted group is selected to receive 100 each month per month of the year. The results of the EOMBs are received by the contracted fiscal agent and if issues are identified the fiscal agent initiates contact with the State agency to take action on and investigate the identified issue. The State agency tracks the number of EOMBs that receive responses from beneficiaries and the average return rate is approx. 50 % year. There have been no issues noted or cases generated related to PCS service expenditures.*
- *Prior authorizations are managed through EMWS and MMIS. These systems are both overseen by the State Medicaid Agency. Dedicated contract managers provide direct oversight of these contracts, as specified in Appendix A. Any changes to waiver billing procedures and criteria must receive the approval of the Change Control Board (CCB) designated for MMIS.*
- *The Medicaid Program Integrity Unit has an electronic referral process in place to receive potential fraud, waste, and abuse referrals from: Medicaid Programs, third party vendors that are contracted with the State agency, and the general public. The Program Integrity Unit also manages the fraud hotline. A designated individual is tasked with receiving and conducting an initial interview to ascertain the pertinent information. If an error is identified, it is reported directly to the Medicaid Program Integrity through the above identified channels. Program Integrity then coordinates with MFCU and other fraud, waste, and abuse agencies as necessary. Programmatic errors are discussed within the State Medicaid Agency via regularly occurring coordination meetings between the units tasked with oversight (DHCF specifically).*

(b) & (c)

The waiver, through the SMA, is part of the annual State Financial Audit which is conducted every year by an external accounting group, McGee, Hearne & Paiz. The audit always includes a sample of waiver claims. The audit includes the entire process of Medicaid from eligibility to final payment. The sample is determined by Program Integrity's contractor for the audit. It is a random statistically valid sample with a 95% confidence interval and a +/-5% margin of error.

Title XIX of the Social Security Act, federal regulations, the Wyoming Medicaid State Plan, state regulations, and contracts establish record maintenance and retention requirements for Medicaid services. Providers must maintain files for each waiver participant, and are required to retain records that document the services provided and support the claims

submitted for a period of six years. Records must be maintained for a minimum of six years, and records must be maintained longer than six years as required to resolve any pending matters such as an ongoing audit or litigation.

DHCF maintains documentation of provider qualifications, which includes copies of the Medicaid Provider Agreement, required training, and any other documentation necessary to demonstrate compliance with the established provider qualification standards.

Claims are submitted, and claims data is maintained through MMIS. The MMIS is designed to meet federal certification requirements for claims processing, and submitted claims are adjudicated against MMIS edits prior to payment.

In accordance with Chapter 45 of the Department of Health's Medicaid rule, the case manager is responsible for ongoing monitoring of IPC implementation. This includes a monthly review of provider billing and documentation, monthly review of service utilization, and at least quarterly service observations. The case manager is responsible for reviewing service and billing documentation of every participant each month. This review includes a verification of the units that were provided, service documentation meets the service definition and participant preferences as outlined in IPC, service documentation aligns with the services that were billed, and identification of any over or underutilization of services. Service documentation is reviewed the month after the service is provided. Billing documentation is reviewed the month after billing is submitted. If concerns are found, the case manager must include the concerns in their monthly documentation, and submit a complaint to the Division using the complaint process. The Division conducts follow up on complaints and refers to Program Integrity or the Medicaid Fraud Control Unit if issues are verified. The Division samples Case Manager Monthly Review forms during the provider certification renewal process to ensure that case managers are conducting their review of documentation as required by rule.

DHCF conducts a documentation review for each provider during the certification renewal process, including complaints or referrals submitted relating to documentation or claims concerns. Results of the documentation reviews are recorded if concerns are found, and referrals to Program Integrity and MFCU are recorded as needed. Reviews and on-site visits may include, but are not limited to:

Examination of records
- Interviews of providers, associates, and employees
- Interviews of program participants
- Verification of the professional credentials of providers, their associates, and their employees
- Examination of any equipment, stock, materials, and other items used in or for the treatment of participants in the program
- Audit of facility financial records for reimbursement
- Random sampling of claims submitted by and payments made to providers

DHCF, in conjunction with the Medicaid Program Integrity Unit, utilizes a process for monitoring the Financial Management Service Fiscal/Employer Agent, including a process to audit claims submitted by the agent, as outlined in Appendix E.

Rules outlining Wyoming's required oversight are found in Chapters 3, 4, 16, 44, 45, and 46 of the Department of Health's Medicaid Rules.

To review Medicaid Chapters, visit https://rules.wyo.gov/.
Select Current Rules
Select Health, Department of (048)
Select Medicaid (0037)
Select the Chapter you wish to review

If data analysis or a review conducted by the Program Integrity Unit results in a determination that there is a credible allegation of fraud, the Program Integrity will refer to the Medicaid Fraud Control Unit (MFCU) or other law enforcement agency for investigation. MFCU may institute criminal or civil cases against a provider. In accordance with 42 CFR §455.23, Medicaid payments may be suspended while credible allegations of fraud are investigated, except when it is determined that there is good cause not to suspend payments, or a law enforcement hold is requested. In such cases where the decision not to suspend is invoked, written documentation shall be retained to support that decision.

Program Integrity conducts: data mining, data analysis, and record reviews, to support identified over payments for recovery action and other authorized provider sanctions listed in Medicaid Rules Chapter 16. Selection of issues or providers for review can be based upon surveillance and utilization review subsystem (SURS) reports, complaints, issues identified internally or externally, referrals, or management. Claim types or providers identified as posing a risk for potential over payments are reviewed to determine if claims were correctly coded and paid in accordance with DHCFs reimbursement methodology. In addition, claims are monitored by Payment Error Reporting Measurement (PERM) audits.

EVV
An approved EVV system is in place for participant-directed services. The State of Wyoming has not fully implemented an EVV system for traditional services. The State of Wyoming received an extension of its EVV system in a letter dated December 2, 2019, which extended the implementation deadline to January 2021. A solution has been procured and will be in place and required for 1915(c) traditional services later by December 2021.

The following services will be subject to EVV:
** Respite;*
** Personal care;*
** Companion; and*
** Child habilitation*

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
I.i.a - Percentage of claims that were paid for services rendered only when participants were enrolled in the waiver and eligible for such services (# of claims paid for services rendered only when participants were enrolled in the waiver and eligible for such services / # of claims paid)

Data Source *(Select one):*
Financial records (including expenditures)

If 'Other' is selected, specify:
MMIS report, exceptions and recoup databases

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☒ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☒ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
I.i.b - Percentage of claims that were paid for services rendered only when services were provided by a qualified provider (# of claims paid for services rendered only when services were provided by a qualified provider / # of claims paid)

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:
MMIS report, exceptions and recoup databases

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☒ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*

	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☒ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
I.i.c - Percentage of claim lines reimbursed using the correct code as specified in the Service Index (# of claims lines reimbursed using the correct code as specified in the Service Index / # of claim lines)

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:
MMIS report, exceptions and recoup databases

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☒ ***Quarterly***	☐ ***Representative***

		Sample *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☒ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
I.ii - Percentage of provider payment rates that were consistent with rate methodology in the approved waiver application (# of claims paid that were consistent with approved waiver rate methodology / # claims paid).

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:
MMIS report

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☒ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other***	

	Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☒ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

DHCFs certification renewal process and complaint process identifies billing errors or potential fraud, as can routine investigative techniques used by the Medicaid Program Integrity Unit. DHCF makes referrals to the Medicaid Program Integrity (PI) Unit or Medicaid Fraud Control Unit (MFCU) for investigation. The status of recoveries and investigations is discussed at monthly CURT (Core Utilization Review Team) meetings held by the Medicaid Program Integrity Unit.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

Billing and claim errors shall be investigated in order to 1) determine why the error occurred, and 2) implement remediation strategies. DHCF shall determine if an error is an isolated incident, or a system issues, which may indicated the need for a systems change. Claims errors will be recovered. DHCF may offer provider reeducation , or refer the case to PI for investigation of fraud. If the preliminary PI investigation indicates the error was unintentional, DHCF will conduct continuing provider reeducation. If fraud is indicated, the case shall be referred to MFCU for further investigation.

Recoveries and investigations are tracked through E-FADS, an enhancement to the Program Integrity Unit's tracking system.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☒ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ ***No***

○ ***Yes***

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

In 2008, the Department of Health was required by state statute (W.S. 42-4-120 (g)) to establish a cost-informed reimbursement system to pay providers of services and supplies under home and community based waiver programs for persons with developmental disabilities or acquired brain injury. This state statue also required that rates be rebased at least once every four (4) years, but not more than once in any two (2) year period. As Wyoming's state statute requires a cost-informed rate methodology, provider cost surveys are collected to inform the rate model. The State Medicaid Agency may adjust rates as directed by the state legislature or Governor in order to balance the State's budget.

In 2017, the Department of Health contracted with Navigant Consulting to conduct a rate study for Wyoming's (HCBS) waivers. The objectives of the rate model included in this study were to:
•Recognize reasonable and necessary costs of providers
•Standardize rates
•Reflect participant needs
•Increase transparency
•Facilitate regular updates
•Provide fiscal stability for providers and the state

Navigant and the DD Section worked with key stakeholders from June 2017 to January 2018 to conduct the rate study and develop proposed waiver program rates. Stakeholder involvement included the following workgroups:
•Provider Team – Composed of small and large providers and case management agencies who reviewed the survey design and materials, gave input on rate component assumptions, and developed related recommendations for consideration by the Steering Committee.
•Steering Committee – Composed of key state agency staff, legislators, and consumer and provider representatives who reviewed and selected key rate assumptions based on materials developed by Navigant and recommendations from the Provider Team.
•Small provider focus group – developed to gather input on how to more effectively gather wage data from small providers (those receiving less than $1 million in Medicaid payments annually).
•Case manager focus group – developed to gather input on how case managers spend their time on activities related to the provision of case management services.

Rate Components:
An independent rate build-up methodology based on cost and wage data from providers and other state and national data sources was used. The independent rate build-up methodology comprises direct care and indirect care components, and uses assumptions about types of employees; wage rates; benefits; program support and administration costs; supervisor span of control; staffing patterns; and direct care work productivity factors. Some components vary between services while others are the same across the services. This rate determination methodology was used to calculate rates for the following services:
•Adult Day Services
•Case Management Services (15 Minute Unit)
•Community Living Services
•Community Support Services
•Homemaker
•Individual Habilitation Training
•Personal Care
•Respite
•Supported Employment
•Child Habilitation Services
•Cognitive Retraining
•Companion Services
•Crisis Intervention Support

Direct Care Unit Cost= (direct care inflated wage/Units per hour/staffing ratio)(1 + benefits factor)*productivity factor*FTE factor*
Direct Care Supervision Costs= (supervisor inflated wage/units per hour/supervisor span of control)(1 + benefits factor)*productivity factor*FTE factor*
Total Direct Care Costs= direct care unit cost + direct care supervision costs
*Non-Direct Care Cost= total direct care costs*administration factor*program support factor*
*Proposed Rate= (total direct care costs + non-direct care cost)*incentive factor or reduction factor*

Direct Care Cost Rate Components
Staff Wages: For the direct care worker wage, an average of two BLS occupational categories was used: Home Health Aide (BLS occupational category 31-1011) and Personal Care Aide (BLS occupational category 39-9021). Provider wage survey data was used to identify the wage for job coaches and vocational trainers and shift and unit supervisors. The median wage for Rehabilitation Counselor (BLS occupational category 21-101) was used to identify the wage for rehabilitation counselors as the survey data were not sufficient. All wage data were inflated to the midpoint of SFY 2019 using a two-year moving average of the quarterly Wyoming Cost of Living Index values (provided by the Wyoming Economic Analysis Division) equal to a 1.55 percent inflation factor for wages collected through the provider survey and 4 percent for BLS wages. BLS wages were identified using May 2017 BLS data.

Employee Related Expense (ERE) Factor: The ERE factor reflects the cost of program employee benefits, specifically:
•Federally required benefits such as FICA, FUTA, SUTA, and workers compensation
•Health and dental insurance
•Retirement benefits
•Long- and short-term disability benefits

Health insurance costs were identified using the Medical Expenditure Panel Survey (MEPS) average employer portion (Wyoming 2016 MEPS Table II.C.1 minus Table II.C.2) with a six percent inflation factor added to update insurance costs to the midpoint of SFY 2019 based on Medicare Market Basket History and Forecasts. (Quarterly Index Levels in the CMS Prospective Payment System Price Index using Global Insight, Inc. Forecast Assumptions, by Expense Category 1996-2024).(using Quarterly Index Levels in the CMS Prospective Payment System Price Index using Global Insights, Inc. Forecast Assumptions, by Expense Category 1996-2024). Retirement benefits were based on June 2017 BLS data for retirement costs as a percent of salary and wages for private industry health care and social assistance "service" workers. Retirement benefit costs were calculated using BLS data reported on retirement costs as a percent of salary and wages for private industry health care and social assistance "service" workers, June 2017. This percentage is calculated by dividing the total cost per hour in retirement and savings ($0.39) by total cost per hour for salary and wages for the "service" worker category ($13.74). Federally required benefits were calculated using national and state percentages, and additional benefits were based on provider cost report data.

Full Time Equivalent (FTE) Factor: The FTE factor represents costs associated with payroll hours required to cover for staff when they are not available to provide direct services (i.e., vacation days, sick time, training). Approximately 22 days per year were included for the FTE factor based on the average number of paid time off and paid training hours per employee reported in the provider cost and wage surveys.

Productivity Adjustment: The rate model includes service-specific productivity factors to account for non-face-to-face time necessary to deliver services (planning, meetings, recordkeeping, etc.). The Provider Team provided productivity factor recommendations to the Steering Committee based on provider experience, service requirements and a review of the productivity factors used in the SFY 2016 study. The proposed factors were reviewed and any changes that were needed were made based on service requirements.

Indirect Care Cost Rate Components
Administration Factor: The administration factor reflects costs associated with operating a provider agency. These costs include: administrative employees' salaries, office supplies and services, information technology expenses, central corporate office other administration expenses allocated to the local level, licenses/taxes, liability and other insurance, background checks, and non-service related transportation. Provider cost data specific to non-case management service providers was used to calculate an admin factor representing approximately 16 to 18 percent of the rate (varies by service). The community living services host home and special family habilitation home service rate does not include an administrative component.

Program Support Factor: The program support factor reflects the costs that support direct care services, such as non-payroll program support costs, non-payroll facility, vehicle and equipment expenses, maintenance costs, and program supplies. The Program Support Factor was tailored by service to reflect if service provision required facility and/or vehicle costs. Costs related to room and board for participants including facility maintenance, upkeep, and improvement related to community living (residential) program services were excluded from the total costs collected for the rate determination. Additionally, cost outliers from provider costs and wage surveys were excluded and the program support portion of the rate for community living services was capped at the level 4 amount. Program support factors vary by

service and range from three percent to approximately 17 percent of the rate. Transportation services are calculated without a program support factor as the program support portion of the rate is provided through the mileage payment adjustment.

Transportation rates: Were developed using the rate methodology described above that combined direct and indirect cost components, with an add-on payment for mileage at the 2017 Federal per-mile business rate of $0.535/mile. No adjustments were made to the mileage rate. Previously, a per-mile rate that did not include staff time was used; the current rate is a tiered per-event rate that includes staff time and a per-mile cost based on the Federal per-mile business rate. The tiers reflect the varying distances that Wyoming providers may need to travel. Tier 1 is based on 5 miles and Tier 2 is based on 10 miles.

Skilled Nursing and assessment; Dietitian; OT; PT; Speech services were not included in the updated rate methodology. These rates shall be based on the rates paid through the Medicaid State Plan. Case Management Monthly Rates were developed using a similar methodology as described above, and adjusted over time using appropriations from the State legislature.

Incentive Factor (or Reduction Factor) – The service rate calculation for Child Habilitation Ages 0-12 includes a reduction to the calculated rate to account for time that a child would normally receive services from school or other child care.

Due to the variable nature of some services, the determination of a standardized reimbursement rate is not possible. The Service Index and Fee Schedule for all services can be found at https://health.wyo.gov/healthcarefin/hcbs/servicesandrates/. Case managers must obtain at least two competitive bids for environmental modification and specialized equipment services. Payment is authorized to the provider with the most cost-effective bid which meets the needs of the participant.

For self-directed services, the participant does not utilize the provider-managed rate methodology. Instead, s/he pays staff a wage that covers the needed services and can be paid within his/her IBA. The cost to the participant's IBA is the wage, which includes employer payroll taxes, state and federal unemployment taxes. The participant may increase the wage to assist with employee medical benefits. The wage minimum is based upon the federal minimum wage and the wage maximum is based upon what the IBA will support.

Due to catastrophic revenue declines in the State of Wyoming, DHCF will implement a 2.5% reduction of the following services, effective February 1, 2021.
** Adult Day - all levels*
** Behavioral Support - all levels*
** Case Management*
** Child Habilitation*
** Cognitive Retraining*
** Community Living - all levels*
** Community Support - all levels*
** Companion*
** Crisis Intervention*
** Individual Habilitation Training*
** Personal Care*
** Respite*
** Specialized Family Habilitation Home*
** Supported Employment*
** Transportation*

Please see additional information box in Main Section for information on Behavioral Support Services and Public Notice.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

The Wyoming Medicaid Management Information System (MMIS) is the system used to accept and process claims for services rendered by waiver providers. Providers will directly submit electronic claims using an electronic software system or via web online entry, which are both direct input tools to MMIS. Once a provider submits a claim, the claim enters MMIS and is processed through the processing cycle, which includes all edits and audits.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- (●) ***No. state or local government agencies do not certify expenditures for waiver services.***
- ( ) ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

All service requests through traditional service delivery are reviewed and subject to prior authorization by DHCF. IPCs are reviewed to ensure the service descriptions, units, rates, and quantity of services requested is within the IBA, that services align with assessed need, and that the units requested do not exceed the specified methodology. Traditional services must receive a prior authorization number that is assigned through MMIS. Billing for waiver services is submitted electronically through MMIS and providers are paid through that system. There are many edits built into MMIS that do not allow payment for more units or dollar requests above the amount approved. System edits include service codes with set rates, limits on number of days that can be billed in a month, number of hours that can be billed in a day, and other time specific rules which limit the amount of services that can be billed. Since all claims are submitted electronically using a prior authorization number, MMIS utilizes edits to assure that payments never exceed authorization. No traditional waiver services are authorized without a prior authorization number.

Self-Directed Services are reviewed by DHCF and authorized in the FMS web-based system. Claims to the FMS are paid through MMIS.

An individual must be an active Medicaid recipient enrolled in the appropriate waiver program in order for services to be processed and paid. This assurance is an integral component managed by MMIS. Additional checks regarding services rendered, including appropriate provider type, no duplicate claims submitted, etc. are also performed.

The Wyoming Claims Processing Subsystem uses a Recipient Master File to verify recipient eligibility for services billed by a provider. Once an individual becomes eligible for services, the participant's eligibility information is updated in MMIS. Only services in the client's plan will be covered based on limits established by the prior authorization number assigned to the service. MMIS posts exceptions if a recipient is not eligible on the service date or is restricted from the service, as indicated in the service restrictions on the Recipient Master File. Service restrictions may include restricting the recipient to a particular provider for treatment or placing the recipient on review.

MMIS checks other service limitations by referencing recipient Medicaid eligibility, TPL, and by various benefit plan specific limits established by the Utilization Review Criteria File. Each claim processed by the Wyoming Claims Processing cycle, regardless of the entry method, has to pass the provider eligibility edit module. The Provider Master File verifies that the provider is actively enrolled and licensed according to the benefit plan for the category of service and dates of service. It also verifies any special restrictions for the provider for the service date on the claim. For each test that fails, MMIS posts an exception code. The claim is adjudicated according to the exception disposition codes maintained on the Exception Control File.

All waiver services must be prior authorized. In order to be prior authorized, a service must be included on the participant's service plan created in the Electronic Waiver Management System (EMWS). Services are included in the participant's service plan in accordance with the participant's assessed needs and within the limits established by the HCBS waiver application. EMWS edits service plans to ensure services are authorized within those established limits and submits a prior authorization request to the Medicaid Management Information System (MMIS). MMIS validates the participant's Medicaid eligibility and verifies enrollment in the particular waiver program for which the prior authorization request is submitted. All agency claims for reimbursement for PCS are submitted to MMIS. MMIS edits PCS claims for participant eligibility and for prior authorization. Claims for eligible participants are posted against the prior authorization and MMIS allows payment only if the services included on the claim are delivered within the authorized dates and amounts.

As additional program safeguards, case managers are required to perform quarterly service observations of every participant they serve. If there are any issues with services provided or services not being provided to the participant, DHCF is notified as well as Medicaid Program Integrity, if necessary.

The Claims Processing Subsystem also uses several edits to verify the reasonableness of provider charges. First the system performs internal balancing of claim charges. Second, the system edits and checks each service charge against pricing information on the reference files. Medicaid determines the disposition of the exception codes posting to claims and the system maintains this information on line in the Exception Code File. The Claims Processing Subsystem has the capability of allowing the force payment of services on an exceptional basis, as directed in writing by Medicaid. Through the life of a claim, the system retains in the claim record all exception codes posting to the claim, the adjudication ID of the person who forced or denied any exceptions to the claim, and the date and adjudication ID of the last person who worked on the claim. These features provide an audit trail to support the claim's payment process.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

◉ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***

○ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

◉ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*

○ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- ○ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- ○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- ◉ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ○ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may

voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***

◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Costs related to room and board for participants, as well as facility maintenance, upkeep and improvement related to residential program services are not covered by home and community based waivers. These costs were excluded from the total costs collected for the rate determination and are therefore excluded from the payment rates. The payment rates are based solely on service costs.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ( ) ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- (●) ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ( ) ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] ***Nominal deductible***
- [ ] ***Coinsurance***
- [ ] ***Co-Payment***
- [ ] ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- (●) ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ( ) ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Nursing Facility, ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	57387.49	5429.00	62816.49	226860.00	37571.00	264431.00	201614.51
2	59447.55	5565.00	65012.55	232557.00	38500.00	271057.00	206044.45

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
3	57341.14	5704.00	63045.14	238397.00	39453.00	277850.00	214804.86
4	58367.32	5846.00	64213.32	244385.00	40430.00	284815.00	220601.68
5	59497.93	5993.00	65490.93	250523.00	41432.00	291955.00	226464.07

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
		Nursing Facility	ICF/IID
Year 1	2150	150	2000
Year 2	2150	150	2000
Year 3	2116	148	1968
Year 4	2082	146	1936
Year 5	2048	143	1905

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The Department analyzed historical growth rates of total waiver enrollment days and average length of stay (ALOS) using CMS 372 Report data for the waiver years through March 31, 2017. The Department selected a standard linear regression model, applied the average growth rate to the previous years' total waiver enrollment days, and divided by the forecasted unduplicated participant count to derive the ALOS estimates.

The average length of stay was calculated by taking the average days of waiver enrollment (687,741)) and dividing it by the number of participants (1,913). 2018 initial COLD report data for enrollment days on the waiver was used for the 2019 projection. The ALOS was capped at 360 days. Applying a growth factor or a year over year percentage growth change caused the ALOS to exceed 365 days. The State will submit a technical amendment if changes are warranted.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

For each waiver service, DHCF initially estimated the number participants utilizing each service, the number of units per user and the average cost per unit. To estimate these factors, DHCF examined historical growth rates, the fraction of the total waiver population that utilized each service, and graphical trends using CMS 372 Report lag data for WY.1061.R00 WY1 – WY3, and initial data for WY4.

Once the historical data was analyzed, DHCF determined that data for many of the service categories varied far beyond what would be reasonably expected moving forward. The WY.1061.R00 waiver was newly developed in 2014 (WY1), and while DHCF used specific models to forecast utilization, estimates did not align with actual usage. Participants transitioned onto the new waiver during WY1, and individuals from the wait list were transitioned onto the waiver during WY2 and WY3. Individuals with an acquired brain injury were transitioned onto the waiver in WY 4. During each of these transitions, and throughout the WY.1061.R00 waiver period, revisions and clarifications to service definitions were made. Additionally, this waiver underwent rate increases in WY3, WY4, and WY5. These modifications have resulted in changes to what services people choose to access. Therefore, we do not have consistent historical data that allows us to determine user and unit utilization over time.

The service set for WY.1061.R00 has been revised. While many of these services will easily map from WY.1061.R00 services, we still anticipate some changes to what services people will choose to use. Due to these changes, and the myriad of changes during the WY.1061.R00 waiver period, it is more challenging to estimate the forecasting of Factor D derivation.

DHCF applied the same regression model, using the participant count and expenditures from the 2018 initial Computer Output on Laser Disc (COLD) reports, to determine user and unit utilization. Current rates were applied to these numbers to calculate an estimated total for 2019 services. However, if the trend factor exceeded 5% growth, the trend factor was capped at 2.5%, a figure equal to the Consumer Price Index (CPI). These forecasted factors were then multiplied to calculate the total estimated expenditure for each service. The total expenditures for each service were added then divided by the forecasted unduplicated participant count to derive the Factor D estimates.

The COLD report details paid claims data from the Medicaid Management Information System (MMIS). The 2018 COLD report contains all information included on the 372 Report but without sufficient run-out to allow for timely filing claims processing. To calculate the units used, the total amount paid for the service is divided first by the number of participants, and then by the rate for that service. As an example, if Adult Day Services cost $2.56 per 15 minute unit, there were 50 participants that used that service and the total expenditure was $193,536, then we know the average number of units used was 1,512. (($193,536/50)/$2.56) = 1,512.

Specific to the skilled nursing assessment, baseline utilization data through October 2019 indicated 13 individuals were expected to use the service. DHCF applied a growth factor of 2.5% to project utilization over the next four years. Projected utilization of this service indicates a constant number of users for WY1 and WY2, and WY3-WY5.

Using the Consumer Price index we can then project the increase for users and units for each service.

Due to a directive issued by the Governor's Office to decrease reimbursement rates across all Medicaid services, DHCF calculated a 2.5% decrease for identified services. This 2.5% reduction is effective February 1, 2021. WY2 rate reductions are being implemented at the end of the waiver year. The average for the full waiver year did not significantly affect the rates for services, so rates were not adjusted for WY2. For WY3 - WY5 the Division calculated a decrease to the number of users for each service based on a simple percentage calculation that aligns with the overall decrease in participants for the waiver year.

The rates do not increase without a legislative appropriation. The State will update projections should one occur.

DHCF will closely monitor these figures, and be prepared to amend the waiver if trends demonstrate extreme variances. As DHCF gathers additional annual data, the model will be reapplied to assure accuracy of the Factor D forecast.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The Department analyzed historical Factor D' growth rates using CMS 372 Report data for the four waiver years ending March 31, 2018. The Department selected a standard linear regression model and applied the average Consumer Price Index (CPI): healthcare of 2.5% to the previous years' non-waiver Medicaid costs and divided by the forecasted unduplicated participant count to derive the Factor D' estimates.

While Factor D' estimates are typically expected to exceed Factor G' estimates, the census at Wyoming's ICF/IID is very low, so one or two outliers can significantly impact the overall average acute care cost per person. This population, in addition to being small, is very medically fragile. Additionally, the rural town in which the ICF/IID is located offers limited hospital services, so individuals requiring care above which the ICF/IID can provide are generally transported via Life Flight to hospitals in surrounding states (Billings, MT; Denver, CO; Salt Lake City, UT). These costs again inflate the overall acute care cost for the ICF/IID population.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

DHCF utilized its initial 2018 CMS 372 Report data for institutional data, as well as projections from the Department of Health's Community Choices Waiver (CCW) for nursing facility costs, to determine the average resident institutional care costs. DHCF used the CCW standard linear regression model and applied the average growth rate to the previous years' institutional costs and divided by the forecasted nursing facility resident count to derive the Factor G estimates. DHCF then used the weighted average of both populations based on the percentage of comparable populations within the waiver program.

The State analyzed historical growth rates of institutional costs for nursing facility and ICF/IID residents using CMS 372 Report data for the four (4) state waiver years through March 31, 2017. The State selected a standard linear regression model and applied the average growth rate to the previous years' institutional costs, then divided by the forecasted nursing facility resident count to derive the Factor G estimates.

Step 2: The weighted average of both populations was based on the percentage of comparable populations within the waiver program. To calculate the weighted average, the State used the average cost per person for nursing facilities, then multiplied that number by the estimated number of waiver participants with an ABI. The same calculation was conducted for participants with a developmental disability, multiplied by the average cost per person at the ICF. These totals were added together, then the total was divided by the total number of participants (1.896).

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The Department analyzed historical growth rates of non-institutional costs for ICF/ID and nursing facility residents using CMS 372 Report data for the four waiver years ending March 31, 2018. The Department selected a standard linear regression model and applied the CPI rate of 2.5% to the previous years' institutional costs and divided by the weighted average of participants for level of care to forecast nursing facility and ICF facility resident count to derive the Factor G' estimates.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Adult Day Services	
Case Management	
Community Living Services	
Community Support Services	

Waiver Services	
Homemaker	
Personal Care	
Respite	
Supported Employment	
Dietician Services	
Occupational Therapy	
Physical Therapy	
Skilled Nursing	
Speech, Hearing and Language Services	
Behavioral Support Services	
Child Habilitation Services	
Cognitive Retraining	
Companion Services	
Crisis Intervention Support	
Environmental Modification	
Individual Habilitation Training	
Special Family Habilitation Home	
Specialized Equipment	
Transportation	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						15190005.99
Adult Day Services Basic (15 Minute)	15 Minute	198	2831.00	2.56	1434977.28	
Adult Day Services Intermediate (15 Minute)	15 Minute	481	3563.00	3.61	6186828.83	
Adult Day Services High (15 Minute)	15 Minute	254	4301.00	6.22	6795063.88	
Adult Day Services Basic (Daily)	Daily	10	260.00	61.44	159744.00	
Adult Day Services Intermediate (Daily)	Daily	10	260.00	86.64	225264.00	
Adult Day Services					388128.00	
GRAND TOTAL:						123383109.46
Total Estimated Unduplicated Participants:						2150
Factor D (Divide total by number of participants):						57387.49
Average Length of Stay on the Waiver:						360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
High (Daily)	Daily	10	260.00	149.28		
Case Management Total:						7472152.26
Case Management (Monthly)	Monthly	2150	12.00	289.39	7466262.00	
Case Management (15 Minute Unit)	15 Minute	127	3.00	15.46	5890.26	
Community Living Services Total:						76410692.43
Community Living Services Basic Individual (15 Minute)	15 Minute	423	1357.00	8.89	5102957.79	
Community Living Services Basic Group of 2 (15 Minute Unit)	15 Minute	32	1198.00	4.66	178645.76	
Community Living Services Basic Group of 3 or more (15 Minute Unit)	15 Minute	2	1198.00	3.42	8194.32	
Community Living Services Basic Group (Daily)	Daily	118	233.00	95.78	2633375.32	
Community Living Services Level 3	Daily	398	227.00	128.26	11587777.96	
Community Living Services Level 4	Daily	256	297.00	170.15	12936844.80	
Community Living Services Level 5	Daily	276	300.00	247.80	20517840.00	
Community Living Services Level 6	Daily	94	365.00	422.08	14481564.80	
Community Living Host Home	Daily	228	158.00	248.82	8963491.68	
Community Support Services Total:						5702746.28
Community Support Services Basic (15 Minute Unit)	15 Minute	92	1188.00	2.83	309307.68	
Community Support Services Intermediate (15 Minute Unit)	15 Minute	280	2041.00	4.28	2445934.40	
Community Support Services High (15 Minute Unit)	15 Minute	147	1435.00	9.16	1932256.20	
Community Support Services Basic (Daily)	Daily	10	260.00	67.92	176592.00	
Community Support Services Intermediate (Daily)	Daily	10	260.00	102.72	267072.00	
Community Support Services High (Daily)	Daily	10	260.00	219.84	571584.00	
Homemaker Total:						212414.72

GRAND TOTAL:	123383109.46
Total Estimated Unduplicated Participants:	2150
Factor D (Divide total by number of participants):	57387.49
Average Length of Stay on the Waiver:	360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Homemaker	15 Minute	112	302.00	6.28	212414.72	
Personal Care Total:						1883428.20
Personal Care	15 Minute	114	2610.00	6.33	1883428.20	
Respite Total:						5386938.58
Respite Individual (Daily)	Daily	145	46.00	232.11	1548173.70	
Respite Individual (15 Minute Unit)	15 Minute	411	1332.00	6.45	3531065.40	
Respite Group (Daily)	Daily	8	176.00	116.05	163398.40	
Respite Group (15 Minute Unit)	15 Minute	22	2037.00	3.22	144301.08	
Supported Employment Total:						1473806.67
Supported Employment Individual	15 Minute	177	761.00	8.12	1093739.64	
Supported Employment Group	15 Minute	77	1831.00	2.69	379255.03	
Supported Employment SEFA	15 Minute	1	100.00	8.12	812.00	
Dietician Services Total:						7404.00
Dietician Services	Session	5	48.00	30.85	7404.00	
Occupational Therapy Total:						316853.70
Occupational Therapy Individual	15 Minute	93	138.00	24.68	316743.12	
Occupational/Physical Therapy Group	Session	3	2.00	18.43	110.58	
Physical Therapy Total:						316018.16
Physical Therapy Individual	15 Minute	236	46.00	29.11	316018.16	
Skilled Nursing Total:						510197.88
Skilled Nursing	15 minute	87	302.00	19.38	509190.12	
Skilled Nursing Assessment	Session	13	1.00	77.52	1007.76	
Speech, Hearing and Language Services Total:						456887.97
Speech, Hearing, and Language Individual	Session	126	76.00	42.02	402383.52	

GRAND TOTAL:	123383109.46
Total Estimated Unduplicated Participants:	2150
Factor D (Divide total by number of participants):	57387.49
Average Length of Stay on the Waiver:	360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Speech, Hearing, and Language Group	Session	35	99.00	15.73	54504.45	
Behavioral Support Services Total:						25250.00
Behavioral Support - BCBA Level	15 Minute	0	1.00	24.54	0.00	
Behavioral Support - BCaBA Level	15 Minute	0	1.00	9.19	0.00	
Behavioral Support - RBT Level	15 Minute	0	1.00	6.79	0.00	
Behavioral Support Services	Event	5	1.00	5050.00	25250.00	
Child Habilitation Services Total:						1212515.22
Child Habilitation (Ages 0 - 12)	15 Minute	63	1832.00	3.18	367022.88	
Child Habilitation (Ages 13 - 17)	15 Minute	121	1778.00	3.93	845492.34	
Cognitive Retraining Total:						96.10
Cognitive Retraining	15 Minute	1	10.00	9.61	96.10	
Companion Services Total:						5481903.66
Companion Individual	15 Minute	530	1535.00	6.45	5247397.50	
Companion Group	15 Minute	84	867.00	3.22	234506.16	
Crisis Intervention Support Total:						205240.20
Crisis Intervention Support	15 Minute	11	2420.00	7.71	205240.20	
Environmental Modification Total:						10000.00
Environmental Modification (New)	Event	1	1.00	5000.00	5000.00	
Environmental Modification (Repair)	Event	1	1.00	5000.00	5000.00	
Individual Habilitation Training Total:						707669.40
Individual Habilitation Training	15 Minute	127	740.00	7.53	707669.40	
Special Family Habilitation Home Total:						325954.20
Special Family Habilitation Home	Daily	5	262.00	248.82	325954.20	
Specialized Equipment Total:						74000.00

GRAND TOTAL:	123383109.46
Total Estimated Unduplicated Participants:	2150
Factor D (Divide total by number of participants):	57387.49
Average Length of Stay on the Waiver:	360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Equipment (New)	Event	36	1.00	2000.00	72000.00	
Specialized Equipment (Repair)	Event	1	1.00	2000.00	2000.00	
Transportation Total:						933.84
Transportation (5 Miles)	Trip	1	48.00	11.87	569.76	
Transportation (10 Miles)	Trip	1	24.00	15.17	364.08	
				GRAND TOTAL:		123383109.46
				Total Estimated Unduplicated Participants:		2150
				Factor D (Divide total by number of participants):		57387.49
				Average Length of Stay on the Waiver:		360

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						15422834.32
Adult Day Services Basic (15 Minute)	15 minute	202	2901.00	2.56	1500165.12	
Adult Day Services Intermediate (15 Minute)	15 Minute	472	3652.00	3.61	6222715.84	
Adult Day Services High (15 Minute)	15 Minute	252	4409.00	6.22	6910842.96	
Adult Day Services Basic (Daily)	Daily	11	260.00	61.44	175718.40	
Adult Day Services Intermediate (Daily)	Daily	10	260.00	86.64	225264.00	
Adult Day Services High (Daily)	Daily	10	260.00	149.28	388128.00	
Case Management Total:						7472291.40
Case Management (Monthly)	Monthly	2150	12.00	289.39	7466262.00	
Case Management (15					6029.40	
				GRAND TOTAL:		127812235.44
				Total Estimated Unduplicated Participants:		2150
				Factor D (Divide total by number of participants):		59447.55
				Average Length of Stay on the Waiver:		360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Minute Unit)	15 Minute	130	3.00	15.46		
Community Living Services Total:						79990975.12
Community Living Services Basic Individual (15 Minute)	15 Minute	434	1391.00	8.89	5366839.66	
Community Living Services Basic Group of 2 (15 Minute Unit)	15 Minute	33	1228.00	4.66	188841.84	
Community Living Services Basic Group of 3 or more (15 Minute Unit)	15 Minute	2	1228.00	3.42	8399.52	
Community Living Services Basic Group (Daily)	Daily	121	239.00	95.78	2769861.82	
Community Living Services Level 3	Daily	408	231.00	128.26	12088248.48	
Community Living Services Level 4	Daily	265	304.00	170.15	13707284.00	
Community Living Services Level 5	Daily	283	308.00	247.80	21599239.20	
Community Living Services Level 6	Daily	96	365.00	422.08	14789683.20	
Community Living Host Home	Daily	235	162.00	248.82	9472577.40	
Community Support Services Total:						5678860.28
Community Support Services Basic (15 Minute Unit)	15 Minute	94	1218.00	2.83	324012.36	
Community Support Services Intermediate (15 Minute Unit)	15 Minute	265	2092.00	4.28	2372746.40	
Community Support Services High (15 Minute Unit)	15 Minute	151	1422.00	9.16	1966853.52	
Community Support Services Basic (Daily)	Daily	10	260.00	67.92	176592.00	
Community Support Services Intermediate (Daily)	Daily	10	260.00	102.72	267072.00	
Community Support Services High (Daily)	Daily	10	260.00	219.84	571584.00	
Homemaker Total:						223159.80
Homemaker	15 Minute	115	309.00	6.28	223159.80	
Personal Care Total:						1913400.75
Personal Care	15 Minute	113	2675.00	6.33	1913400.75	

GRAND TOTAL:	127812235.44
Total Estimated Unduplicated Participants:	2150
Factor D (Divide total by number of participants):	59447.55
Average Length of Stay on the Waiver:	360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:						5656814.15
Respite Individual (Daily)	Daily	149	47.00	232.11	1625466.33	
Respite Individual (15 Minute Unit)	15 Minute	422	1365.00	6.45	3715393.50	
Respite Group (Daily)	Daily	8	181.00	116.05	168040.40	
Respite Group (15 Minute Unit)	15 Minute	22	2088.00	3.22	147913.92	
Supported Employment Total:						1546074.87
Supported Employment Individual	15 Minute	181	780.00	8.12	1146381.60	
Supported Employment Group	15 Minute	79	1877.00	2.69	398881.27	
Supported Employment SEFA	15 Minute	1	100.00	8.12	812.00	
Dietician Services Total:						7712.50
Dietician Services	Session	5	50.00	30.85	7712.50	
Occupational Therapy Total:						319025.54
Occupational Therapy Individual	15 Minute	91	142.00	24.68	318914.96	
Occupational/Physical Therapy Group	Session	3	2.00	18.43	110.58	
Physical Therapy Total:						331097.14
Physical Therapy Individual	15 Minute	242	47.00	29.11	331097.14	
Skilled Nursing Total:						533977.14
Skilled Nursing	15 Minute	89	309.00	19.38	532969.38	
Skilled Nursing Assessment	Session	13	1.00	77.52	1007.76	
Speech, Hearing and Language Services Total:						545121.72
Speech, Hearing, and Language Individual	Session	129	78.00	42.02	422805.24	
Speech, Hearing, and Language Group	Session	36	216.00	15.73	122316.48	
Behavioral Support Services Total:						35846.72
Behavioral Support - BCBA Level	15 Minute	12	40.00	24.54	11779.20	

GRAND TOTAL:	127812235.44
Total Estimated Unduplicated Participants:	2150
Factor D (Divide total by number of participants):	59447.55
Average Length of Stay on the Waiver:	360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Behavioral Support - BCaBA Level	15 Minute	4	40.00	9.19	1470.40	
Behavioral Support - RBT Level	15 Minute	16	208.00	6.79	22597.12	
Behavioral Support Services	Event	0	0.00	5050.00	0.00	
Child Habilitation Services Total:						1283731.35
Child Habilitation (Ages 0 - 12)	15 Minute	65	1878.00	3.18	388182.60	
Child Habilitation (Ages 13 - 17)	15 Minute	125	1823.00	3.93	895548.75	
Cognitive Retraining Total:						96.10
Cognitive Retraining	15 Minute	1	10.00	9.61	96.10	
Companion Services Total:						5615284.43
Companion Individual	15 Minute	543	1533.00	6.45	5369102.55	
Companion Group	15 Minute	86	889.00	3.22	246181.88	
Crisis Intervention Support Total:						210413.61
Crisis Intervention Support	15 Minute	11	2481.00	7.71	210413.61	
Environmental Modification Total:						10000.00
Environmental Modification (New)	Event	1	1.00	5000.00	5000.00	
Environmental Modification (Repair)	Event	1	1.00	5000.00	5000.00	
Individual Habilitation Training Total:						742985.10
Individual Habilitation Training	15 Minute	130	759.00	7.53	742985.10	
Special Family Habilitation Home Total:						195572.52
Special Family Habilitation Home	Daily	3	262.00	248.82	195572.52	
Specialized Equipment Total:						76000.00
Specialized Equipment (New)	Event	37	1.00	2000.00	74000.00	
Specialized Equipment (Repair)	Event	1	1.00	2000.00	2000.00	
Transportation Total:						960.88

GRAND TOTAL:	127812235.44
Total Estimated Unduplicated Participants:	2150
Factor D (Divide total by number of participants):	59447.55
Average Length of Stay on the Waiver:	360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation (5 Miles)	Trip	1	49.00	11.87	581.63	
Transportation (10 Miles)	Trip	1	25.00	15.17	379.25	
			GRAND TOTAL:			127812235.44
			Total Estimated Unduplicated Participants:			2150
			Factor D (Divide total by number of participants):			59447.55
			Average Length of Stay on the Waiver:			360

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						14737101.24
Adult Day Services Basic (15 Minute)	15 minute	199	2974.00	2.50	1479565.00	
Adult Day Services Intermediate (15 Minute)	15 Minute	449	3743.00	3.52	5915736.64	
Adult Day Services High (15 Minute)	15 Minute	240	4519.00	6.06	6572433.60	
Adult Day Services Basic (Daily)	Daily	11	260.00	59.90	171314.00	
Adult Day Services Intermediate (Daily)	Daily	10	260.00	84.47	219622.00	
Adult Day Services High (Daily)	Daily	10	260.00	145.55	378430.00	
Case Management Total:						7170619.65
Case Management (Monthly)	Monthly	2116	12.00	282.16	7164606.72	
Case Management (15 Minute Unit)	15 Minute	133	3.00	15.07	6012.93	
Community Living Services Total:						75800780.41
Community Living Services Basic Individual (15 Minute)	15 Minute	413	1426.00	8.67	5106092.46	
Community Living					182907.52	
			GRAND TOTAL:			121333848.31
			Total Estimated Unduplicated Participants:			2116
			Factor D (Divide total by number of participants):			57341.14
			Average Length of Stay on the Waiver:			360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services Basic Group of 2 (15 Minute Unit)	15 Minute	32	1259.00	4.54		
Community Living Services Basic Group of 3 or more (15 Minute Unit)	15 Minute	2	1259.00	3.33	8384.94	
Community Living Services Basic Group (Daily)	Daily	115	245.00	93.39	2631263.25	
Community Living Services Level 3	Daily	388	236.00	125.05	11450578.40	
Community Living Services Level 4	Daily	252	312.00	165.90	13043721.60	
Community Living Services Level 5	Daily	269	316.00	241.61	20537816.44	
Community Living Services Level 6	Daily	92	365.00	411.53	13819177.40	
Community Living Host Home	Daily	224	166.00	242.60	9020838.40	
Community Support Services Total:						5365762.28
Community Support Services Basic (15 Minute Unit)	15 Minute	90	1248.00	2.76	310003.20	
Community Support Services Intermediate (15 Minute Unit)	15 Minute	252	2145.00	4.17	2254051.80	
Community Support Services High (15 Minute Unit)	15 Minute	144	1409.00	8.93	1811861.28	
Community Support Services Basic (Daily)	Daily	10	260.00	66.22	172172.00	
Community Support Services Intermediate (Daily)	Daily	10	260.00	100.15	260390.00	
Community Support Services High (Daily)	Daily	10	260.00	214.34	557284.00	
Homemaker Total:						218983.60
Homemaker	15 Minute	110	317.00	6.28	218983.60	
Personal Care Total:						1827159.12
Personal Care	15 Minute	108	2742.00	6.17	1827159.12	
Respite Total:						5379786.27
Respite Individual (Daily)	Daily	142	48.00	226.31	1542528.96	
Respite Individual (15 Minute Unit)	15 Minute	401	1399.00	6.29	3528683.71	
Respite Group (Daily)					167462.00	

GRAND TOTAL:	121333848.31
Total Estimated Unduplicated Participants:	2116
Factor D (Divide total by number of participants):	57341.14
Average Length of Stay on the Waiver:	360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Daily	8	185.00	113.15		
Respite Group (15 Minute Unit)	15 Minute	21	2140.00	3.14	141111.60	
Supported Employment Total:						1473491.76
Supported Employment Individual	15 Minute	172	800.00	7.92	1089792.00	
Supported Employment Group	15 Minute	76	1923.00	2.62	382907.76	
Supported Employment SEFA	15 Minute	1	100.00	7.92	792.00	
Dietician Services Total:						7866.75
Dietician Services	Session	5	51.00	30.85	7866.75	
Occupational Therapy Total:						311448.78
Occupational Therapy Individual	15 Minute	87	145.00	24.68	311338.20	
Occupational/Physical Therapy Group	Session	3	2.00	18.43	110.58	
Physical Therapy Total:						321374.40
Physical Therapy Individual	15 Minute	230	48.00	29.11	321374.40	
Skilled Nursing Total:						536380.26
Skilled Nursing	15 Minute	85	325.00	19.38	535372.50	
Skilled Nursing Assessment	Session	13	1.00	77.52	1007.76	
Speech, Hearing and Language Services Total:						532395.60
Speech, Hearing, and Language Individual	Session	123	80.00	42.02	413476.80	
Speech, Hearing, and Language Group	Session	35	216.00	15.73	118918.80	
Behavioral Support Services Total:						34946.56
Behavioral Support - BCBA Level	15 Minute	12	40.00	23.92	11481.60	
Behavioral Support - BCaBA Level	15 Minute	4	40.00	8.96	1433.60	
Behavioral Support - RBT Level	15 Minute	16	208.00	6.62	22031.36	
Behavioral Support Services	Event	0	0.00	5050.00	0.00	
				GRAND TOTAL:		121333848.31
				Total Estimated Unduplicated Participants:		2116
				Factor D (Divide total by number of participants):		57341.14
				Average Length of Stay on the Waiver:		360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Child Habilitation Services Total:						**1221171.16**
Child Habilitation (Ages 0 - 12)	15 Minute	62	1924.00	3.10	**369792.80**	
Child Habilitation (Ages 13 - 17)	15 Minute	119	1868.00	3.83	**851378.36**	
Cognitive Retraining Total:						**93.70**
Cognitive Retraining	15 Minute	1	10.00	9.37	**93.70**	
Companion Services Total:						**5200393.48**
Companion Individual	15 Minute	516	1530.00	6.29	**4965829.20**	
Companion Group	15 Minute	82	911.00	3.14	**234564.28**	
Crisis Intervention Support Total:						**210356.96**
Crisis Intervention Support	15 Minute	11	2543.00	7.52	**210356.96**	
Environmental Modification Total:						**10000.00**
Environmental Modification (New)	Event	1	1.00	5000.00	**5000.00**	
Environmental Modification (Repair)	Event	1	1.00	5000.00	**5000.00**	
Individual Habilitation Training Total:						**708104.48**
Individual Habilitation Training	15 Minute	124	778.00	7.34	**708104.48**	
Special Family Habilitation Home Total:						**190683.60**
Special Family Habilitation Home	Daily	3	262.00	242.60	**190683.60**	
Specialized Equipment Total:						**74000.00**
Specialized Equipment (New)	Event	36	1.00	2000.00	**72000.00**	
Specialized Equipment (Repair)	Event	1	1.00	2000.00	**2000.00**	
Transportation Total:						**948.25**
Transportation (5 Miles)	Trip	1	50.00	11.57	**578.50**	
Transportation (10 Miles)	Trip	1	25.00	14.79	**369.75**	

GRAND TOTAL:	**121333848.31**
Total Estimated Unduplicated Participants:	**2116**
Factor D (Divide total by number of participants):	**57341.14**
Average Length of Stay on the Waiver:	360

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						14869641.12
Adult Day Services Basic (15 Minute)	15 minute	196	3048.00	2.50	1493520.00	
Adult Day Services Intermediate (15 Minute)	15 Minute	442	3837.00	3.52	5969758.08	
Adult Day Services High (15 Minute)	15 Minute	237	4632.00	6.06	6652571.04	
Adult Day Services Basic (Daily)	Daily	10	260.00	59.90	155740.00	
Adult Day Services Intermediate (Daily)	Daily	10	260.00	84.47	219622.00	
Adult Day Services High (Daily)	Daily	10	260.00	145.55	378430.00	
Case Management Total:						7055634.00
Case Management (Monthly)	Monthly	2082	12.00	282.16	7049485.44	
Case Management (15 Minute Unit)	15 Minute	136	3.00	15.07	6148.56	
Community Living Services Total:						75912532.29
Community Living Services Basic Individual (15 Minute)	15 Minute	407	1461.00	8.67	5155416.09	
Community Living Services Basic Group of 2 (15 Minute Unit)	15 Minute	32	1198.00	4.54	174045.44	
Community Living Services Basic Group of 3 or more (15 Minute Unit)	15 Minute	2	1198.00	3.33	7978.68	
Community Living Services Basic Group (Daily)	Daily	114	233.00	93.39	2480625.18	
Community Living Services Level 3	Daily	382	240.00	125.05	11464584.00	
Community Living Services Level 4	Daily	248	320.00	165.90	13165824.00	
Community Living					20680607.95	

GRAND TOTAL:	121520767.63
Total Estimated Unduplicated Participants:	2082
Factor D (Divide total by number of participants):	58367.32
Average Length of Stay on the Waiver:	360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services Level 5	Daily	265	323.00	241.61		
Community Living Services Level 6	Daily	91	365.00	411.53	13668968.95	
Community Living Host Home	Daily	221	170.00	242.60	9114482.00	
Community Support Services Total:						5346292.58
Community Support Services Basic (15 Minute Unit)	15 Minute	89	1280.00	2.76	314419.20	
Community Support Services Intermediate (15 Minute Unit)	15 Minute	248	2198.00	4.17	2273083.68	
Community Support Services High (15 Minute Unit)	15 Minute	142	1395.00	8.93	1768943.70	
Community Support Services Basic (Daily)	Daily	10	260.00	66.22	172172.00	
Community Support Services Intermediate (Daily)	Daily	10	260.00	100.15	260390.00	
Community Support Services High (Daily)	Daily	10	260.00	214.34	557284.00	
Homemaker Total:						222469.00
Homemaker	15 Minute	109	325.00	6.28	222469.00	
Personal Care Total:						1855133.90
Personal Care	15 Minute	107	2810.00	6.17	1855133.90	
Respite Total:						5431991.66
Respite Individual (Daily)	Daily	140	49.00	226.31	1552486.60	
Respite Individual (15 Minute Unit)	15 Minute	395	1434.00	6.29	3562844.70	
Respite Group (Daily)	Daily	8	190.00	113.15	171988.00	
Respite Group (15 Minute Unit)	15 Minute	21	2194.00	3.14	144672.36	
Supported Employment Total:						1492338.00
Supported Employment Individual	15 Minute	170	820.00	7.92	1104048.00	
Supported Employment Group	15 Minute	75	1972.00	2.62	387498.00	
Supported Employment SEFA	15 Minute	1	100.00	7.92	792.00	

GRAND TOTAL:	121520767.63
Total Estimated Unduplicated Participants:	2082
Factor D (Divide total by number of participants):	58367.32
Average Length of Stay on the Waiver:	360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Dietician Services Total:						**8021.00**
Dietician Services	Session	5	52.00	30.85	**8021.00**	
Occupational Therapy Total:						**316360.10**
Occupational Therapy Individual	15 Minute	86	149.00	24.68	**316249.52**	
Occupational/Physical Therapy Group	Session	3	2.00	18.43	**110.58**	
Physical Therapy Total:						**330398.50**
Physical Therapy Individual	15 Minute	227	50.00	29.11	**330398.50**	
Skilled Nursing Total:						**530081.76**
Skilled Nursing	15 Minute	84	325.00	19.38	**529074.00**	
Skilled Nursing Assessment	Session	13	1.00	77.52	**1007.76**	
Speech, Hearing and Language Services Total:						**539286.88**
Speech, Hearing, and Language Individual	Session	122	82.00	42.02	**420368.08**	
Speech, Hearing, and Language Group	Session	35	216.00	15.73	**118918.80**	
Behavioral Support Services Total:						**34946.56**
Behavioral Support - BCBA Level	15 Minute	12	40.00	23.92	**11481.60**	
Behavioral Support - BCaBA Level	15 Minute	4	40.00	8.96	**1433.60**	
Behavioral Support - RBT Level	15 Minute	16	208.00	6.62	**22031.36**	
Behavioral Support Services	Event	0	0.00	0.01	**0.00**	
Child Habilitation Services Total:						**1244675.70**
Child Habilitation (Ages 0 - 12)	15 Minute	62	1973.00	3.10	**379210.60**	
Child Habilitation (Ages 13 - 17)	15 Minute	118	1915.00	3.83	**865465.10**	
Cognitive Retraining Total:						**93.70**
Cognitive Retraining	15 Minute	1	10.00	9.37	**93.70**	
Companion Services Total:						**5120002.52**
Companion Individual					**4882448.96**	

GRAND TOTAL:	**121520767.63**
Total Estimated Unduplicated Participants:	**2082**
Factor D (Divide total by number of participants):	**58367.32**
Average Length of Stay on the Waiver:	360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	15 Minute	508	1528.00	6.29		
Companion Group	15 Minute	81	934.00	3.14	237553.56	
Crisis Intervention Support Total:						215651.04
Crisis Intervention Support	15 Minute	11	2607.00	7.52	215651.04	
Environmental Modification Total:						10000.00
Environmental Modification (New)	Event	1	1.00	5000.00	5000.00	
Environmental Modification (Repair)	Event	1	1.00	5000.00	5000.00	
Individual Habilitation Training Total:						719547.54
Individual Habilitation Training	15 Minute	123	797.00	7.34	719547.54	
Special Family Habilitation Home Total:						190683.60
Special Family Habilitation Home	Daily	3	262.00	242.60	190683.60	
Specialized Equipment Total:						74000.00
Specialized Equipment (New)	Event	36	1.00	2000.00	72000.00	
Specialized Equipment (Repair)	Event	1	1.00	2000.00	2000.00	
Transportation Total:						986.18
Transportation (5 Miles)	Trip	1	52.00	11.57	601.64	
Transportation (10 Miles)	Trip	1	26.00	14.79	384.54	
				GRAND TOTAL:		121520767.63
				Total Estimated Unduplicated Participants:		2082
				Factor D (Divide total by number of participants):		58367.32
				Average Length of Stay on the Waiver:		360

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						**14919710.32**
Adult Day Services Basic (15 Minute)	15 minute	193	3048.00	2.50	**1470660.00**	
Adult Day Services Intermediate (15 Minute)	15 Minute	435	3933.00	3.52	**6022209.60**	
Adult Day Services High (15 Minute)	15 Minute	234	4748.00	6.06	**6732853.92**	
Adult Day Services Basic (Daily)	Daily	10	260.00	59.90	**155740.00**	
Adult Day Services Intermediate (Daily)	Daily	9	260.00	84.47	**197659.80**	
Adult Day Services High (Daily)	Daily	9	260.00	145.55	**340587.00**	
Case Management Total:						**6940648.35**
Case Management (Monthly)	Monthly	2048	12.00	282.16	**6934364.16**	
Case Management (15 Minute Unit)	15 Minute	139	3.00	15.07	**6284.19**	
Community Living Services Total:						**76575023.55**
Community Living Services Basic Individual (15 Minute)	15 Minute	401	1498.00	8.67	**5208051.66**	
Community Living Services Basic Group of 2 (15 Minute Unit)	15 Minute	32	1322.00	4.54	**192060.16**	
Community Living Services Basic Group of 3 or more (15 Minute Unit)	15 Minute	2	1322.00	3.33	**8804.52**	
Community Living Services Basic Group (Daily)	Daily	113	257.00	93.39	**2712138.99**	
Community Living Services Level 3	Daily	376	245.00	125.05	**11519606.00**	
Community Living Services Level 4	Daily	244	328.00	165.90	**13277308.80**	
Community Living Services Level 5	Daily	261	332.00	241.61	**20935989.72**	
Community Living Services Level 6	Daily	90	365.00	411.53	**13518760.50**	
Community Living Host Home	Daily	218	174.00	242.60	**9202303.20**	
Community Support Services Total:						**5229678.80**
Community Support Services Basic (15 Minute Unit)	15 Minute	88	1312.00	2.76	**318658.56**	

GRAND TOTAL:	**121851756.44**
Total Estimated Unduplicated Participants:	**2048**
Factor D (Divide total by number of participants):	**59497.93**
Average Length of Stay on the Waiver:	360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Support Services Intermediate (15 Minute Unit)	15 Minute	244	2253.00	4.17	2292382.44	
Community Support Services High (15 Minute Unit)	15 Minute	140	1382.00	8.93	1727776.40	
Community Support Services Basic (Daily)	Daily	9	260.00	66.22	154954.80	
Community Support Services Intermediate (Daily)	Daily	9	260.00	100.15	234351.00	
Community Support Services High (Daily)	Daily	9	260.00	214.34	501555.60	
Homemaker Total:						225853.92
Homemaker	15 Minute	108	333.00	6.28	225853.92	
Personal Care Total:						1883577.60
Personal Care	15 Minute	106	2880.00	6.17	1883577.60	
Respite Total:						5485204.63
Respite Individual (Daily)	Daily	138	51.00	226.31	1592769.78	
Respite Individual (15 Minute Unit)	15 Minute	389	1470.00	6.29	3596810.70	
Respite Group (Daily)	Daily	7	195.00	113.15	154449.75	
Respite Group (15 Minute Unit)	15 Minute	20	2248.00	3.14	141174.40	
Supported Employment Total:						1510293.88
Supported Employment Individual	15 Minute	168	840.00	7.92	1117670.40	
Supported Employment Group	15 Minute	74	2021.00	2.62	391831.48	
Supported Employment SEFA	15 Minute	1	100.00	7.92	792.00	
Dietician Services Total:						6540.20
Dietician Services	Session	4	53.00	30.85	6540.20	
Occupational Therapy Total:						321037.12
Occupational Therapy Individual	15 Minute	85	153.00	24.68	320963.40	
Occupational/Physical Therapy Group	Session	2	2.00	18.43	73.72	

GRAND TOTAL:	121851756.44
Total Estimated Unduplicated Participants:	2048
Factor D (Divide total by number of participants):	59497.93
Average Length of Stay on the Waiver:	360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Physical Therapy Total:						332552.64
Physical Therapy Individual	15 Minute	224	51.00	29.11	332552.64	
Skilled Nursing Total:						536574.06
Skilled Nursing	15 Minute	83	333.00	19.38	535643.82	
Skilled Nursing Assessment	Session	12	1.00	77.52	930.24	
Speech, Hearing and Language Services Total:						542612.40
Speech, Hearing, and Language Individual	Session	121	84.00	42.02	427091.28	
Speech, Hearing, and Language Group	Session	34	216.00	15.73	115521.12	
Behavioral Support Services Total:						32254.40
Behavioral Support - BCBA Level	15 Minute	11	40.00	23.92	10524.80	
Behavioral Support - BCaBA Level	15 Minute	3	40.00	8.96	1075.20	
Behavioral Support - RBT Level	15 Minute	15	208.00	6.62	20654.40	
Behavioral Support Services	Event	0	0.00	0.01	0.00	
Child Habilitation Services Total:						1262000.13
Child Habilitation (Ages 0 - 12)	15 Minute	61	2022.00	3.10	382360.20	
Child Habilitation (Ages 13 - 17)	15 Minute	117	1963.00	3.83	879639.93	
Cognitive Retraining Total:						93.70
Cognitive Retraining	15 Minute	1	10.00	9.37	93.70	
Companion Services Total:						5036523.40
Companion Individual	15 Minute	500	1525.00	6.29	4796125.00	
Companion Group	15 Minute	80	957.00	3.14	240398.40	
Crisis Intervention Support Total:						200934.40
Crisis Intervention Support	15 Minute	10	2672.00	7.52	200934.40	
Environmental Modification Total:						10000.00
Environmental					5000.00	

GRAND TOTAL:	121851756.44
Total Estimated Unduplicated Participants:	2048
Factor D (Divide total by number of participants):	59497.93
Average Length of Stay on the Waiver:	360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Modification (New)	Event	1	1.00	5000.00		
Environmental Modification (Repair)	Event	1	1.00	5000.00	5000.00	
Individual Habilitation Training Total:						725610.38
Individual Habilitation Training	15 Minute	121	817.00	7.34	725610.38	
Special Family Habilitation Home Total:						0.00
Special Family Habilitation Home	Daily	0	0.00	242.60	0.00	
Specialized Equipment Total:						74000.00
Specialized Equipment (New)	Event	36	1.00	2000.00	72000.00	
Specialized Equipment (Repair)	Event	1	1.00	2000.00	2000.00	
Transportation Total:						1032.56
Transportation (5 Miles)	Trip	1	53.00	11.80	625.40	
Transportation (10 Miles)	Trip	1	27.00	15.08	407.16	

GRAND TOTAL:	121851756.44
Total Estimated Unduplicated Participants:	2048
Factor D (Divide total by number of participants):	59497.93
Average Length of Stay on the Waiver:	360