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:
Community Choices Waiver (CCW)

C. Waiver Number:WY.0236
Original Base Waiver Number: WY.0236.90.R2

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)
04/01/23
Approved Effective Date of Waiver being Amended: 07/01/21

2. Purpose(s) of Amendment

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

The Division of Healthcare Financing, Home and Community-Based Services (HCBS) Section intends to seek approval from the Centers for Medicare and Medicaid Services (CMS) for an amendment to the Community Choices Waiver. This amendment will include necessary program changes to allow for the implementation of new transition services, which were identified as a need during input sessions focused on how to best utilize funding available through the American Rescue Plan Act. Other proposed changes are listed below:
The following outlines the proposed changes to the Community Choices Waiver:

Appendix A: No proposed changes

Appendix B:
- Remove language that references the Program of All Inclusive Care for the Elderly (PACE) program.
  Change performance measures to reflect current Division practices.

Appendix C:
- Align barrier crimes with Wyoming Statute Title 6, Chapter 2 (Offenses Against the Person) and Chapter 4 (Offenses Against Morals, Decency and Family). All crimes
  listed in these Chapters will be considered barrier crimes
- Add required background screenings for Adult Day - Social Model.
- Add the requirement of subsequent background screenings every 5 years.
- Clarify the federal requirement of monthly OIG Exclusions Database checks for any person with an ownership or control interest or who is an agent or managing
  employee of the provider.
- Add the following service definitions and provider qualifications:
  - Case Management - Certificate Tier
  - Homemaker Services
  - Environmental Modifications
  - Transition Setup
  - Transition Intensive Case Management
  - Independent Living Support
- Update the following service definitions and provider qualifications:
  - Personal Support Services
  - Home Health Aide Service
- Update Non-Medical Transportation service cap to reflect an equal number of trips for all service types.
- Add that spouses are allowed to provide Personal Support Services in certain situations.
- Change performance measures to reflect current Division practices.

Appendix D:
- Update the service plan process to reflect current EMWS processes.
- Remove the participant directed assessment as a requirement, and remove the case manager’s determination of competency for a participant to act as their own
  employer of record.
- Change performance measures to reflect current Division practices

Appendix E:
- Remove additional criteria for participant-direction in order to provide every participant the opportunity to elect to direct waiver services. This aligns with
  changes made to Appendix D.
- Remove the Power of Attorney designation from participant-directed employers of record. A power of attorney document will no longer need to be in place for a
  participant to choose an individual to act as the employer of record.

Appendix F: No proposed changes

Appendix G:
- Add the requirement to report death, serious injury, elopement, medical and behavior admissions, use of restraint, restrictive interventions, and seclusion as part
  of the incident reporting process.
- Update critical incident reporting timelines. Providers must report critical incidents immediately upon ensuring the safety and health of the participant, and must

report non-critical incidents within one business day of ensuring the safety and health of the participant.
- Update the Incident Report process to reflect current practices.
- Change performance measures to reflect current Division practices.

Appendix H: Change references made to the Quality Improvement Committee to the Performance Review Committee to reflect Division practices.

Appendix I: Update rate methodology to include new services.

Appendix J: Add rates and utilization projections for new service

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**	QIS
☒ **Appendix B Participant Access and Eligibility**	B-6-f,QIS
☒ **Appendix C Participant Services**	C-1/C-3,C-2-a,C-2-b,C-2-e,QIS
☒ **Appendix D Participant Centered Service Planning and Delivery**	D-1-d,D-1-e,D-2-a,QIS
☒ **Appendix E Participant Direction of Services**	E-1-a,E-1-d,E-1-f,E-1-m
☐ **Appendix F Participant Rights**	
☒ **Appendix G Participant Safeguards**	G-1-b-e,QIS
☒ **Appendix H**	H-1-a,H-1-b
☒ **Appendix I Financial Accountability**	I-1, I-2-a
☒ **Appendix J Cost-Neutrality Demonstration**	J-2-c-i

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*):

Community Choices Waiver (CCW)

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**

Original Base Waiver Number: WY.0236
Draft ID: WY.002.06.01

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/21
Approved Effective Date of Waiver being Amended: 07/01/21

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:

○ **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:

☒ **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 Community Choices Waiver (CCW) provides older adults and adults with disabilities a community-based alternative to nursing facility care. Participants are supported to achieve independence, maintain health and safety, and fully participate in community living through access to high quality, cost effective community-based services.

Program goals and objectives:

Individual Authority Over Services & Supports – Provide program participants with the opportunity and authority to exert control over his/her services, supports, and other life circumstances to the greatest extent possible.

Person-Centered Service Planning & Service Delivery – Acknowledge and promote the participant's strengths, goals, preferences, needs, and desires through a person-centered service planning process. Respect and support the participant's strengths, goals, preferences, needs, and desires through person-centered service delivery.

Promote Community Relationships – Support and encourage the participant's self-determined goals to be active members of their communities. Recognize that the nature and quality of community relationships are central to participant health and wellness.

Health & Safety – Effectively manage risk and balance the participant's ability to achieve independence and maintain health and safety.

Service Array – Offer services which are responsive to the needs of the target population and complement and/or supplement the services that are available through the Medicaid State plan and other federal, state, and local public programs as well as the supports that families and communities provide to individuals.

Responsible Use of Public Dollars – Demonstrate sound stewardship of limited public resources.

The CCW program is administered directly by the Wyoming Department of Health, Division of Healthcare Financing (the Division), which serves as the Medical Assistance Unit within the Single State Agency. The Division retains the ultimate administrative authority and responsibility for the operation of the waiver program through memoranda of understanding (MOUs) with other governmental agencies and contracts with vendors who conduct delegated administrative functions.

Services are delivered through a statewide network of providers and are reimbursed according to a standard fee schedule on a fee-for-service basis. The Division allows for the open, continuous enrollment of all willing and qualified service providers. The CCW program also offers the opportunity for participant-direction of select services.

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 Community Choice amendment will run from October 21st – November 21st, 2022. Communications will be sent to the Community Choice Waiver email lists on October 21st, November 4th, and November 18th. A public forum will conducted via phone conference on Wednesday, November 9th, 2022 from 11:00am – 12:00pm. Case managers will be strongly encouraged to ensure that participants and families are aware of the public comment period, and provide information on where the documents and other relevant information can be found.

The Community Choice Waiver summary of the proposed changes, the proposed fee schedule, and the full waiver application will be published to the DHCF website at https://health.wyo.gov/healthcarefin/hcbs/hcbs-public-notices/ on October 21st, 2022.

DHCF distributed a Notice of Intent to Amend to Tribal Governments on September 19th, 2022. The notice invited Tribal Governments to submit written comments and/or request additional consultation within 30 days of the notice. The Tribal Governments were invited and encouraged to submit public comments through the broader public comment period as well.

A public notification will be published to the Casper Star Tribune and the Wyoming Tribune on October 23rd, 2022 and November 6th, 2022. The text of the public notice will be available upon request.

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: Crandall

First Name: Matthew

Title: Policy Analyst

Agency: Wyoming Department of Health, Division of Healthcare Financing

Address: 122 W. 25th Street, 4 West

Address 2:

City: Cheyenne

State: **Wyoming**

Zip:

82002

Phone:

(307) 777-7366 **Ext:** ☐ **TTY**

Fax:

(307) 777-8685

E-mail:

matthew.crandall2@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:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Wyoming**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

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:

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 compliance with the State of Wyoming's Statewide Transition Plan for Home and Community-Based Settings approved on June 29, 2018. All required changes will be implemented by the end of the transition period on March 17, 2023.

The Division assures that this waiver will be subject to any provisions or requirements in the approved home and community-based settings Statewide Transition Plan. The Division 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):

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:
   Wyoming Department of Health, Division of Healthcare Financing
   (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.:*

The Wyoming Department of Health, Division of Healthcare Financing (the Division) delegates the following waiver operational and administrative functions to other public or private entities:

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.

Prior Authorization of Waiver Services
The Division contracts with a Quality Improvement Organization (QIO) to conduct a peer review of skilled nursing services before they are authorized or delivered. Peer reviews facilitate coordination and minimize the duplication of Medicaid benefits to ensure the most effective use of public resources. A registered nurse conducts a review of the skilled nursing care plan to ensure those services are authorized:

- Within the scope and limitations of the skilled nursing services benefit;
- According to the assessed needs of the waiver participant;
- Consistent with the practice of nursing as defined by the Wyoming Nurse Practice Act;
- In such a manner that does not duplicate other services provided under the waiver program or the Medicaid State Plan.

Qualified Provider Enrollment
The Division contracts with a private corporation to act as its Fiscal Agent and to maintain the Medicaid Management Information System (MMIS), process provider claims for reimbursement, maintain a call center, respond to provider questions and complaints, produce reports, and assist in the provider enrollment/application process. In performance of its delegated provider enrollment functions, the contractor:

- Processes all provider enrollment applications through an online portal;
- Conducts an initial screening of provider qualifications;
- Searches the List of Excluded Individuals/Entities (LEIE) to verify that the applicant/provider is not excluded from participation in Federally-funded healthcare programs by the US Department of Health and Human Services, Office of Inspector General (OIG);
- Obtains confirmation from the Division that the applicant/provider meets all applicable provider qualifications as specified in the waver application;
- Notifies applicant/provider of approval/disapproval;
- Enrolls approved providers in the MMIS; and
- Maintains documentation of executed Medicaid Provider Agreements.

The Division maintains a MOU with the Wyoming Department of Health, Aging Division to conduct initial and periodic reviews to verify that waiver service providers maintain compliance with applicable provider qualification standards. This includes onsite inspections and complaint investigations for providers of certain waiver services.

The Division contracts with a private corporation to act as its Financial Management Services (FMS) agency to support the employers of record for participant-directed waiver services by performing financial administrative activities such as withholding taxes and processing payroll. In performance of its delegated provider enrollment functions, the FMS verifies provider qualifications, conducts background investigations, and facilitates provider enrollment.

Quality Assurance and Quality Improvement Activities
The Division contracts with a QIO to conduct peer reviews of the level of care evaluations performed by the Public Health Nursing County Offices. Registered nurses review a representative sample of evaluations to determine whether the level of care evaluation processes and instruments were applied appropriately. The contractor's detailed findings and any recommendations for improving the quality and/or statewide consistency in the application of the level of care evaluation criteria are compiled into an annual report submitted to the Division. Additionally, registered nurses conduct a peer reviews of level of care evaluations disputed by the participant/applicant as part of a reconsideration request or request for fair hearing.

○ **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:

The Wyoming Department of Health, Division of Healthcare Financing retains ultimate administrative authority and is responsible for assessing the performance of other public and private entities in conducting delegated waiver operational and administrative functions.

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:

Contracts, memoranda of understanding (MOUs), letters of agreement (LOAs), interagency agreements (IAs), Medicaid provider agreements, or other forms or written agreement are used to document the assignment and delegation of any waiver operational or administrative function to another public or private entity in accordance with state procurement and contracting policies. Once executed, each agreement is assigned to a Division staff member with the primary responsibility for its maintenance and oversight.

Division staff ensure compliance with the provisions of the written agreement and assess the performance of delegated functions 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 as specified in the written agreement.

The performance of each public/private entity is assessed at least annually but may be assessed more frequently in accordance state and federal regulatory standards or as specified in the written agreement.

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.a1 Percentage of Financial Management Services (FMS) agency on-site quarterly performance reviews in which there were no deficiencies or the deficiencies were corrected or a corrective action plan is accepted within 30 days. Numerator: On-site performance reviews without deficiency or with timely remediation. Denominator: On-site performance reviews conducted.

Data Source (Select one):
On-site observations, interviews, monitoring
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**	☐ **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:
A.a2 Percentage of monthly Prior Authorization and Quality Improvement Organization contractor reports submitted in which there were no deficiencies or the deficiencies were corrected or a corrective action plan is accepted within 30 days. Numerator: Monthly reports submitted without deficiency or with timely remediation. Denominator: Monthly reports submitted.

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**	☐ **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** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
A.a3 Percentage of annual Fiscal Agent Security Operations Center (SOC) audits in which there were no deficiencies or the deficiencies were corrected or a corrective action plan is accepted within 30 days. Numerator: SOC audits without deficiency or with timely remediation. Denominator: SOC audits conducted.

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: Independent auditor contracted by the MMIS vendor	☒ **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.

Individual deficiencies identified through the Division's regular monitoring activities or through the waiver performance measures are remediated by Division staff through the provision of technical assistance, the imposition of a corrective action or sanction, and/or the enforcement of contract service level agreements.

In accordance with CMS guidance issued March 12, 2014, any performance measure with less than an 86% success rate warrants further analysis to determine the cause. The Division conducts a root cause analysis to identify contributing factors and determine underlying causes of deficiency for any measure with less than an 86% success rate. Based upon the findings of the root cause analysis, the Division may initiate a Quality Improvement Project (QIP). The QIP includes, at minimum:

- A description of remedial actions to be taken (e.g. training, revised policies/procedures, additional staff, different staffing patterns, provider/vendor corrective action);
- A timeline of remedial actions to be taken;
- The individuals responsible for effectuating remedial actions; and,
- The frequency with which performance/compliance is measured.

The HCBS Quality Improvement Committee assures accountability to the Division’s stakeholders and provides oversight of quality improvement activities, including regular monitoring of QIP effectiveness.

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**	65		☒
	☐	**Disabled (Physical)**			
	☒	**Disabled (Other)**	19	64	
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☐ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

Disability is demonstrated through a disability determination by the Social Security Administration (SSA) or by the Department or its agent using SSA determination criteria.

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:

Individuals served by the waiver under the disability target subgroup transition without interruption to the aged target subgroup upon their 65th birthday.

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

○ **The following dollar amount:**

Specify dollar amount:

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)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

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:

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:

☐ **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	3271
Year 2	3464
Year 3	3669
Year 4	3886
Year 5	4116

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	
Year 2	
Year 3	
Year 4	
Year 5	

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).**

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:

Participants are enrolled chronologically based on the date of eligibility determination.

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)**
- [ ] **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:

Populations outlined at 42 CFR 435.110

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:

- ○ **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:

- ○ **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:

The Wyoming Department of Health, Public Health Division

- ( ) **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:

A registered nurse licensed to practice in the State of Wyoming and qualified by the Wyoming Department of Health, or its agent, as having successfully completed all requisite education and training.

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.

The LT101 Level of Care Assessment instrument was developed by the Division to establish standardized methods for measuring the applicant/participant's level of functional impairment and to ensure the statewide consistency in the level of care evaluation process. The information obtained using the LT101 Level of Care Assessment instrument is used in the Division's determination of whether an applicant/participant requires, or continues to require, the services or level of care typically provided in a nursing facility. The Division has established a minimum total score necessary to demonstrate the applicant/participant's need for the nursing facility level of care, and this determination is used in the consideration of eligibility for certain Wyoming Medicaid long-term care programs and services.

The LT101 Level of Care Assessment instrument is designed to evaluate an applicant/participant's current functional capacity across 13 domains and measure the “burden of care,” or how much assistance the applicant/participant needs in performing Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and social and cognitive activities. The 13 domains included in the assessment are:

ADLs
- Eating
- Bathing
- Grooming
- Dressing
- Toileting
- Functional Mobility

IADLs
- Meal Preparation
- Medication Management

Social and Cognitive Activities
- Social Interaction
- Comprehension
- Expression
- Problem Solving
- Memory

The applicant/participant's level of assistance needed is scored using the following zero to four scale:

0 = Independent: The applicant/participant is independent in completing activity safely without modification, assistive devices, or aids.
1 = Modified Independent: The applicant/participant is able to complete the activity independently with the use of adaptive equipment or light cueing.
2 = Supervision/Setup: The applicant/participant requires another person to provide routine setup assistance in preparation for the activity or requires the presence of another person throughout the activity to provide supervision for safety, cueing, or other stand-by assistance.
3 = Moderate Assistance: The applicant/participant requires the presence of another person throughout the activity to provide hands-on assistance.
4 = Dependent: The applicant/participant is dependent on another person to complete the activity and can contribute little or no effort on his or her own.

In scoring the level of assistance needed, a variety of data sources are considered (e.g. direct observations, individual self-reports, caregiver reports, case manager/service provider reports, and medical chart reviews). The evaluator uses professional and clinical judgement in assessing the level of assistance needed for each domain. The evaluator summarizes the scoring rationale and documents information gathered in support of that assessment in the Division's case management information system.

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:

Any individual, his/her legal guardian, or such person(s) authorized by a power of attorney may request a level of care determination. Employees or authorized representatives from a nursing facility, hospital, or any other such healthcare or social services provider may also request a level of care determination on behalf of any individual for which that agency has the responsibility for the provision or coordination of healthcare services. Requests are entered into the Division's case management information system, matched to an application for or enrollment in a Medicaid long-term care program or service which requires a level of care evaluation/reevaluation, and screened for completeness and a reasonable indication of need for long-term care supports.

The Division submits an electronic referral to the Public Health Nursing County Office, serving the applicant/participant's county of residence or the county in which the applicant/participant is temporarily located. The Public Health Nursing County Office contacts the applicant/participant to schedule an appointment to conduct the evaluation/reevaluation. A registered nurse trained on the administration of the LT101 Level of Care Assessment instrument conducts the evaluation/reevaluation and submits the evaluation data through the Division's case management information system. The evaluation/reevaluation is typically conducted in the applicant/participant's residence, temporary residence, or the healthcare facility to which the applicant/participant has been admitted. The evaluation/reevaluation may be conducted in alternate location when justified by extenuating circumstances, such as homelessness.

The Division's case management information system applies the logic and scoring criteria established by the Division and returns a determination of whether the applicant/participant meets the nursing facility level of care. Applicants/participants determined not to require the nursing facility level of care are provided with a notice of their right to request a reconsideration and/or a fair hearing in accordance with the processes described in Appendix F of the waiver application.

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):*

The Division's case management information system automatically generates a reevaluation referral to the Public Health Nursing County Offices for active waiver participants 60 days prior to the expiration of the annual service plan. Reevaluation timeliness is monitored by Division staff, the Public Health Nursing County Offices, and the Public Health Division through automated alerts, task lists, and reports generated by the Division's case management information system. Division staff follow up on outstanding/overdue reevaluations with the Public Health Nursing County Offices and/or the Public Health Division and require justification for any evaluations completed outside of the Division's established timelines.

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:

Level of care evaluation/reevaluation records are maintained in the Division’s case management information system for a minimum of 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.a1 The percentage of applicants who received the level of care assessment (LOC). Numerator: Number of applicants who received the LOC. Denominator: Total number of applicants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case management information system

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:

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.

Performance Measure:
Pursuant to CMS guidance issued March 12, 2014, reporting on this subassurance is no longer required

Data Source (Select one):
Other
If 'Other' is selected, specify:
N/A

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 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.c1 Percentage of annual level of care (LOC) assessments conducted for each eligible participant in accordance with Division standards and the approved waiver. Numerator: Number of LOC assessments conducted for each eligible participant in accordance with Division standards and the approved waiver. Denominator: Total LOC evaluations conducted.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case management information system

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.

The QIO conducts peer reviews of the level of care evaluations performed by the Public Health Nursing County Offices in order to determine if those evaluations were performed using the standardized methods, tools, and processes described in the waiver application. The reports on these peer reviews serve as the data source for the second performance measure for sub-assurance (c), performance measure two.

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.

Individual deficiencies identified through regular monitoring activities or through waiver performance measures are remediated by the Division staff through the provision of technical assistance, the imposition of a corrective action or sanction, and/or the enforcement of contract service level agreements.

In accordance with CMS guidance issued March 12, 2014, any performance measure with less than an 86% success rate warrants further analysis to determine the cause. The Division conducts a root cause analysis to identify contributing factors and determine underlying causes of deficiency for any measure with less than an 86% success rate. Based upon the findings of the root cause analysis, the Division may initiate a Quality Improvement Project (QIP). The QIP includes, at minimum:

- A description of remedial actions to be taken (e.g. training, revised policies/procedures, additional staff, different staffing patterns, provider/vendor corrective action);
- A timeline of remedial actions to be taken;
- The individuals responsible for effectuating remedial actions; and,
- The frequency with which performance/compliance is measured.

The HCBS Quality Improvement Committee assures accountability to the Division's stakeholders and provides oversight of quality improvement activities, including regular monitoring of QIP effectiveness.

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).

Case managers provide options counseling on all feasible alternatives and document the participant's (and/or legal representative's, as appropriate) choices in the person-centered service plan. The person-centered service plan includes an explanation of the participant's rights and responsibilities, including their rights to exercise freedom of choice among feasible alternatives available under the waiver and to choose institutional services. The person-centered service plan is agreed to with the informed consent of the participant and signed by all individuals and providers responsible for its implementation.

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.

The person-centered service plan, including documentation of the participant's freedom of choice, is maintained in the Division's case management information system for a minimum of six 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):

Individuals with limited English language proficiency are not denied access to waiver services. The Division maintains a contract with a translation and interpretation provider. The provider offers translation services for documents and telephonic interpretation services in over 160 languages. Case managers assist applicants/participants with limited English language proficiency in accessing the telephonic translation services to support enrollment and service plan development activities, free of charge.

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	**Homemaker**		
Statutory Service	**Personal Support Services**		
Statutory Service	**Respite**		
Extended State Plan Service	**Home Health Aide**		
Extended State Plan Service	**Skilled Nursing**		

Service Type	Service		
Other Service	Assisted Living Facility Services		
Other Service	Environmental Modification		
Other Service	Home-Delivered Meals		
Other Service	Independent Living Support		
Other Service	Non-Medical Transportation		
Other Service	Personal Emergency Response Systems (PERS)		
Other Service	Transition Intensive Case Management		
Other Service	Transition Setup		

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: 04 Day Services

Sub-Category 2: 04050 adult day health

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Services generally furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the service plan, in a non-institutional, community-based setting, which may encompass health and/or social services needed to ensure the optimal functioning of the participant. Meals provided as part of these services shall not constitute a full nutritional regimen. Adult day services may not be provided for purely diversional/recreational purposes.

Adult day (health model) services include group socialization and companionship, assistance with activities of daily living, and supervision as specified in a program plan. The program plan is individualized to the participant's assessed needs and includes realistic and measurable goals.

Adult day (social model) services include group socialization and companionship supports to participants at risk for isolation or loneliness. Only incidental assistance with activities of daily living may be provided.

Participant transportation costs are not associated with the provision of adult day services and must be billed separately. Adult day services do not include and do not replace or supplant the physical, occupational, and/or speech/language therapies available through the state plan.

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

Services are authorized by a case manager based on the participant's assessed needs. Adult day (social model) services are limited to the prorated equivalent of three days per week. Adult Day (health model) services are limited to the prorated equivalent of five days per week. Adult day services may not be provided virtually.

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	Adult Day Care Facility
Agency	Senior Center

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:

Adult Day Care Facility

Provider Qualifications

License *(specify):*

Adult Day Care Facility License granted by the Wyoming Department of Health, Division of Aging pursuant to W.S. 35-2-901(a)(xxiii).

Certificate *(specify):*

Other Standard *(specify):*

Adult day care facilities may provide both health and social models of adult day services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

Frequency of Verification:

Annually

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:

Senior Center

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

An agency determined as an eligible senior center in accordance with W.S. 9-2-1201(a)(iii) and overseen by the Wyoming Department of Health, Aging Division as credible and capable to receive grants for Older Americans Act services pursuant to W.S. 9-2-1204(a)(vii). Senior centers may provide only the social model of adult day services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

Frequency of Verification:

Annually

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

Service Definition *(Scope):*

Services that assist participants in gaining access to needed waiver and other state plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

The assistance that case managers provide in assisting participants obtain services includes:

(1) Comprehensive assessment and periodic reassessment of participant needs, to determine the need for any medical, educational, social, or other services.

(2) Facilitation and oversight of the development (and periodic revision) of a person-centered service plan as described in Appendix D-1.

(3) Service coordination, referral, and other related activities (such as scheduling appointments for the participant) to help the participant obtain needed services, including activities that help link the participant with medical, social, and educational providers or other programs and services that are capable of providing needed services to address the identified needs and achieve the goals specified in the service plan.

(4) Service plan implementation, monitoring, and follow-up activities, including activities and contacts that are necessary to ensure that the service plan is effectively implemented and adequately addresses the needs of the participant. Contacts may be with the participant (and/or legal representative, as appropriate), family members, service providers, or other entities or individuals and are conducted as frequently as necessary in order to:
(i) Ensure services are being furnished in accordance with the participant's service plan;
(ii) Evaluate the effectiveness of the service plan in meeting the participant's needs;
(iii) Identify any changes in the participant's condition or circumstances;
(iv) Periodically screen for any potential risks or concerns;
(v) Periodically assess the participant's satisfaction with services and supports; and
(vi) Make any necessary adjustments in the service plan and service arrangements with providers.

(5) Information and assistance in support of participant direction as necessary to:
(i) Inform participants of participant direction opportunities;
(ii) Ensure participants who express an interest in participant direction are informed of the potential benefits, liabilities, risks, and responsibilities associated with each service delivery option;
(iii) Determine whether participants meet the additional criteria for participant direction as described in Appendix E-1-d;
(iv) Assist the participant/designated employer of record in obtaining and completing required documents;
(v) Determine the participant’s monthly budget allocation;
(vi) Coordinate with the Financial Management Services (FMS) agency; and
(vii) Monitor participant-directed service effectiveness, quality, and expenditures against the monthly budget allocation.

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
Agency	Case Management Agency

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:

Case Management Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Case managers who complete Division sponsored training on person-centered planning and case management best practices
are eligible to bill using the Case management - Certificate rate.

Other Standard *(specify):*

Must be a County Public Health Nursing Agency designated by the Wyoming Department of Health, Public Health Division; or corporation, Limited Liability Company (LLC), non-profit organization, sole proprietorship, or other business entity registered in good standing with the Wyoming Secretary of State.

Case management agencies must ensure all case managers meet the training, education, experience, and conflict of interest requirements as described in Appendix D-1-a of this application. Case management agencies must maintain adequate administrative and staffing resources and emergency backup systems to deliver case management services in accordance with all state and federal requirements. Each case management agency must have internal mechanisms for assessing and managing the performance of each case manager. Should the case management agency fail to address case manager performance concerns to the Division's satisfaction, the Division may require retraining or other progressive disciplinary actions, up to and including termination of the case manager's status as a Community Choices Waiver program case manager.

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

Frequency of Verification:

Annually

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):

Homemaker

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 and routine household care that is not covered by Personal Support Services, and is otherwise considered a non-direct service. Homemaker is not a direct care service as providers do not prompt or assist the participant in the completion of a task, and the participant is not required to be present when the service occurs.

Examples of covered tasks include but are not limited to meal preparation, shopping for groceries and personal items, laundry and ironing, and household cleaning to include regular home maintenance and more involved cleaning tasks such as cleaning appliances and washing windows. All tasks must be completed for the benefit of the participant.

Homemaker is not a direct care service, so other waiver direct care services can be provided by a different provider or provider staff during the same time frame.

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.

A provider of Homemaker Services shall not bill for two participants during the same time frame.

Transportation costs are not associated with the provision Homemaker 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 Provider

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 Provider

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 of this service must be enrolled as a Medicaid provider, and is required to attain and maintain a certification for this service from the Division.

Other Standard *(specify):*

A provider or provider staff member shall be at least 18 years of age and pass a criminal background screening. Providers shall adhere to the standards and requirements of all applicable Wyoming Medicaid Rules, and requirements specified in the CCW Provider Manual and Medicaid Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

Employee qualifications are verified by the Wyoming Department of Health, Aging Division as part of the initial and periodic agency licensure surveys.

Frequency of Verification:

Annually

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):

Personal Support Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
08 Home-Based Services	08050 homemaker
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Personal Support Services include part-time or intermittent assistance to enable participants to accomplish activities of daily living such as eating, bathing, grooming, dressing, using the restroom, and functional mobility tasks that they would normally do for themselves if they did not have a disability. Personal support assistance may take the form of hands-on assistance (actually performing a task for the person) or prompting the participant to perform a task.

Personal support services may also consist of general household tasks when those tasks are incidental to the Personal Support Service being provided during the visit, the participant is unable to manage the home and care for themselves independently, and the individual regularly responsible for these activities is temporarily absent or unable to conduct these activities.

Personal Support Services may be provided in the home or in the community when the participant requires assistance with activities of daily living in order to participate in community activities or to access other services in the community. The participant must be present during the delivery of Personal Support Services, and the provider must be able to demonstrate how they encouraged participant engagement during service delivery.

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

Personal Support Services may not include companionship or other services which are diversional or recreational in nature. Participant transportation costs are not associated with the provision of Personal Support Services and must be billed separately.

Personal Support Services delivered by non-licensed or non-certified employees of a home health agency is limited to prompting the participant to perform activities of daily living and may not include hands-on assistance.

Waiver services shall not duplicate services offered through another funding source, such as Section 110 of the Rehabilitation Act of 1973 (Vocational Rehabilitation or Workforce Services), the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.), third-party insurance, or the Medicaid State Plan. Medically necessary personal care services for individuals under the age of 21 are provided under the Medicaid State Plan in accordance with Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) coverage requirements.

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	Home Health Agency
Individual	Participant-directed employee hired under the participant direction service delivery option

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Support Services

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Licensed by the Wyoming Department of Health, Division of Aging pursuant to W.S. 35-2-901(a)(xi). The individual providing the service must meet the training requirements established by the Aging Division's Rules and Regulations for Home Health Agency Administration.

Certificate *(specify):*

Other Standard *(specify):*

Non-licensed/non-certified employees of a home health agency must meet the training requirements established by the Aging Division's Rules and Regulations for Home Health Agency Administration.

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

Employee qualifications are verified by the Wyoming Department of Health, Aging Division as part of the initial and periodic agency licensure surveys.

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Support Services

Provider Category:

Individual

Provider Type:

Participant-directed employee hired under the participant direction service delivery option

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The participant or designated the employer of record must be determined to meet the criteria for election of the participant-directed service option as described in Appendix E-1, and submit all necessary documentation to enroll with the contracted Financial Management Services (FMS) agency and the Division's fiscal agent as the employer of record.

Individuals employed under the participant-directed service delivery option must be at least 18 years of age and successfully complete the Division-sponsored training curriculum. The participant or designated employer of record may require that their employees meet additional training, education, or experience requirements.

Prior to providing services, an 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; and
- Be able to complete record keeping as required by the employer.

A spouse can be hired as an employee if there is evidence that demonstrates the spouse is not authorized to make financial decisions on behalf of the participant.

The employer of record, 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 service plan and has received training on the following Division requirements:

- 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:

The contracted FMS agency verifies and maintains documentation of employment eligibility status, criminal history and background investigation, and required training.

The participant or designated employer of record must verify and maintain documentation of any additional qualifications.

The contracted FMS agency maintains a directory of individuals who are interested in additional employment opportunities under the participant-directed service delivery option.

Frequency of Verification:

The FMS verifies minimum provider qualifications upon hire and submits a report to the Division on a representative sample of employee files annually.

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:	Sub-Category 1:
09 Caregiver Support	09012 respite, in-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09011 respite, out-of-home
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant.

In-home respite services provided by a home health agency may be delivered in the participant's home or in the community when the participant requires assistance with activities of daily living in order to participate in community activities or to access other services in the community.

Out-of-home respite services may be provided in an assisted living or nursing care facility.

Respite services may not be authorized based on the participant's needs for companionship or those which are diversional/recreational in nature. Participant transportation costs are not associated with the provision of respite services and must be billed separately. Reimbursement does not include the costs for room and board except when provided as part of respite care furnished in an assisted living or nursing care facility.

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

Services are authorized by a case manager based on the participant's assessed need and are limited to the prorated equivalent of thirty (30) days per service plan 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	Home Health Agency
Agency	Nursing Care Facility
Agency	Assisted Living Facility

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Home Health Agency License granted by the Wyoming Department of Health, Aging Division pursuant to W.S. 35-2-901(a)(xi).

Certificate *(specify):*

Employee: Certified Nursing Assistant/Nurse Aide by the Wyoming State Board of Nursing in accordance with the Wyoming Nurse Practice Act [W.S. 33-21-120 et seq.].

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

Employee qualifications are verified by the Wyoming Department of Health, Aging Division as part of the initial and periodic agency licensure surveys.

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Nursing Care Facility

Provider Qualifications

License *(specify):*

Nursing Care Facility License granted by the Wyoming Department of Health, Aging Division pursuant to W.S. 35-2-901(a)(xvi).

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Assisted Living Facility

Provider Qualifications

License *(specify):*

Assisted Living Facility License granted by the Wyoming Department of Health, Aging Division pursuant to W.S. 35-2-901(a)(xxii).

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

Frequency of Verification:

Annually

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:

Home Health Aide

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08020 home health aide
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Home Health Aide Services include part-time or intermittent assistance with personal care and other daily living needs that is within the scope of practice and required to be delivered by a Certified Nurse Aide (CNA) under the Wyoming Nurse Practice Act.

HCBS Home Health Aide Services differ in nature and scope from Medicaid State Plan home health aide services. HCBS Home Health Aide Services are not limited to rehabilitative services, may be provided on a long-term basis, are not subject to a physician's review every 60 days, and may include general household tasks, such as meal preparation, grocery or personal needs shopping, and light housekeeping when those tasks are incidental to the personal care provided during the visit, the participant is unable to complete these tasks independently, and the individual regularly responsible for these activities is temporarily absent or unable to conduct these activities.

Home Health Aide Services may be provided in the home or in the community when the participant requires assistance in order to participate in community activities or to access other services. The participant must be present during the delivery of Home Health Aide Services, and the provider must be able to demonstrate how they encouraged participant engagement during service delivery.

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

Home Health Aide Services do not include companionship or other services which are diversional or recreational in nature.

Waiver services shall not duplicate services offered through another funding source, such as Section 110 of the Rehabilitation Act of 1973 (Vocational Rehabilitation or Workforce Services), the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.), third-party insurance, or the Medicaid State Plan. Participant transportation costs are not associated with the provision of home health aide services and must be billed separately.

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	Home Health Agency

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Home Health Aide

Provider Category:
Agency
Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Home Health Agency License granted by the Wyoming Department of Health, Aging Division pursuant to W.S. 35-2-901(a)(xi).

Certificate *(specify):*

Employee: Certified Nursing Assistant/Nurse Aide by the Wyoming State Board of Nursing in accordance with the Wyoming Nurse Practice Act [W.S. 33-21-120 et seq.].

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

Employee qualifications are verified by the Wyoming Department of Health, Aging Division as part of the initial and periodic agency licensure surveys.

Frequency of Verification:

Annually

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):*

Part-time or intermittent skilled nursing care which is within the scope of practice and required to be delivered by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) under the Wyoming Nurse Practice Act. Waiver skilled nursing services are provided in addition to the skilled nursing services as defined by 42 CFR §440.70 and furnished under the Wyoming Medicaid State Plan.

Skilled nursing services under the waiver differ in nature and scope from state plan skilled nursing services in that the waiver services are not limited to rehabilitative services as defined by 42 CFR §440.130, may be provided on a long-term basis, and are not subject to a physician's review every 60 days.

Skilled nursing services may be provided in the home or in the community when the participant requires assistance in order to participate in community activities or to access other services in the community. Skilled nursing may not include companionship or other services which are diversional/recreational in nature. Participant transportation costs are not associated with the provision of skilled nursing services and must be billed separately.

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

Skilled nursing services may not duplicate those available through the state plan or those included in the participant's Individualized Education Plan (IEP) and are authorized by a contracted Quality Improvement Organization (QIO) in accordance with the participant's assessed needs. Medically necessary skilled nursing services for individuals under the age of 21 are provided under the state plan in accordance with Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) coverage requirements.

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	Home Health Agency

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:

Home Health Agency

Provider Qualifications

License *(specify):*

Home Health Agency License granted by the Wyoming Department of Health, Aging Division pursuant to W.S. 35-2-901(a)(xi).

Employee: Registered Nurse or Licensed Practical Nurse by the Wyoming State Board of Nursing in accordance with the Wyoming Nurse Practice Act [W.S. 33-21-120 et seq.].

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

Employee qualifications are verified by the Wyoming Department of Health, Aging Division as part of the initial and periodic agency licensure surveys.

Frequency of Verification:

Annually

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:

Assisted Living Facility Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02013 group living, other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Personal care and supportive services (to the extent permitted under state law) that are furnished to waiver participants who reside in a setting that meets the home and community-based setting requirements and includes 24-hour on-site response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security. Services also include social and recreational programming, and medication assistance (to the extent permitted under state law). Services that are provided by third parties must be coordinated with the assisted living facility.

Nursing and skilled therapy services are incidental rather than integral to the provision of assisted living services, and payment is not be made for 24-hour skilled care. Reimbursement does not include the costs for room and board, items of comfort or convenience, or facility maintenance, upkeep, and improvement.

Assisted living facility services do not include services which are available through the state plan. Participant transportation costs are not associated with the assisted living facility services and must be billed separately.

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
Agency	Assisted Living Facility

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assisted Living Facility Services

Provider Category:
Agency
Provider Type:

Assisted Living Facility

Provider Qualifications

License *(specify):*

Assisted Living Facility License granted by the Wyoming Department of Health, Aging Division pursuant to W.S. 35-2-901(a)(xxii).

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

Frequency of Verification:

Annually

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 Modification Services include the installation of functionally necessary physical adaptations to the private residence of the participant or the participant's family, as outlined in the participant's service plan, that are necessary to ensure the health, welfare, and safety of the participant in order for them to remain in their home instead of an institutional setting. 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 and 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 applies to this service.

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 the entrance or egress of 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 Division of Vocational Rehabilitation are excluded. Case managers 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 Community Choices Waiver is the payer of last resort. Environmental modifications shall not be furnished to modify settings that are owned or leased by providers of waiver services.

The case manager shall not obtain quotes until the overall scope of the project is approved by the Division.

The Division 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.

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 provider certified by the Division to provide the service
Agency	Agency provider certified by the Division to provide the service

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modification

Provider Category:

Individual

Provider Type:

Individual provider certified by the Division to provide the service

Provider Qualifications

License *(specify):*

A provider of this service shall have the applicable building, electrical, plumbing, or contractor's license, as required by local and state regulations.

Certificate *(specify):*

A provider of this service must be enrolled as a Medicaid provider and present a current Certificate of Good Standing from the Wyoming Secretary of State.

Other Standard *(specify):*

A provider must obtain and maintain general liability insurance commensurate with the service. In addition, providers shall adhere to the standards and requirements of all applicable Wyoming Medicaid Rules, and requirements specified in the CCW Provider Manual and Medicaid Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

Frequency of Verification:

Annually

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 provider certified by the Division to provide the service

Provider Qualifications

License *(specify):*

A provider of this service shall have the applicable building, electrical, plumbing, or contractor's license, as required by local and state regulations.

Certificate *(specify):*

A provider of this service must be enrolled as a Medicaid provider and present a current Certificate of Good Standing from the Wyoming Secretary of State.

Other Standard *(specify):*

A provider must obtain and maintain general liability insurance commensurate with the service. In addition, providers shall adhere to the standards and requirements of all applicable Wyoming Medicaid Rules, and requirements specified in the CCW Provider Manual and Medicaid Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

Frequency of Verification:

Annually

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:

Home-Delivered Meals

HCBS Taxonomy:

Category 1:	Sub-Category 1:
06 Home Delivered Meals	06010 home delivered meals
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope)*:

Hot or frozen meals delivered to the home of the participant when the participant is unable to prepare a meal for him or herself and the individual regularly responsible for these activities is temporarily absent or unable to conduct these activities. Meals must meet the standards for the nutritional services delivered under Title III of the Older Americans Act.

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

Limited to two meals per day and shall not constitute a full nutritional regimen.

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	Older Americans Act Nutritional Services Provider
Agency	Commercial Food Service Operator

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home-Delivered Meals

Provider Category:

Agency

Provider Type:

Older Americans Act Nutritional Services Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

An agency overseen by the Wyoming Department of Health, Aging Division as credible and capable to receive grants for Older Americans Act nutritional services pursuant to W.S. 9-2-1204(a)(vii).

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home-Delivered Meals

Provider Category:

Agency

Provider Type:

Commercial Food Service Operator

Provider Qualifications

License *(specify):*

Provider must maintain a current food service license or permit from the state in which the commercial food service preparation facility is located and comply with all federal, state and local food service regulations.

Certificate *(specify):*

Other Standard *(specify):*

The provider must demonstrate the ability to procure, handle, store, prepare and deliver food under current federal, state and local food handling safety standards. Nutritional analysis and facility inspection records must be available upon request.

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

Frequency of Verification:

Annually

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:

Independent Living Support

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08010 home-based habilitation

Category 2:	Sub-Category 2:
16 Community Transition Services	16010 community transition services

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

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

Independent Living Support (ILS) is training and assistance to support the participant in developing and maintaining skills needed to live in the community. Skills training will focus on physical, emotional, social, and economic elements of community living. Assistance will focus on assessing, training, supervising, and assisting the participant with self-care and activities of daily living, medication reminders and supervision, time management, safety awareness, task completion, communication, interpersonal relationships, socialization, community mobility, identification and access to medical and mental health services, reduction or elimination of maladaptive behaviors, understanding and following plans for occupational or sensory skill development, problem solving, benefits and resource coordination, financial management, and household management.

Providers of ILS will collaborate with the participant and the participant's providers to achieve an integrated service plan that will reinforce skills training during and beyond the provision of ILS. ILS shall be delivered according to the service plan.

To access ILS, a participant must be transitioning from an extended nursing facility placement to a community living arrangement. The participant must complete a needs assessment that demonstrates that, without the training and assistance provided through this service, they are at risk for reinstitutionalization. The participant must demonstrate that, with this training, they have the ability to acquire and maintain necessary skills within 365 days.

Virtual Support
Virtual support is defined as the use of telephonic or video conferencing technology to deliver face-to-face services to participants. The purpose of the virtual support option is to maintain or improve a participant's ability to support relationships while also encouraging and promoting their ability to participate in the community. At a minimum, the virtual support delivery option must meet the following requirements:

- The participant must have an informed choice between in person and virtual support services, and that choice must be documented in the participant's service plan and demonstrated through a signed consent form.
- The participant must have a choice in where and how the service will be received, and it must be documented in the participant's service plan. Documentation must demonstrate that opportunities for community integration, support for employment, and social interactions are still incorporated in the participant's life.
- The participant's service must include the specific technologies that will be utilized and the initial and ongoing training that the participant will need in order to use the technologies. During their monthly review, case managers will discuss any concerns the participant has with their virtual support technology, and follow up with the provider to ensure the concerns are addressed.
- The participant must have full control of virtual support devices, and have the ability to turn off the device and end services any time they wish.
- The participant's services may not be delivered virtually 100% of the time. The participant must always have the option to request in-person services.
- The use of the virtual support option must not block, prohibit or discourage the use of in-person services or access to the community. The participant must be encouraged to participate in services, engage with their community and their friends, when they choose or when they otherwise would not be able to do so due to illness, transportation issues, pandemics, or other personal reasons.
- A participant who requires in-person assistance during the provision of the service must receive services in-person. In order to ensure the health and safety of the participant, the plan of care team must assess the appropriateness of virtual support with the participant. If it is determined that in-person assistance is required, virtual support may not be provided.
- Virtual support must not be used for the provider's convenience. The option must be used to support a participant to reach identified outcomes in the participant's individualized plan of care.

Provider Standards for Virtual Support
All providers that deliver services using the virtual support option must meet all Division requirements established for virtual support. At a minimum:
- Providers must have written policies that assure the participant's right to privacy.
- Providers that deliver virtual support services must use a HIPAA-compliant telehealth service delivery platform approved by the Division. During the provider certification renewal process, providers that deliver virtual support services must sign an attestation that indicates:
  (1) They are using the HIPAA-compliant platform; and
  (2) They have adopted and enforced all necessary policy and procedures under the HIPAA Privacy & Security Rules.

At all times, the Division may review a provider's compliance in this regard. If a provider is found to not use the HIPAA-compliant platform or to not have adopted or enforced necessary policies and procedures, the Division may prohibit or restrict each provider's ability to provide virtual support. Provider requirements and assurances regarding HIPAA have been approved by the Wyoming Department of Health's HIPAA Compliance Officer.
- Providers must receive training on participant specific needs, including the support the participant will need in order to learn and utilize virtual support technologies. Providers must develop and implement a policy that describes how they will support initial and ongoing participant training in areas that include, but are not limited to, emergency drills, virtual support equipment, disengaging the system, and responding to system failure. Provider policies must be approved before they will be certified to provide virtual support services.
- Providers must not use video monitoring in participant bedrooms or bathrooms.

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

ILS is billed in 15 minute units, and is available to the participant for a period of 6 months following the first day the service is provided. Participants may utilize up to 20 units (five hours) a day, but not more than 30 hours per week, for the first 3 months the service is available. After that time, the service must include a schedule of services that includes a reasonable step-down of support that covers the remaining service period. This service is limited to 2080 total units (520 hours).

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	Center for Independent Living
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Independent Living Support

Provider Category:

Agency

Provider Type:

Center for Independent Living

Provider Qualifications

License *(specify):*

Centers for Independent Living, designated by the U.S. Department of Human Services Administration for Community Living and the Wyoming Department of Workforce Services Division of Vocational Rehabilitation, which comply with US Code is 29 U.S.C 796f-4, Standards and Assurances for Centers for Independent Living in Section 725 of the Rehabilitation Act of 1973, as amended.

Certificate *(specify):*

Other Standard *(specify):*

Within a year of being certified in this service, and annually thereafter, the staff member providing this service must successfully complete at least eight (8) hours of continuing education in any of the following areas: person-centered services, money management, writing and implementing measurable objectives, or other educational opportunities relevant to independent living skills.

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

Employee qualifications are verified by the Wyoming Department of Health, Aging Division as part of the initial and periodic agency licensure surveys.

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Independent Living Support

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Home health agencies licensed by the Wyoming Department of Health, Division of Aging pursuant to W.S. 35-2-901(a)(xi).
The individual providing the service must meet the training requirements established by the Aging Division's Rules and Regulations for Home Health Agency Administration.

Certificate *(specify):*

Other Standard *(specify):*

Within a year of being certified in this service, and annually thereafter, the staff member providing this service must successfully complete at least eight (8) hours of continuing education in any of the following areas: person-centered services, money management, writing and implementing measurable objectives, or other educational opportunities relevant to independent living skills.

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

Employee qualifications are verified by the Wyoming Department of Health, Aging Division as part of the initial and periodic agency licensure surveys.

Frequency of Verification:

Annually

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:

Non-Medical 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):*

Service offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the service plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the state plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them. Transportation services under the waiver are offered in accordance with the participant's service plan. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized.

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

Reimbursement for non-medical transportation is limited to a total of 18 trips per month.

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	Contract Motor Carrier
Agency	Public Transit Agency
Agency	Senior Center

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:

Agency

Provider Type:

Contract Motor Carrier

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must be a corporation, Limited Liability Company (LLC), non-profit organization, sole proprietorship, or other business entity registered in good standing with the Wyoming Secretary of State.

Must maintain intrastate operating authority as a contract motor carrier through the Wyoming Department of Transportation pursuant to W.S. 31-18-101(ii).

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:
Agency
Provider Type:

Public Transit Agency

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must be a county, city, town, or other local government agency determined by the Wyoming Department of Transportation as eligible grantee to receive public transit funds in accordance with W.S. 24-15-101(a)(iii).

Verification of Provider Qualifications
Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:
Agency
Provider Type:

Senior Center

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

An agency determined as an eligible senior center in accordance with W.S. 9-2-1201(a)(iii) and overseen by the Wyoming Department of Health, Aging Division as credible and capable to receive grants for Older Americans Act services pursuant to W.S. 9-2-1204(a)(vii).

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

Frequency of Verification:

Annually

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:

Personal Emergency Response Systems (PERS)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Personal Emergency Response Systems (PERS) include electronic devices that are programmed to signal a response center once a help button is activated and enables the waiver participant to secure help in an emergency. PERS are limited to participants who demonstrate needs based criteria for the service including: those who live alone; those who live with others who are unable to summon help; or those who are alone for significant portions of the day, have no regular caregiver for extended periods of time, and would otherwise require routine supervision.

Monthly monitoring and maintenance fees include the equipment rental; access to a 24 hour response center monitored by live, professional staff; equipment testing and troubleshooting; responses to alerts and alarms; and documentation of communications with participants, caregivers, case managers, and first responders.

Installation fees are billed separately and include the delivery, installation, and activation of all necessary equipment as well as participant/caregiver education and training on equipment use.

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

Reimbursement for installation is limited to a one-time fee per participant unless otherwise warranted by extenuating circumstances (e.g. the participant moves, a change in service provider, or lost/stolen devices). Reimbursement for installation fees for the repair or replacement of equipment may not be granted if it is determined that there has been abuse or misuse of the equipment or if the repair or replacement is sought before the equipment's ordinary life cycle.

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	Personal Emergency Response System Vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response Systems (PERS)

Provider Category:
Agency
Provider Type:

Personal Emergency Response System Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

A corporation, limited liability corporation, non-profit organization, sole proprietorship, or other business entity registered in good standing with the Wyoming Secretary of State. The vendor must also produce documentation that the agency is an authorized dealer, supplier, or manufacturer of Personal Emergency Response Systems.

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

Frequency of Verification:

Annually

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:

Transition Intensive Case Management

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Transition Intensive Case Management is intended to assist individuals who are currently residing in nursing facilities who want to transition into the community. Transition intensive case managers must perform activities necessary to arrange for the individual to live in the community, and support participants in coordinating and facilitating the purchase of one-time, non-recurring expenses necessary for the participant to establish a basic household upon transitioning from an institutional setting to a community living arrangement. Activities must be documented and not overlap the scope of case management annual service planning or monthly monitoring services.

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

This service is only available to participants during their transition from an extended nursing facility stay to the community, and is available to a participant once during their lifetime. Case managers may assist individuals with their community transition for no more than 180 calendar days while the individual is still residing in a nursing home.

Transition Intensive Case Management shall not overlap with the scope of other Case Management services; therefore, duplicate billing is not allowed. This service is billed in 15 minute unit increments and must not exceed 160 units (40hours) per participant.

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	Case Management Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transition Intensive Case Management

Provider Category:

Agency

Provider Type:

Case Management Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Case managers who complete Division sponsored training on person-centered planning and case management best practices are eligible to bill using the Case management - Certificate rate.

Other Standard *(specify):*

Must be a County Public Health Nursing Agency designated by the Wyoming Department of Health, Public Health Division; or corporation, Limited Liability Company (LLC), non-profit organization, sole proprietorship, or other business entity registered in good standing with the Wyoming Secretary of State.

Case management agencies must ensure all case managers meet the training, education, experience, and conflict of interest requirements as described in Appendix D-1-a of this application. Case management agencies must maintain adequate administrative and staffing resources and emergency backup systems to deliver case management services in accordance with all state and federal requirements. Each case management agency must have internal mechanisms for assessing and managing the performance of each case manager. Should the case management agency fail to address case manager performance concerns to the Division's satisfaction, the Division may require retraining or other progressive disciplinary actions, up to and including termination of the case manager's status as a Community Choices Waiver program case manager.

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

Frequency of Verification:

Annually

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:

Transition Setup

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

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

Transition Setup expenses are one-time, non-recurring expenses necessary for a participant to establish a basic household, and support the participant to transition from an extended nursing facility placement to a community living arrangement.

To access the Transition Setup, a participant must demonstrate:
- A need for the coordination and purchase of one-time, non-recurring expenses necessary for them to establish a basic household in the community;
- A health, safety, or institutional risk; and
- Verification that other services or resources are not available to meet the need.

Allowable setup expenses include:
- Security deposits that are required to obtain a lease on an apartment or home.
- Setup fees or deposits to access basic utilities or services (telephone, electricity, heat, and water).
- Services necessary for the individual's health and safety such as pest eradication or one-time cleaning prior to occupancy.
- Essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, or bed or bath linens.
- Expenses incurred directly from the moving, transport, provision, or assembly of household furnishings. Fees associated with obtaining legal documents necessary for a housing application such as a birth certificate, state issued ID, or criminal background screening.

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

Transition Setup does not cover rental or mortgage expenses, ongoing food costs, regular utility charges, or items that are intended for purely diversional, recreational, or entertainment purposes. Transition Setup does not include payment for room and board. Equipment or other markups shall not be paid through this service.

Transition Setup must not exceed a total of $2,500 per participant, unless otherwise authorized by the Division, and must be prior approved in the participant's service plan. The Division may authorize additional funds above the $2,500 limit, not to exceed a total value of $3,000, when it is demonstrated as a necessary expense to ensure the health, safety, and welfare of the participant.

This service is only available to participants during their transition from an extended nursing facility stay to the community, and is available to a participant once during their lifetime. Transition services are not available to a participant who is transitioning to a provider owned or controlled setting.

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	Case Management Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transition Setup

Provider Category:
Agency
Provider Type:

Case Management Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must be a County Public Health Nursing Agency designated by the Wyoming Department of Health, Public Health Division; or corporation, Limited Liability Company (LLC), non-profit organization, sole proprietorship, or other business entity registered in good standing with the Wyoming Secretary of State.

Case management agencies must ensure all case managers meet the training, education, experience, and conflict of interest requirements as described in Appendix D-1-a of this application. Case management agencies must maintain adequate administrative and staffing resources and emergency backup systems to deliver case management services in accordance with all state and federal requirements. Each case management agency must have internal mechanisms for assessing and managing the performance of each case manager. Should the case management agency fail to address case manager performance concerns to the Division's satisfaction, the Division may require retraining or other progressive disciplinary actions, up to and including termination of the case manager's status as a Community Choices Waiver program case manager.

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

Frequency of Verification:

Annually

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):

(a) A criminal history and background investigation must be conducted for those employees, contractors, and volunteers who may have unsupervised direct contact with waiver participants in the regular course of their work delivering the following waiver services:
- Adult Day Services (Health Model)
- Adult Day Services (Social Model)
- Assisted Living Facility Services
- Case Management
- Home Health Aide
- Homemaker
- Independent Living Support
- Personal Support Services
- Respite
- Skilled Nursing
- Transition Intensive Case Management
- Independent Living Support

(b) The criminal history and background investigation includes the following screenings:
- United States Department of Health and Human Services, Office of Inspector General, List of Excluded Individuals/Entities Database search
- A national, name and social security based criminal history database screening
- United States Department of Justice, National Sex Offender Public Website search

The screening must confirm that the individual has not been excluded from federally-funded healthcare programs and has not been convicted of, has not pleaded "no contest" to, and does not have a pending deferred prosecution of any crimes listed in Wyoming Statute Title 6, Chapter 2 (Offenses Against the Person) and Chapter 4 (Offenses Against Morals, Decency and Family).

(c) Medicaid reimbursement is not available for the above waiver services delivered by employees, contractors, and volunteers excluded from federally-funded healthcare programs or who have a criminal history including a barrier crime. Provider agencies must maintain employee files including documentation of successful criminal history and background investigation results. Employee files are periodically reviewed as part of the regulatory oversight activities conducted for agencies licensed or regulated by the Wyoming Department of Health, Aging Division. Case management agency employee files are periodically reviewed by the Division as part of regular quality and performance review activities. Service provider agencies may choose to exclude applicants for additional crimes not included on the Division's list of barrier crimes.

The contracted Financial Management Services (FMS) agency facilitates criminal history and background investigations for individuals employed under the participant-directed service delivery option. The FMS verifies that the applicant/employee has not been excluded from federally-funded healthcare programs and does not have a criminal history including a barrier crime. Following this verification, the participant/designated employer of record is provided the criminal history and background investigation results and makes the hiring decision. The participant/designated employer of record may choose to exclude applicants for additional crimes not included on the Division's list of barrier crimes. The FMS agency maintains employee files including documentation of successful criminal history and background investigation results, and these files are subject to periodic reviews conducted as part of the Division's contractor oversight activities.

Provider agencies and participants/designated employers of record under the participant-directed service delivery option may choose to permit individuals to begin delivering waiver services pending the results of the criminal history and background investigation if that individual has signed an attestation affirming that he/she has not been convicted of, has not pleaded "no contest" to, and does not have a pending deferred prosecution of any barrier crime.

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.

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):

(a) The Central Registry of Abuse and Neglect is maintained by the Wyoming Department of Family Services.

(b) A Central Registry check must be conducted for those employees, contractors, and volunteers who may have unsupervised direct contact with waiver participants in the regular course of their work delivering the following waiver services:

- Adult Day Services (Health Model)
- Adult Day Services (Social Model)
- Assisted Living Facility Services
- Case Management
- Home Health Aide
- Homemaker
- Independent Living Support
- Personal Support Services
- Respite
- Skilled Nursing
- Transition Intensive Case Management
- Independent Living Support

(c) Medicaid reimbursement is not available for the above waiver services delivered by employees, contractors, who have been substantiated by the Wyoming Department of Family Services for abuse and/or neglect. Provider agencies must maintain employee files including documentation of successful Central Registry check results. Employee files are periodically reviewed as part of the regulatory oversight activities conducted for agencies licensed or regulated by the Wyoming Department of Health, Aging Division. Case management agency employee files are periodically reviewed by the Division as part of regular quality and performance review activities.

The contracted Financial Management Services (FMS) agency facilitates Central Registry checks for individuals employed under the participant-directed service delivery option. The FMS verifies that the applicant/employee in not included on the Central Registry. Following this verification, the participant/designated employer of record is provided the Central Registry check results and makes the hiring decision. The FMS agency maintains employee files including documentation of successful criminal history and background investigation results, and these files are subject to periodic reviews conducted as part of the Division's contractor oversight activities.

DHCF requires a subsequent central registry check be conducted every 5 years.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

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.*

- [ ] **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.*

The relative of a participant may be reimbursed for personal support services delivered under the participant-directed service delivery option. The relative must meet all qualifications specified in Appendix C-1/C3 and may not be a legal guardian or designated employer of record for the participant. A spouse can be hired as an employee if there is evidence that demonstrates the spouse is not authorized to make financial decisions on behalf of the participant. In accordance with the provisions of the 21st Century Cures Act, Electronic Visit Verification (EVV) is required for personal support services to ensure payments are made only for services rendered. The employee and participant/designated employer of record must sign an attestation affirming the veracity of the information included on the timesheet and that the timesheet is an accurate representation of services rendered. Misrepresentation or false statements may result in disciplinary actions up to or including involuntary termination from the participant-directed service delivery option and criminal prosecution.

- ( ) **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.

○ **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:

Any institution, agency, person, or organization may submit an application to enroll as a waiver service provider through an online portal. Applicants are screened by the Division and/or its agent against the qualifications specified in Appendix C-1/C-3 of this waiver application. Applicants are notified of the approval/disapproval of the provider application or any additional information required by the Division or its agent. Service providers qualified by the Division and/or its agent are enrolled without restriction upon execution of a Medicaid Provider Agreement. Applicants denied enrollment are provided with a notice of rights to request a reconsideration and/or fair hearing in accordance with Chapter 4 of the Rules and Regulations for Medicaid.

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.a1.1 Percentage of providers that initially met licensing and/or certification standards prior to delivering services. Numerator: Number of providers that initially met licensing and/or certification standards prior to delivering services. Denominator: Total number of providers that require a licensure and/or certification.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider management information system

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:
C.a1.2 Percentage of providers that continually met licensing and/or certification standards prior to delivering services. Numerator: Number of providers that continually met licensing and/or certification standards prior to delivering services. Denominator: Total number of providers that require licensure and/or certification.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider management information system

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 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.b1 Percentage of employees in a representative sample of individuals employed under the participant-directed service delivery option whose records demonstrate compliance with provider qualification requirements. Numerator: Number of

employees in the sample whose records demonstrate compliance with provider qualification requirements. Denominator: Total number of employees in the sample.

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

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 = 95% confidence +/- 5% MOE
☒ **Other** Specify: Contracted FMS Agency	☐ **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:

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.c1 Percentage of case managers that have completed all required training prior to delivering services and as periodically required thereafter. Numerator: Number of case managers that have completed all required training prior to delivering services and as periodically required thereafter. Denominator: Total number of case managers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider management information system

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:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

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.

Individual deficiencies identified through regular monitoring activities or through waiver performance measures are remediated by the Division staff through the provision of technical assistance, the imposition of a corrective action or sanction, referrals to the appropriate regulatory/law enforcement agencies, and/or the suspension or termination of a Medicaid provider agreement.

In accordance with CMS guidance issued March 12, 2014, any performance measure with less than an 86% success rate warrants further analysis to determine the cause. The Division conducts a root cause analysis to identify contributing factors and determine underlying causes of deficiency for any measure with less than an 86% success rate. Based upon the findings of the root cause analysis, the Division may initiate a Quality Improvement Project (QIP). The QIP includes, at minimum:

- A description of remedial actions to be taken (e.g. training, revised policies/procedures, additional staff, different staffing patterns, provider/vendor corrective action);
- A timeline of remedial actions to be taken;
- The individuals responsible for effectuating remedial actions; and,
- The frequency with which performance/compliance is measured.

The HCBS Quality Improvement Committee assures accountability to the Division’s stakeholders and provides oversight of quality improvement activities, including regular monitoring of QIP effectiveness.

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**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **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.

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.

The State of Wyoming's Statewide Transition Plan for Home and Community-Based Settings received final approval on June 29, 2018. One assisted living facility remains presumptively institutional due to its location within a building which is also a privately operated facility that provides inpatient institutional treatment and will be submitted to CMS for review under the heightened scrutiny process. All other settings have been assessed and have been determined to be in full compliance with home and community-based settings requirements. Settings are regularly reviewed to assure ongoing compliance.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Service Plan

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:

Case managers must be employed or contracted by a qualified case management agency and must have:

(1) A master's degree from an accredited college or university in human services, social services or a related field of study;
(2) A bachelor's degree from an accredited college or university in human services, social services, or a related field of study and one year of related work experience in human or social services; or
(3) An associate's degree from an accredited college or university in human services, social services, or a related field of study and four years of related work experience in human or social services.

A case manager employed by a case management agency prior to July 1, 2016 may continue to provide case management services, without meeting the above criteria, as long as the case manager has a high school diploma or high school equivalency certificate and six years of experience as a case manager.

Prior to conducting service planning and case management activities and periodically thereafter, case managers must demonstrate requisite knowledge, skills, and abilities through successful completion of the Division-sponsored case management training curriculum.

The case management agency and case manager responsible for the development of the participant's service plan must meet the following conflict of interest standards:

(1) The case manager must not be related by blood or marriage to the participant, or to any person paid to provide Medicaid home and community-based services to the participant;
(2) The case manager must not share a residence with the participant or with any person paid to provide Medicaid home and community-based services to the participant;
(3) The case manager/case management agency must not be financially responsible for the participant;
(4) The case manager/case management agency must not be empowered to make financial or health-related decisions on behalf of the participant; and
(5) The case manager/case management agency must not own, operate, be employed by, or have a financial interest in any entity that is paid to provide Medicaid home and community-based services to the participant. Financial interest includes a direct or indirect ownership or investment interest and/or any direct or indirect compensation arrangement.

☐ **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:*

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.

(a) At the time of application for the waiver program, participants are provided with an informational handout on the range of services and supports offered through the waiver and a list of approved case management agencies serving the participant's county of residence. Upon enrollment in the waiver program, the participant's assigned case manager uses a person-centered planning approach to facilitate service plan development as described in Appendix D-1-d. Case managers provide and explain participant materials, including a participant welcome packet/handbook containing:

-Program overview
-Participation agreement
-Introduction to person-centered planning
-Participant rights and responsibilities
-Information on freedom of choice between institutional care and waiver services, among all feasible service alternatives within the waiver, and among all willing and qualified service providers.

(b) The participant (and/or legal representative, as appropriate) is afforded the authority to determine who is included and/or excluded from the service plan development process.

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):

(a) At the time of application for the waiver program, the participant selects a case management agency from a list of approved agencies serving the participant's county of residence. Upon enrollment in the waiver program, the case manager facilitates a person-centered service plan development process. Within five business days following participant enrollment approval, the case manager must contact the participant (and/or legal representative, as appropriate) to initiate the service planning process and to schedule the service plan meeting. The case manager, the participant, and any other individuals freely chosen by the participant may participate in the service plan development process. Prior to the service plan meeting, the case manager gathers information on the language needs, any cultural considerations, the individuals to be included in the service plan development process, and the potential times and locations for the meeting. The case manager must schedule the service plan meeting at a time and location convenient to the participant and, when applicable, others included in the service plan development process.

(b) The Division has developed an assessment to support the service plan development process and to establish standardized methods for gathering all necessary information on participant needs, preferences, goals, and overall health status.

The Participant Profile assessment is used to gather basic information on the participant's background, family/natural support system, home environment, participation in the community, interest in participant-directed service options, and overall health status. The participant profile assessment is also designed to build rapport with the participant; to identify participant strengths, preferences, support needs, and potential risk factors; and to facilitate meaningful goal development using a series of open-ended questions and guided conversation techniques.

(c) Case managers provide an informational handout including a list of all services and service delivery options available under the waiver and explaining the key features of the program. Case managers are required to present and explain the participant's choice between community-based and institutional care options and among all feasible service alternatives within the waiver.

(d) The case manager summarizes the information gathered through the Participant Profile assessment and confirms there is agreement among all individuals participating in the service plan development process on the goals, strengths, preferences, needs, and risks to be addressed by the service plan. The participant is encouraged and supported to direct the service planning process to the maximum extent possible. The case manager provides information and options counseling as needed to facilitate discussion among the individuals participating in the service plan development process and to assist the participant in determining which services and supports will be included in the service plan.

The service plan focuses primarily on the services available through the waiver, but may include additional services and supports available through the Medicaid State Plan; other federal, state, and local public programs; the participant’s family/natural support system; and/or any other relevant community resource.

For each service and support to be included in the service plan, the case manager drafts a brief description of the tasks to be performed by the service/support provider and documents the specific needs, preferences, and goals to be addressed by that service/support. For each waiver service, the case manager considers the scope of the covered benefit, prior authorization review requirements, and any applicable service limits to recommend service frequency and duration in accordance with the participant’s assessed needs and preferences.

The case manager is responsible for the development of a comprehensive service plan which reasonably assures the health and welfare of the participant; acknowledges participant’s strengths; promotes the participant’s self-determined goals; addresses all of the participant’s assessed needs; includes a plan to mitigate all identified risks, and accommodates participant preferences to the extent possible within the established service limitations and the availability of local resources.

(e) The case manager coordinates all services and supports included in the service plan. For each waiver service, the case manager must submit a referral to the participant’s chosen service provider. This referral includes the specific service requested, a brief description of the tasks to be performed by the service provider, the requested service frequency and duration, and any other relevant information regarding the participant’s specific needs and preferences.

The waiver service provider is required to review the services requested by the participant and indicate whether the provider accepts, declines, or accepts with modification (e.g. the participant prefers a male caregiver, but the service

provider only female caregiver is available). The case manager must confirm the participant's acceptance of any modifications proposed by the service provider. The case manager facilitates the participant's selection of an alternate provider and/or service alternative for any declined referrals or for modifications not accepted by the participant.

The case manager conducts additional referral and outreach activities as necessary to confirm availability and coordinate the delivery of non-waiver services and supports included in the service plan.

(f) The case manager submits service referrals through the Wyoming Health Provider (WHP) portal referral process and obtains electronic acceptance of the service referral from each individual/provider responsible for service plan implementation. The case manager obtains the participant's agreement and informed consent and submits the service plan for the Division's review and finalization through the Division's case management information system. Service plans are screened through an automated review process and may be subject to a manual review by Division staff, then are finalized in the case management information system.

Upon service plan finalization, a copy of the service plan will be delivered to the participant and legally authorized representative, if applicable. Information necessary for each provider to coordinate, provide, and be reimbursed for waiver services is contained within the service referral in EMWS. The case manager is responsible for monitoring service plan implementation.

(g) The service plan must be reviewed and updated at least annually but may be reviewed more frequently upon request by the participant or in response to a significant change in the participant's condition or circumstances.

The case manager, the participant, and any other individuals freely chosen by the participant may participate in the service plan review and update process. The case manager facilitates a discussion among the individuals participating in the service plan review process to confirm/update the participant's assessed needs, preferences, goals, and overall health status and to identify any necessary modifications to the participant's existing service plan. The case manager may conduct a new Participant Profile assessment as needed to document changes in the participant's condition or circumstances. Modifications to the service plan are made and the services and supports are coordinated in accordance with the initial service plan development processes described above.

The case manager assigns responsibility for implementation of the updated service plan and obtains electronic acceptance of the modification of the service referral from each individual/provider, as necessary, through the referral process. The case manager obtains the participant's agreement and informed consent and submits the updated service plan for the Division's review and finalization through the Division's case management information system. Service plans are screened through an automated review process and may be subject to a manual review by Division staff, then are finalized in the case management information system. The case manager is responsible for monitoring the implementation of the updated service plan.

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.

Case managers must create a risk mitigation plan for all potential risks identified by the Participant Profile assessment during the service plan development process. The case manager facilitates a conversation among all individuals participating in service plan development to identify strategies to mitigate risk and to reasonably assure the health and welfare of the participant.

The service plan must include a backup plan or identify an alternate service or support to ensure the continuity of critical waiver services, e.g. personal support services or skilled nursing services. The arrangements that are used for backup are tailored to the participant's needs, preferences, and available resources. Backup arrangements may include, but are not limited to, seeking temporary assistance from a member of the participant's natural support network, contacting the provider agency for assignment of an on-call or alternate caregiver, contacting the case manager to coordinate delivery of an alternate service or support, and employing and an on-call or alternate caregiver under the participant-directed service delivery option.

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.

At the time of application for the waiver program, participants are provided with an informational handout on the range of services and supports offered through the waiver and a list of approved case management agencies serving the participant's county of residence. Upon enrollment in the waiver program, the participant's assigned case manager uses a person-centered planning approach to facilitate service plan development as described in Appendix D-1-d.

Case managers must provide a list of all enrolled providers serving the participant's county of residence. The participant's case manager must disclose any ownership, affiliation, or financial interest in any entity enrolled to provide Medicaid home and community-based services. The participant must be afforded the option to receive case management services from another agency or choose to receive services from a provider without conflict of interest.

The service plan includes an explanation of the participant's (and/or legal representative's, as appropriate) rights and responsibilities, including the right to exercise freedom of choice among all willing and qualified service providers. The service plan is agreed to with the informed consent of the participant and signed by all individuals and providers responsible for its implementation.

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 case manager submits the service plan and any subsequent service plan updates for the Division's approval and finalization through the Division's case management information system. Service plans are screened through an automated review process and may be subject to a manual review by Division staff. Once approved by the Division, service plan is finalized in the case management information system and can be reviewed by Division staff at any time.

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.

(a) The case manager is responsible for monitoring service plan implementation and the participant's ongoing health and welfare.

(b)&(c) Case managers must conduct monthly service plan monitoring activities in order to identify any changes in the participant's condition or circumstances, screen for any potential risks or concerns, assess the participant's (and/or legal representative's, as appropriate) satisfaction with services and supports, evaluate the effectiveness of the service plan and risk mitigation plan in meeting the participant's needs, and to ensure services are delivered in accordance with the service plan.

Service plan monitoring visits are typically conducted face-to-face in the participant's home but may occur by phone/video call or at another location within the community in accordance with the participant's needs and preferences. Face-to-face service plan monitoring visits must be conducted at least quarterly. Case managers must conduct service plan monitoring visits at a time and place convenient to the participant.

Monthly service plan monitoring activities must be documented in the Division's case management information system within five business days, and the case manager may be required to review and update the participant's service plan in response to any significant changes in condition or circumstances as described in Appendix D-1-d or as needed to implement backup plans. Service utilization data is available in the Division's case management information system as claims are submitted and reimbursed. Case managers monitor service utilization data and compare against the authorized amounts to identify any potential problems with service access or delivery and may follow up with service providers as necessary to support service plan implementation. The case management information system is used to compile and compare service plan monitoring results with service plan modification and critical incident data in order to assure remediation of any identified problems.

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:*

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.a1 Percent of service plans with the 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. Numerator: Number of signed service plans that address participant assessed needs, goals, and health and safety risk factors. Denominator: Total number of service plans.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case management information system

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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **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.

Performance Measure:
Pursuant to CMS guidance issued March 12, 2014, reporting on this subassurance is no longer required.

Data Source (Select one):
Other
If 'Other' is selected, specify:
N/A

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: 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.c1 Percentage of service plans that were revised to address changing needs. Numerator: Number of service plans updated when warranted by changes in the participant's needs. Denominator: Total number of participants with a documented change in needs which warrant a service plan update.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case management information system

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.c2 Percent of service plans that were updated or revised every 12 months.
Numerator: Number of service plans updated or revised every 12 months.
Denominator: Total number of service plans which require an update or revision every 12 months.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case management information system

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.d1 Percentage of of services delivered in accordance with the service plan, including the the type, scope, amount, duration, and frequency (TSADF). Numerator: Number of services delivered in accordance with the service plan, including the the (TSADF). Denominator: Total number services delivered.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Management Information System

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.e1 Percentage service plans stating participants/legally authorized representatives were given a choice of providers. Numerator: Number of service plans stating participants/legally authorized representatives were given a choice of providers. Denominator: Total number of service plans.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case management information system

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:
D.e2 Percentage of service plans stating participants/legally authorized representatives were given a choice of services. Numerator: Number of service plans stating participants/legally authorized representatives were given a choice of services. Denominator: Total number of service plans.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case management information system

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.

Individual deficiencies identified through regular monitoring activities or through waiver performance measures are remediated by the Division staff through the provision of technical assistance, the imposition of a corrective action or sanction, and/or the suspension or termination of a Medicaid provider agreement.

In accordance with CMS guidance issued March 12, 2014, any performance measure with less than an 86% success rate warrants further analysis to determine the cause. The Division conducts a root cause analysis to identify contributing factors and determine underlying causes of deficiency for any measure with less than an 86% success rate. Based upon the findings of the root cause analysis, the Division may initiate a Quality Improvement Project (QIP). The QIP includes, at minimum:

- A description of remedial actions to be taken (e.g. training, revised policies/procedures, additional staff, different staffing patterns, provider/vendor corrective action);
- A timeline of remedial actions to be taken;
- The individuals responsible for effectuating remedial actions; and,
- The frequency with which performance/compliance is measured.

The HCBS Quality Improvement Committee assures accountability to the Division's stakeholders and provides oversight of quality improvement activities, including regular monitoring of QIP effectiveness.

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.

Appendix E-1-a - Description of Participant Direction

(a) The Community Choices Waiver affords participants the opportunity to direct their personal support services. The participant (and/or legal representative, as appropriate) may choose to direct their own services or to designate another individual to act as the employer of record and direct services on their behalf. Participants who choose to direct personal support services are granted both the employer and budget authorities.

Employer authority grants the participant/designated employer of record the ability to recruit, select, discharge, terminate, schedule, supervise, set wages, and otherwise manage employees of their choosing. Employer authority is executed under the Fiscal/Employer Agent (F/EA) model. The participant/designated individual serves as the employer of record. If the participant chooses not to manage the responsibilities associated with participant-directed care, the participant must designate an employer of record to direct services on their behalf.

Budget authority grants the participant/designated employer of record the ability to direct services within a participant-directed budget. The case manager calculates the participant-directed budget based on the participant's assessed needs using the Division's guidelines and prescribed methods.

(b) The case manager informs the participant of all possible service alternatives, including opportunities for participant direction as part of the service plan development processes described in Appendix D-1-d. Participants who express an interest in participant direction are assisted by the case manager in completing the required documents and are referred to the contracted Financial Management Services (FMS) agency for enrollment support.

(c) The contracted FMS agency supports the employers of record for participant-directed waiver services by performing financial administrative activities such as withholding taxes and processing payroll. In performance of its delegated provider enrollment functions, the FMS verifies provider qualifications, conducts background investigations, and facilitates provider enrollment. The FMS maintains a separate account for each participant in order to track and report the expenditures and balance of the participant’s participant-directed budget.

Case management activities also support participant direction. Case managers provide information about participant direction opportunities; determine whether participants meet the additional criteria described in Appendix E-1-d; assist the participant/designated employer of record in obtaining and completing required documents; determine the participant’s monthly budget allocation; coordinate with the FMS agency; and monitor participant-directed service effectiveness, quality, and expenditures.

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.

(a) Participants (and/or legal representatives, as appropriate) are informed of all possible service alternatives, including opportunities for participant direction as part of the service plan development process described in Appendix D-1-d. Participants who express an interest in participant direction are informed of the potential benefits, liabilities, risks, and responsibilities associated with participant direction.

(b) & (c) Case managers provide this information during the development of the initial service plan development, at the annual service plan review, at any time the service plan is updated due to a significant change in the participant's condition, or at any other time it is requested by the participant.

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:

The participant's court appointed guardian may also act as the designated employer of record for participant direction.

The participant or their court appointed guardian, as appropriate, may also choose to designate another individual to act as the employer of record for participant direction.

The designated employer of record must attest to their understanding and capability to manage the activities and responsibilities associated with participant direction of waiver services by signing an agreement of understanding that the designated employer of record is willing and able to assume responsibilities as the employer of record, does not and cannot receive compensation to act as the designated employer of record, and cannot delegate or assign the responsibilities of the employer of record to another person or entity. The designated employer of record cannot be reimbursed to provide waiver services to the participant for whom they are the employer of record.

If the employer of record fails to meet the responsibilities associated with participant-directed care, they can be removed from participant direction and the participant or their court appointed guardian must designate another individual to act as the employer of record. If the employer of record is removed from participant direction, they are prohibited from serving as an employer of record for any CCW participant indefinitely.

Case managers monitor participant-directed service effectiveness, quality, and expenditures against the monthly budget allocation on a monthly basis.

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
Personal Support Services	☒	☒

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:

The Division contracts with a private corporation to act as its Financial Management Services (FMS) agency. The FMS agency is procured competitively through a Request for Proposal (RFP) process in accordance with state procurement laws [WS 9-2-1016, et seq.].

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The FMS agency is reimbursed on a fee-for-service basis at a standard per member, per month (PMPM) rate. PMPM payments are made in accordance with the state fiscal rules.

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:

Assist the participant/designated employer of record in verifying employee qualifications as described in Appendix C-1/C-3 and Appendix C-2 by facilitating criminal history and background investigation processes and by maintaining documentation of compliance with any other applicable qualification standards required to receive reimbursement for waiver services.

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.

As described in Appendix A, the Division retains ultimate administrative authority and is responsible for assessing the performance of the contracted FMS agency. The Division's contract with the FMS specifies the scope of work and documents the delegation of administrative and operational activities conducted by the FMS.

FMS agency performance is assessed on a quarterly basis through onsite performance reviews. These performance reviews include an inspection of participant-directed employer/employee files, operational policies and procedures, data reports, and other administrative records as necessary to validate compliance with contractual obligations and service line agreements.

Financial integrity of participant-directed service claims is assured through the post payment audit and billing validation processes described in Appendix I. Additionally, the quarterly onsite performance review procedures include validation of a random convenience sample of FMS claims. The FMS agency must produce the approved timesheets to substantiate the delivery and reimbursement of participant-directed waiver services for claims included in the sample. Any potential overpayments identified are referred to the Division's Program Integrity Unit for further investigation and for the potential payment recovery and reimbursement of Federal Financial Participation (FFP).

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:

☒ **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
Non-Medical Transportation	☐
Independent Living Support	☐
Assisted Living Facility Services	☐
Transition Intensive Case Management	☐
Transition Setup	☐
Homemaker	☐
Adult Day Services	☐
Home Health Aide	☐
Case Management	☒
Environmental Modification	☐
Personal Support Services	☐
Skilled Nursing	☐
Respite	☐
Personal Emergency Response Systems (PERS)	☐
Home-Delivered Meals	☐

☐ **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:

Participant-direction is a voluntary service delivery option from which the participant (and/or legal representative, as appropriate) may choose to withdraw at any time.

Participants who elect to voluntarily terminate participant direction must contact their case manager to facilitate the transition to an alternative service delivery option. Case managers must make all reasonable efforts to assure service continuity through the service plan update processes described in Appendix D-1-d. This includes planning for and coordinating the transition to agency-based care or other service alternatives in such a manner that assures participant health and welfare and that the participant's assessed needs are met during that transition.

Participants who voluntarily terminate participant direction may return to the participant-directed service delivery option at any time, as long as the participant continues to meet the criteria described in Appendix E-1-d.

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.

Participants may be involuntarily terminated from participant direction if:

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

(2) There is documented misuse or abuse of the monthly budget allocation, and the Division has determined that adequate attempts to assist the employer of record to resolve the misuse or abuse have failed;

(3) There has been an intentional submission of fraudulent timesheets or other program documentation;

(4) The employer of record has been convicted of fraud or abuse; or

(6) The employer of record is included on the List of Excluded Individuals/Entities (LEIE) and is therefore excluded from participation in Federally-funded healthcare programs by the US Department of Health and Human Services, Office of Inspector General (OIG).

Participants involuntarily terminated from participant direction are provided a Notice of Adverse Action and informed of the opportunity to request a fair hearing in accordance with the processes described in Appendix F-1. Case managers facilitate the transition to an alternative service delivery option and must make all reasonable efforts to assure service continuity through the service plan update processes described in Appendix D-1-d. This includes planning for and coordinating the transition to agency-based care or other service alternatives in such a manner that ensures the participant's needs are met during that transition.

Participants who are involuntarily terminated from participant direction may be prohibited from electing the participant-directed service delivery option in the future.

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		663
Year 2		667
Year 3		671
Year 4		675
Year 5		679

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 costs for required criminal history and/or background investigations are reimbursed by the Division as an administrative expense.

☒ **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:

Background checks are conducted in accordance with the processes described in Appendix C-2-a.

☒ **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:

The participant-directed budget is allocated and prior authorized on a monthly basis. Participants/designated employers of record must schedule and manage the provision of services to remain within the monthly budget allocation.

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.

The participant-directed budget is determined as part of the service plan development and update processes described in Appendix D-1-d. The case manager facilitates a discussion among all individuals participating in the service planning process, and a worksheet is used to estimate the frequency and duration of assistance required to support the participant in completing activities of daily living and general household tasks. The case manager considers the participant's assessed goals, strengths, preferences, needs, risks, the availability of natural supports and other resources, and the scope of the service definition detailed in Appendix C in calculating the estimated number of service hours.

The case manager converts the estimated number of service hours into standard units of reimbursement, and the participant-directed budget is calculated by multiplying the number of units by the standard rate for participant-directed services. The worksheet for estimating service frequency and duration and other service planning guidance documents are publicly available on the Division's 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.

The case manager informs the participant (and/or legal representative, as appropriate) of the participant-directed budget amount and obtains agreement and informed consent prior to submitting the service plan for the Division's approval and finalization. The service plan, including the participant-directed budget, must be reviewed and updated at least annually but may be reviewed more frequently upon request by the participant or in response to a significant change in the participant's condition or circumstances.

Participants whose requests for adjustment to the participant-directed budget are denied, suspended, reduced, or terminated are provided with a Notice of Adverse Action and may request a fair hearing in accordance with the processes described in Appendix F-1.

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:

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:

The participant-directed budget is allocated and prior authorized on a monthly basis to prevent the premature depletion. Participants/designated employers of record must schedule and manage the provision of services to remain within the monthly budget allocation. Upon election of the participant-directed service delivery option, the participant/designated employer of record signs an agreement acknowledging understanding of responsibility for managing services within the participant-directed budget and that timesheets submitted in excess of the participant-directed budget will not be reimbursed by the FMS agency.

The contracted FMS agency's payroll processing information system edits submitted timesheets against prior authorization amounts and will not process timesheets submitted in excess of the participant's monthly budget allocation. The FMS agency maintains an online portal and a customer service line to provide participants/designated employers of record with an up-to-date accounting of expenditures and participant-directed budget remaining.

Case managers must conduct monthly service plan monitoring activities to ensure services are delivered in accordance with the service plan. Service utilization data is available in the Division's case management information system as claims are submitted and reimbursed. Case managers monitor service utilization data and compare against the authorized amounts to identify any potential problems with service access or delivery and may follow up with the participant/designated employer of record as necessary.

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.

At the time of application for the waiver program, participants are provided with an informational handout on the range of services and supports offered through the waiver and a list of approved case management agencies serving the participant's county of residence. Upon enrollment in the waiver program, the participant's assigned case manager uses a person-centered planning approach to facilitate service plan development as described in Appendix D-1-d.

Case managers provide a Participant Handbook including a list of all services and service delivery options available under the waiver and explaining the key features of the program. Case managers are required to present and explain the participant's (and/or legal representative's, as appropriate) choice between community-based and institutional care options, all feasible service alternatives within the waiver, the right to exercise freedom of choice among all willing and qualified service providers, and the right to request a fair hearing in response to an adverse action. The service plan includes a documentation of the participant’s understanding of these rights and responsibilities, is agreed to with the informed consent of the participant, and is signed by all individuals and providers responsible for its implementation.

The opportunity to request a fair hearing is provided to all participants who are subject to an adverse action. Applicants/participants who are denied home and community-based services as an alternative to institutional care, services of their choice, providers of their choice, or whose services are denied, suspended, reduced, or terminated are provided with a Notice of Adverse Action in accordance with Chapter 4 of the Rules and Regulations for Medicaid. The Notice of Adverse Action includes:

-An explanation of the individual’s right to request a hearing, the methods and instructions for requesting a fair hearing;
-A description of the intended adverse action;
-The effective date of the adverse action;
-The reason(s) for the intended action;
-The specific regulations or changes in federal/state law that require the adverse action; and
-Where applicable, an explanation of the circumstances under which benefits may be continued if a hearing is requested pursuant to 42 CFR §431.231.

A copy of the Notice of Adverse Action is maintained in the case management information system as part of the participant's record.

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.

Applicants/participants who disagree with the nursing facility level of care determination made pursuant to the process described in Appendix B-6 may request a fair hearing or may submit a written request for reconsideration to the Division within 30 days of the level of care determination notice. The Division contracts with a Quality Improvement Organization (QIO) to conduct reconsideration reviews of the level of care evaluations performed by the Public Health Nursing County Offices. A registered nurse form the QIO conducts a peer review of the level of care determination to assess whether the Division's tools and policies were applied appropriately. A second level of care evaluation may be conducted or the first evaluation may be sustained as a result of the peer review.

Applicants/participants who choose to request a reconsideration are not denied the right to a fair hearing and may still request a fair hearing upon receiving the results of the reconsideration review. The opportunity to request a fair hearing is provided to all participants who are subject to an adverse action and is not limited to the level of care determination. The notice of adverse action provided to applicants/participants determined not to meet the nursing facility level of care includes an explanation of the additional dispute resolution and fair hearing processes. Applicants/participants are informed that they may request either and that they may still choose to request a fair hearing if they disagree with the results of the additional dispute resolution process.

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:

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).

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).

Critical incidents may be identified and reported by any individual, including: participants; family members, guardians, or friends of a participant; waiver service providers; case managers; federal, state, or local regulatory or law enforcement officials; or any other concerned third parties.

Case managers and waiver service providers must report critical incidents immediately through the Division's web-based reporting system after assuring the health and safety of the participant.

Critical incidents which require review and follow-up action include the following categories:

- Abuse: The intentional or reckless infliction of injury or physical/emotional harm.
  - Physical Abuse
  - Verbal/Emotional Abuse
  - Sexual Abuse
  - Intimidation

- Neglect: The deprivation of, or failure to provide, the minimum food, shelter, clothing, supervision, physical and mental health care, and/or other care and prescribed medication as necessary to maintain the participant’s life or health, or which may result in a life-threatening situation.
  - Self-Neglect
  - Neglect of a participant by a service provider
  - Neglect of a participant by family member of other natural support

- Exploitation: Fraudulent, unauthorized, or improper acts or processes of an individual who uses the resources of the participant for monetary or personal benefit, profit, or gain or that results in depriving the participant of his/her rightful access to, or use of, benefits, resources, belongings, or assets.
  - Financial Exploitation
  - Sexual Exploitation
  - Prescription Drug Theft/Diversion
  - Other Material Exploitation

- Unexpected Death: Death of a participant when not a result of an expected medical prognosis.
  - Death as a result of an unexpected natural cause, illness, or disease
  - Death as a result of neglect
  - Death as a result of trauma inflicted by another person
  - Death as a result of a medication error
  - Death as a result of an accident
  - Suicide
  - Death of an unknown/other cause

Case managers and waiver service providers must report non-critical incidents through the Division's web-based reporting system within one (1) business day after assuring the health and safety of the participant.

- Use of Restraint to include injuries caused by restraints
- Unauthorized Use of Restrictive Interventions
- Any use of seclusion
- Serious injury to the participant
- Elopement
- Medical or behavioral admission and Emergency Room visits while receiving services that are not scheduled medical visits
- All death which does not meet the definition of death as defined under critical incidents

Additionally, the Wyoming Adult Protective Services Act [W.S. §35-20-101, et seq.] requires that, "any person or agency who knows or has reasonable cause to believe that a vulnerable adult is being or has been abused, neglected, exploited, intimidated or abandoned or is committing self neglect shall report the information immediately to a law enforcement agency or the [Department of Family Services]."

Waiver service providers licensed by the Wyoming Department of Health, Aging Division must also report incidents and

occurrences as required by the applicable licensing regulations.

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.

Participants (and/or legal representatives, as appropriate) are provided information concerning protections from abuse, neglect, and exploitation and the process for notifying appropriate authorities when the participant may have experienced abuse, neglect, or exploitation as part of the service plan development processes described in Appendix D-1-d.

Case managers are required to present and explain the participant's rights and responsibilities. The service plan includes documentation of the participant’s understanding of these rights and responsibilities, is agreed to with the informed consent of the participant, and is signed by all individuals and providers responsible for its implementation upon the initial service plan finalization and at least annually thereafter.

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.

The Division begins an investigation of all reported incidents including potential instances of abuse, neglect, exploitation, unexpected death, use of restraint, and/or unauthorized use of restrictive interventions within three business days. The investigation consists of a review of the incident report and other relevant documentation.

For all incidents requiring investigation, the Division reviews the actions taken by the provider agency, case manager, and/or other responsible parties to assure the health and safety of the participant(s) and to determine if those actions constitute an adequate and timely response commensurate with the circumstances of the incident. If those actions are insufficient, the Division requires immediate follow up actions. The Division may conduct those follow up actions directly and/or direct the case manager, provider agency, and/or other responsible parties to conduct additional follow up actions. These actions may include, but are not limited to:

- Notifying the participant’s legally authorized representative;;
- Making appropriate medical or behavioral health referrals;
- Performing an on-site visit;
- Making a referral to law enforcement or regulatory/oversight agency (e.g. Wyoming Department of Family Services, Adult Protective Services, Wyoming Long-Term Care Ombudsman Program, Division of Aging Healthcare Licensing and Surveys, or Wyoming Protection and Advocacy System);
- Making a referral to the Division’s Program Integrity Unit;
- Making a referral to the Wyoming Attorney General’s Office, Medicaid Fraud Control Unit.

Investigations are not considered concluded until all required follow up actions have been taken to reasonably assure the health and safety of the participant(s). The duration of an investigation varies based on circumstances and follow up actions required.The Division monitors required follow up actions as part of the internal investigation process.

A summary of the investigation results and follow up actions taken is provided to the participant(s) (and/or legal representative(s), as appropriate) and other relevant parties.

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.

The Division may share the responsibility for overseeing the response to individual critical incidents or events with other agencies (e.g Adult Protective Services, Law Enforcement agencies, and the Aging Division) depending on the type and circumstances of the incident or event. However, the Division is ultimately responsible for the oversight of critical incidents or events that affect waiver participants.

Data compiled from the Division's web-based reporting system is analyzed to identify potential trends and patterns in the types of incidents, affected participants, service providers, and reporting and follow-up timeliness.

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).

Personal, chemical, and mechanical restraints are permitted in the delivery of assisted living facility services and respite services delivered in an assisted living or nursing care facility.

Restraints must be ordered by a physician and required by the participant's medical symptoms. Assisted living and nursing care facilities may not impose restraints for purposes of discipline or convenience, and must establish resident rights policies which prohibit the use of restraints unless ordered by a physician and required to treat the participant's medical symptoms.

The potential use of restraints must supported by a specific assessed need and justified in the participant's service plan pursuant to 42 CFR §441.301(c). The service plan must:

- Identify a specific and individualized assessed need.
- Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
- 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 a 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 informed consent of the individual.
- Include an assurance that interventions and supports will cause no harm to the individual.

Assisted living and nursing care facilities must comply with all protocols, practices, record keeping and personnel education and training requirements for the application of restraints in accordance with Chapter 12 of the Aging Division Rules for Program Administration of Assisted Living Facilities, Chapter 11 of the Aging Division Rules for Program Administration of Assisted Living Facilities, and 42 CFR §483.12. The Wyoming Department of Health, Aging Division monitors for the unauthorized use or misapplication of restraints as part of the facility survey and licensure processes.

Case managers conduct monthly service plan monitoring activities in order to identify any changes in the participant's condition or circumstances, screen for any potential risks or concerns, assess the participant's (and/or legal representative's, as appropriate) satisfaction with services and supports, evaluate the effectiveness of the service plan in meeting the participant's needs, and to ensure services are delivered in accordance with the service plan. Case managers must report the unauthorized use or misapplication of restraints as critical incident.

Upon initial enrollment of assisted living and nursing care facility providers and periodically thereafter, the Division reviews resident agreements, handbooks, and other provider materials for references to potential use of restraints and restrictive intervention in order to ensure compliance with waiver provider participation standards.

The Long Term Care Ombudsman investigates, advocates, and mediates on behalf of adults applying for or receiving long term care services, to resolve complaints concerning actions or inactions that may adversely affect participant health, safety, welfare or rights. Following an investigation, the ombudsman reports findings and recommendations to the participant or participant's guardian and may report the findings to any other entity deemed appropriate.

Additionally, the Adult Protective Services Act [WS 35-20-101, et seq.] requires that any person or agency who knows or has reasonable cause to believe that a vulnerable adult is being or has been abused neglected, exploited or abandoned or is committing self-neglect shall report the information immediately to a law enforcement agency or the Wyoming Department of Family Services, Adult Protective Services (APS).

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:

The Wyoming Department of Health, Aging Division has the primary oversight responsibility regarding the use of restraints and ensures compliance with the safeguards concerning their use as part of the facility survey and licensure processes. Facility surveys are conducted upon initial licensure, in response to a complaint, and periodically thereafter. Aging Division surveyors inspect the facility, interview facility administrators and personnel, review documents, and undertake other procedures necessary to evaluate the extent to which the facility meets licensure standards and Medicare Conditions of Participation, as applicable. All survey results are submitted to the Division.

Assisted living facilities must document and report all accidents; injuries; incidents; illnesses; and allegations of abuse, neglect, or exploitation to the participant's family or other responsible party. The use of a restraint must be reported as a critical incident. Critical incidents including the use of restraints are analyzed to enable the identification of trends and development of quality improvement strategies as described in Appendix G-1.

The Division does not have the authority to provide oversight of or to impose information sharing requirements on the Adult Protective Services or Long-Term Care Ombudsman programs. However, the Division encourages collaboration and information sharing and intends to use the HCBS Quality Committee as an opportunity to establish formal cooperation and information sharing agreements in the future.

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.

Limitation on the participant's full access to the greater community, privacy, independence in making life choices, freedom to control their own schedules and activities, access to food, or ability to have visitors of their choosing at any time may be permitted in the delivery of assisted living facility services, adult day services (health model), and respite services delivered in an assisted living or nursing care facility.

The use of restrictive interventions must supported by a specific assessed need and justified in the participant's service plan pursuant to 42 CFR §441.301(c). The service plan must:

- Identify a specific and individualized assessed need.
- Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
- 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 a 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 informed consent of the individual.
- Include an assurance that interventions and supports will cause no harm to the individual.

Assisted living, adult day care, and nursing care facilities must comply with all protocols, practices, record keeping and personnel education and training requirements for the application of restrictive interventions in accordance with Chapter 12 of the Aging Division Rules for Program Administration of Assisted Living Facilities, Chapter 7 of the Aging Division Rules for Program Administration of Adult Day Care Facilities, Chapter 11 of the Aging Division Rules for Program Administration of Assisted Living Facilities, and 42 CFR §483.12. The Wyoming Department of Health, Aging Division monitors for the unauthorized use or misapplication of restrictive interventions as part of the facility survey and licensure processes.

When required, restrictive interventions are typically applied on an ongoing basis, e.g., restricted egress in a memory care unit or limited access to food due to prescribed dietary restrictions; therefore, documentation is not required each time a restrictive intervention is applied. Case managers conduct monthly service plan monitoring activities in order to identify any changes in the participant's condition or circumstances, screen for any potential risks or concerns, assess the participant's (and/or legal representative's, as appropriate) satisfaction with services and supports, evaluate the effectiveness of the service plan in meeting the participant's needs, and to ensure services are delivered in accordance with the service plan. Case managers must report the unauthorized use or misapplication of restrictive interventions as critical incident.

The Long Term Care Ombudsman investigates, advocates, and mediates on behalf of adults applying for or receiving long term care services, to resolve complaints concerning actions or inactions that may adversely affect participant health, safety, welfare or rights. Following an investigation, the ombudsman reports findings and recommendations to the participant or participant's guardian and may report the findings to any other entity deemed appropriate.

Additionally, the Adult Protective Services Act [WS 35-20-101, et seq.] requires that any person or agency who knows or has reasonable cause to believe that a vulnerable adult is being or has been abused neglected, exploited or abandoned or is committing self-neglect shall report the information immediately to a law enforcement agency or the Wyoming Department of Family Services, Adult Protective Services (APS).

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:

The Division has the primary oversight responsibility regarding the use of restrictive interventions through its oversight of the service plan development and implementation processes. Case managers monitor the use of restrictive interventions through monthly service plan monitoring activities to ensure services are delivered in accordance with the service plan. The unauthorized use of a restrictive intervention must be reported as a critical incident. Critical incidents including the unauthorized use of a restrictive intervention are analyzed as described in Appendix G-1. The Division is working to modify its case management information system to allow for collection and aggregation of service plan data related to the use and monitoring of restrictive interventions in order to enable the identification of trends and development of quality improvement strategies.

The Wyoming Department of Health, Aging Division also oversees the use of restrictive interventions and ensures compliance with the safeguards concerning their use as part of the facility survey and licensure processes. Facility surveys are conducted upon initial licensure, in response to a complaint, and periodically thereafter. Aging Division surveyors inspect the facility, interview facility administrators and personnel, review documents, and undertake other procedures necessary to evaluate the extent to which the facility meets licensure standards and Medicare Conditions of Participation, as applicable. All survey results are submitted to the Division.

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:

The Wyoming Department of Health, Aging Division has the primary oversight responsibility regarding the unauthorized use of involuntary seclusion as part of the facility survey and licensure processes. Facility surveys are conducted upon initial licensure, in response to a complaint, and periodically thereafter. Aging Division surveyors inspect the facility, interview facility administrators and personnel, review documents, and undertake other procedures necessary to evaluate the extent to which the facility meets licensure standards and Medicare Conditions of Participation, as applicable. All survey results are submitted to the Division.

Case managers conduct monthly service plan monitoring activities in order to identify any changes in the participant's condition or circumstances, screen for any potential risks or concerns, assess the participant's (and/or legal representative's, as appropriate) satisfaction with services and supports, evaluate the effectiveness of the service plan in meeting the participant's needs, and to ensure services are delivered in accordance with the service plan. Case managers must report the unauthorized use of involuntary seclusion as a critical incident.

The Long Term Care Ombudsman investigates, advocates, and mediates on behalf of adults applying for or receiving long term care services, to resolve complaints concerning actions or inactions that may adversely affect resident health, safety, welfare or rights. Following an investigation, the ombudsman reports findings and recommendations to the resident or resident's guardian and may report the findings to any other entity deemed appropriate.

Additionally, the Adult Protective Services Act [WS 35-20-101, et seq.] requires that any person or agency who knows or has reasonable cause to believe that a vulnerable adult is being or has been abused neglected, exploited or abandoned or is committing self-neglect shall report the information immediately to a law enforcement agency or the Wyoming Department of Family Services, Adult Protective Services (APS).

○ **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.

Assisted living facility service providers may manage the medications of participants who have been determined by a physician as incapable of administering their own medications. A registered nurse is required to review the participant's medication regimen every two months, whenever new medication is prescribed, or when a medication is changed.

The registered nurse oversees the participant's medication regimen and the administration of prescribed medications and treatments in accordance with the Wyoming Nurse Practice Act. In order to ensure medications are managed appropriately and to identify and follow up on potentially harmful practices, the registered nurse:

- Accepts responsibility for judgments, individual nursing actions, competence, decisions, and behavior in the course of nursing practice;
- Bases nursing decisions on nursing knowledge, evidence-based practice, skills, standards, and the needs of the participant;
- Participates as a member of the interdisciplinary healthcare team;
- Communicates and consults with other healthcare team members and seeks clarification of orders or direction when needed;
- Conducts a comprehensive assessment;
- Evaluates the participant’s response to nursing care and other therapies;
- Identifies changes in the participant’s health status and comprehends clinical implications of the client’s signs, symptoms, and changes as part of expected or unexpected participant course and emergent situations; and
- Takes preventative measures to protect the participant, others, and self by identifying unsafe care situations and correcting problems or referring problems to appropriate management level when needed.

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.

The Wyoming Department of Health, Aging Division oversees the medication management activities conducted by assisted living facilities and ensures compliance with medication management standards as part of the facility survey and licensure processes. Facility surveys are conducted upon initial licensure, in response to a complaint, and periodically thereafter. Aging Division surveyors inspect the facility, interview facility administrators and personnel, review documents, and undertake other procedures necessary to evaluate the extent to which the facility meets licensure standards. Facility surveys include oversight of the medication management and administration activities and are used to detect potentially harmful practices. The Wyoming Department of Health, Aging Division may take disciplinary action or refuse to issue, renew, relicense, or reinstate a license should an assisted living facility demonstrate non-compliance with its licensure standards. All survey results are submitted to the Division.

The Wyoming State Board of Nursing may take disciplinary action or refuse to issue, renew, relicense, or reinstate a license should the registered nurse fail to meet the standards of the Wyoming Nurse Practice Act in conducting medication management activities.

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).

Waiver service provider personnel who administer medications must be a professional nurse licensed and authorized to do so under the Wyoming Nurse Practice Act. Assisted living facilities, adult day care facilities, nursing care facilities, and home health agencies must comply with all protocols, practices, record keeping, and personnel education and training requirements for the storage and administration of medications in accordance with Chapter 12 of the Aging Division Rules for Program Administration of Assisted Living Facilities, Chapter 7 of the Aging Division Rules for Program Administration of Adult Day Care Facilities, Chapter 11 of the Aging Division Rules for Program Administration of Assisted Living Facilities, and Chapter 9 of the Aging Division Rules for Program Administration of Home Health Agencies.

A registered nurse oversees the participant's medication regimen and the administration of prescribed medications and treatments in accordance with the Wyoming Nurse Practice Act. In order to ensure medications are managed appropriately and to identify and follow up on potentially harmful practices, the registered nurse:

- Accepts responsibility for judgments, individual nursing actions, competence, decisions, and behavior in the course of nursing practice;
- Bases nursing decisions on nursing knowledge, evidence-based practice, skills, standards, and the needs of the participant;
- Participates as a member of the interdisciplinary healthcare team;
- Communicates and consults with other healthcare team members and seeks clarification of orders or direction when needed;
- Conducts a comprehensive assessment;
- Evaluates the participant’s response to nursing care and other therapies;
- Identifies changes in the participant’s health status and comprehends clinical implications of the client’s signs, symptoms, and changes as part of expected or unexpected participant course and emergent situations; and
- Takes preventative measures to protect the participant, others, and self by identifying unsafe care situations and correcting problems or referring problems to appropriate management level when needed.

The medication assistance provided by Certified Nurse Assistants (CNAs) includes “assistance with medications that are ordinarily self-administered and that do not require the skills of a licensed nurse to be provided safely and effectively” as outlined in the §42 CFR 409.45(b)(1)(iii). After delegation by a licensed nursing professional, the CNA may assist the participant with self-administered medications. This assistance is limited to reminding the participant to take medications; removing medication container from storage; assisting with removal of a cap; assisting with the removal of a medication from a container for participants with a disability (i.e., arthritis) which prevents independence in this act; and observing the participant take the medication , opening and pouring premixed unit dose medication into a nebulizer cup when the patient is physically unable to do so, assisting in putting over the counter eye drops in the participant’s eyes, assisting in applying topical ointments to intact skin, assisting with insertion of a rectal suppository.

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:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the state:

◉ **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:

Medication errors resulting in emergency medical treatment and those related to the abuse, neglect, exploitation, or unexpected death of a participant must be reported as an incident.

Waiver service providers must record the following types of medication errors in the medication administration record:
- Incorrect medication administered to participant
- Medication not administered
- Medication not administered timely
- Medication administered in wrong dosage
- Medication administered via wrong route
- Allergic reaction to a medication

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.

The Wyoming Department of Health, Aging Division monitors the performance of waiver providers in the administration of medications as part of the facility/agency survey and licensure processes. Facility/agency surveys are conducted upon initial licensure, in response to a complaint, and periodically thereafter. Aging Division surveyors inspect the facility/agency, interview facility/agency administrators and personnel, review documents, and undertake other procedures necessary to evaluate the extent to which the facility/agency meets licensure standards. All survey results are submitted to the Division.

The Wyoming State Board of Nursing may take disciplinary action or refuse to issue, renew, relicense, or reinstate a license should the nurse or CNA fail to meet the standards of the Wyoming Nurse Practice Act in conducting medication administration/assistance activities.

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.a1 Percentage of participants for which the service plan documents receipt of information and education on how to report abuse, neglect, and exploitation (ANE). Numerator: Number of participants for which the service plan documents receipt of information and education on how to report ANE. Denominator: Total number of participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Management Information System

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.a1.1 Percentage of abuse, neglect, exploitation and unexplained deaths (ANEU) that were reported to the appropriate authority in accordance with Division policy and within the required timeframe. Numerator: Number of ANEU's that were reported and referred to the appropriate authority in accordance with Division policy and within the required timeframe. Denominator: Total number of ANEU's.

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**

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

Performance Measure:
G.a2 Percentage of abuse, neglect, exploitation, and unexplained death (ANEU's) incidents that were reviewed in accordance with Division policy AND within required timeframes. Numerator: Number of ANEU's that were reviewed in accordance with Division policy AND within required timeframes. Denominator: Total number ANEU's.

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.a3 Percentage of critical incident reports submitted by the waiver case manager or provider within the required timeframe of being notified of the incident. Numerator: Number of critical incident reports submitted by the waiver case manager or provider within the required timeframe. Denominator: Total number of critical incident reports submitted by waiver case managers or providers.

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:

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.b1 Percentage of substantiated abuse, neglect, exploitation, unexplained death incidents (ANEUD's) in which required/recommended follow up was completed in accordance with Division policy and within required timeframes. Numerator:Number of ANEUD's where follow up was completed in accordance with Division policy and within required timeframes. Denominator:Total number of substantiated ANEUD's.

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:

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.c1 Percent of critical incidents including use of a restrictive intervention which were determined compliant with state policies procedures. Numerator: Number of critical incidents including use of a restrictive intervention which were determined compliant with state policies and procedures. Denominator: Total number of critical incidents including use of a restrictive intervention.

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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **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.d1 Percentage of service plans that document the provision of education and information on age and gender appropriate preventative healthcare services.
Numerator: Number of service plans that document the provision of education and information on age and gender appropriate preventative healthcare services.
Denominator: Total number of service plans.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case management information system

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.

Individual deficiencies identified through regular monitoring activities or through waiver performance measures are remediated by the Division staff through the provision of technical assistance, the imposition of a corrective action or sanction, referrals to the appropriate regulatory/law enforcement agencies, and/or the suspension or termination of a Medicaid provider agreement.

In accordance with CMS guidance issued March 12, 2014, any performance measure with less than an 86% success rate warrants further analysis to determine the cause. The Division conducts a root cause analysis to identify contributing factors and determine underlying causes of deficiency for any measure with less than an 86% success rate. Based upon the findings of the root cause analysis, the Division may initiate a Quality Improvement Project (QIP). The QIP includes, at minimum:

- A description of remedial actions to be taken (e.g. training, revised policies/procedures, additional staff, different staffing patterns, provider/vendor corrective action);
- A timeline of remedial actions to be taken;
- The individuals responsible for effectuating remedial actions; and,
- The frequency with which performance/compliance is measured.

The HCBS Quality Improvement Committee assures accountability to the Division's stakeholders and provides oversight of quality improvement activities, including regular monitoring of QIP effectiveness.

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:

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

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 Performance Review Committee (PRC) identifies opportunities for system improvement and recommends system design changes to the Division for its consideration and implementation. The PRC meets on a quarterly basis to monitor ongoing discovery and remediation activities, critical incident trends, participant experience/quality of life survey data, and progress reports on existing quality improvement projects and system improvement initiatives.

In prioritizing system improvements, the PRC and the Division may consider the frequency, likelihood, and potential consequences of deficiencies; data on past performance in relation to performance indicators; external drivers (e.g. federal/state policy priorities and regulatory compliance standards); and/or stakeholder input. The PRC and the Division may also use brainstorming, the nominal group technique, Healthcare Failure Mode and Effects Analyses (HFMEAs), prioritization matrices, or other decision-making methods and tools to establish system improvement priorities. The PRC and the Division research best practices using credible sources (e.g. the National Quality Forum and the Agency for Healthcare Research and Quality) to identify and establish quality benchmarks and key performance indicators.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Quality Improvement Committee**	☐ **Annually**
☐ **Other** Specify:	☐ **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.

The primary functions of the PRC are to assure accountability to the Division's stakeholders and to monitor system design change progress and effectiveness. Quarterly progress reports on the recently concluded and ongoing quality improvement projects and system improvement initiatives are provided to the PRC. Additionally, the effectiveness of system improvement initiatives is measured using data reports and trends in comparison with the established quality benchmarks and key performance indicators. PRC quarterly meeting summaries and materials are available to the public through the Division's website.

The PRC membership currently includes Division staff responsible for waiver program management, waiver program evaluation and quality improvement, and waiver provider licensure/certification. The Division intends to extend an invitation for membership to include representatives from the Aging Division, the Wyoming Department of Family Services, the State Council on Developmental Disabilities, the State Protection and Advocacy System, the University Center for Excellence in Developmental Disabilities, and other interested stakeholder groups in the future.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The PRC and Division evaluate the Quality Improvement Strategy at least every five years in coordination with the evidentiary report development and in preparation for the waiver renewal application. Evaluation of the Quality Improvement Strategy includes a review of:

• The measures and processes used to determine that each waiver assurance is met during the period that the waiver is in effect (discovery);
• The measures and processes employed to correct identified problems (remediation);
• The roles and responsibilities of the parties involved in measuring performance and making improvements;
• The processes employed to aggregate and analyze trends in the identification and remediation of problems;
• The processes employed to establish priorities, develop strategies for, and assess implementation of system improvements (system improvement);
• The process and timelines for compiling the information and communicating to waiver participants, families, service providers, other interested parties, and the public;
• The frequency and processes used to evaluate and revise the QIS; and
• How and by whom information about performance is used to identify and prioritize areas for system improvement;

Performance measures are also reviewed annually for face validity and reliability as part of the CMS 372 Report generation and submission. Waiver amendments are submitted during the waiver period to update performance measures and to modify the Quality Improvement Strategy as necessary.

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) Pursuant to 2 CFR §200.502(i), Medicaid payments to a sub-recipient for providing patient care services to Medicaid-eligible individuals are not considered federal awards unless a state requires the funds to be treated as awards expended because reimbursement is made on a cost-reimbursement basis. Waiver service providers are reimbursed on a fee-for-service basis according to a standard fee schedule and are therefore not subject to an independent audit.

(b) All claims for reimbursement are submitted to the Medicaid Management Information System (MMIS) for processing. The MMIS is designed to meet federal certification requirements for claims processing, and submitted claims are adjudicated against MMIS edits prior to payment. Providers must maintain records which document the services provided and substantiate the claims submitted for reimbursement for a minimum of six years. Records must be maintained longer than six years as necessary to resolve any pending matters such as an ongoing audit or litigation.

The Division's Program Integrity Unit conducts scheduled and unscheduled post-payment audits on continuous and ongoing basis. Audits may consist of a desk and/or on-site review of provider records to evaluate veracity and integrity of the provider claims for reimbursement. A statistically valid, random sampling methodology (95% confidence interval with +/- 5% margin of error) is used to identify the scope of any given audit. Audits may be focused on a specific service provider or on a broader group of service providers within an enrollment taxonomy/type prioritized by the Program Integrity Unit for review. Providers and/or claims may also be selected for an audit when identified as a statistical outlier.

At the conclusion of an audit conducted by the Program Integrity Unit, there may be up to three (concurrent) outcomes. All outcomes are communicated to the providers via certified mail (as outlined in Chapter 16 of the Rules and Regulations for Medicaid).

1) A final audit report will be issued to the provider, this report will list all findings and requirements for the provider to develop a corrective action plan or quality improvement plan. These corrective action or quality improvement plans are reviewed and approved by the Program Integrity Unit and compliance is monitored at three and six months post implementation.

2) There may be monetary findings which result in the initiation of the overpayment recovery process. Overpayments are recovered by the Division's Program Integrity Unit. Providers may return overpayments in full by check or by entering into a legally binding payment plan agreement in order to return overpayments in installment payments according to the timeline and terms established by that agreement. The Division may also use the MMIS to impose a credit balance on the provider's account and deduct all or a portion of the provider's future claims until the overpayments have been fully recovered. Federal Financial Participation (FFP) reimbursement and accounting is managed by the Program Integrity Unit in collaboration with the Wyoming Department of Health, Fiscal Services Unit. The Program Integrity Unit uses the Division's Fraud, Waste, and Abuse information system to track identified overpayments, join them with MMIS claims data, and calculate the associated FFP amounts. The Program Integrity Unit shares this information with the Fiscal Services Unit which then reduces the FFP received by the Division through a CMS 64 Report adjustment in order to refund the federal share of overpayments.

3) A law enforcement referral may be made to the Medicaid Fraud Control Unit or other law enforcement agency. Each of these outcomes are monitored by the Program Integrity Unit.

Claims submitted for reimbursement of services delivered under the participant-directed service delivery option are subject to the same auditing standards as those delivered under the agency-based service delivery option.

The Division has implemented an EVV solution for participant-directed personal support services. However, an EVV system has not yet been implemented for agency-based personal care services as required by the 21st Century Cures Act. The Division has applied for and was granted a Good Faith Effort extension in November of 2019. The EVV solution has been procured and expected to be operational in October of 2021. Community Choices Waiver services which will be subject to EVV requirements include:
- Personal Support Services
- Home Health Aide
- Skilled Nursing
- Respite (In-Home)

(c) The Wyoming State Auditor's Office is responsible for conducting the single statewide audit under the provisions of the Single Audit Act.

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.a1 Percent of claim lines reimbursed within prior authorization unit limits. Numerator: Number of claim lines reimbursed within prior authorization limits. Denominator: Total number of claim lines.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Medicaid Management Information System (MMIS)

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.a2 Percent of claim lines reimbursed using the correct code as specified in the provider manual. Numerator: Number of claim lines reimbursed using the correct code. Denominator: Total number of claim lines.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:

Medicaid Management Information System (MMIS)

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.a3 Percentage of Beneficiary Verification (BV) letters for waiver services referred to the Division which were investigated according to Division procedures. Numerator: Number of BV letters for waiver services referred which were investigated according to Division procedures. Denominator: Total number of BV letters for waiver services referred.

Data Source *(Select one):*
Record reviews, off-site
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:
I.a4 Percentage of monthly service plan monitoring records that include the case manager's confirmation that services were rendered according to the service plan. Numerator: Number of monthly service plan monitoring records that include the case manager's confirmation that services were rendered according to the service plan. Denominator: Total number of monthly service plan monitoring records.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Case management information system data

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*** *Specify:*

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*

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.b1 Percent of claim lines reimbursed at or below the maximum allowable rate for that service, as specified in the established fee schedule. Numerator: Number of claim lines reimbursed at or below the maximum allowable rate for that service, as specified in the established fee schedule. Denominator: Total number of claim lines reimbursed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Medicaid Management Information System (MMIS)

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.*

Upon full implementation of its Electronic Visit Verification (EVV) systems, the Division will consider adding a performance measure to sub-assurance (a) in order to provide additional assurance that the personal care services reimbursed were actually rendered.

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.*

Individual deficiencies identified through regular monitoring activities or through waiver performance measures are remediated by the Division staff through the provision of technical assistance, the imposition of a corrective action or sanction, referrals to the appropriate regulatory/law enforcement agencies, and/or the suspension or termination of a Medicaid provider agreement.

In accordance with CMS guidance issued March 12, 2014, any performance measure with less than an 86% success rate warrants further analysis to determine the cause. The Division conducts a root cause analysis to identify contributing factors and determine underlying causes of deficiency for any measure with less than an 86% success rate. Based upon the findings of the root cause analysis, the Division may initiate a Quality Improvement Project (QIP). The QIP includes, at minimum:

- A description of remedial actions to be taken (e.g. training, revised policies/procedures, additional staff, different staffing patterns, provider/vendor corrective action);
- A timeline of remedial actions to be taken;
- The individuals responsible for effectuating remedial actions; and,
- The frequency with which performance/compliance is measured.

The HCBS Quality Improvement Committee assures accountability to the Division's stakeholders and provides oversight of quality improvement activities, including regular monitoring of QIP effectiveness.

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).*

The Division uses a prospective, fee-for-service reimbursement structure for all Community Choices Waiver services. That is, the maximum reimbursement amounts for waiver services are established by the Division prior to service delivery, and each service is reimbursed separately according to the Division's established fee schedule. The Community Choices Waiver fee schedule is posted publicly on the Division's website at: https://health.wyo.gov/healthcarefin/hcbs/servicesandrates.

A cost-informed rate determination methodology is utilized to recognize reasonable and necessary provider costs and to reflect participant needs and the scope of the covered service. Additionally, the Division's rate determination methods are intended to be consistent with the efficiency, economy, and quality of care; be sufficient to enlist enough providers so that services under the waiver are available to participants at least to the extent that those services are available to the general population; minimize the provider reporting and survey burden; and increase transparency in the rate setting process. The Division's rate-setting methods for participant-directed services do not differ from the methods used to determine agency-based service rates, and service rates do not differ by provider or geographic region.

The Division's rate model employs an independent cost factor build-up approach to establish rates for the following waiver services:

- Adult Day Services
- Case Management
- Home Health Aide
- Personal Support Services
- Respite (In-Home and Assisted Living Facility)
- Skilled Nursing
- Assisted Living Facility Services
- Home-Delivered Meals (Hot)
- Non-Medical Transportation (Per Trip)

The Case Management – Certificate rate includes a 5% incentive above the base rate to account for the expertise the case manager gains by completing the Division sponsored training that addresses person-centered planning and case management best practices.

The independent cost factor build-up approach identifies and calculates the direct and indirect cost factors associated with the provision of these services. To estimate cost factors, credible sources such as the United States Bureau of Labor Statistics wage data and consumer price/producer indices are relied upon to the maximum extent possible. The Division's rate model combines the estimated cost factors to calculate the maximum allowable reimbursement rate for each waiver service.

The Division's rate model employs a market rates approach for the following waiver services:

- Home-Delivered Meals (Frozen)
- Personal Emergency Response Systems
- Non-Medical Transportation (Multipass)
- Transition Setup
- Environmental Modification Services

For these commodity-like services which do not rely on participant interaction with a direct caregiver, the Division's rate model relies on data from a market survey to determine a maximum allowable reimbursement rate for the service when the market has already determined the rate.

In accordance with 42 CFR §441.310(a)(2), the Division's rate setting methodology for assisted living facility services excludes costs for room and board. Waiver participants are responsible for reimbursing assisted living facilities for room and board costs pursuant to the provisions of the participant's lease or similarly enforceable residential agreement. Rates for respite services delivered in an assisted living facility were determined by adding a daily allowance for room and board to the standard rates for assisted living facility services. The daily room and board allowance was calculated by dividing the monthly Social Security Income Federal Benefit Rate (less a $50.00 personal needs allowance) by 30.42. Rates for respite services delivered in a nursing care facility were determined using a statewide weighted average of daily reimbursements for nursing facility services as of January 1, 2020.

The Division had not conducted a comprehensive review of or rebased Community Choices Waiver service rates since the program was last renewed in 2016. In preparation for Community Choices Waiver program renewal, the Division retained the services of Guidehouse Consulting, Inc. to assist the Division in the reexamination of its rate determination methods and to facilitate a stakeholder engagement and public input process. Beginning in January 2020, Guidehouse provided expert research and consulting services to:

- Identify the potential cost factors and research credible data sources to estimate those cost factors;
- Determine those cost factors for which the provider survey is the most reliable/credible data source;
- Design and administer a provider survey;
- Incorporate cost factor research into a standard rate model;
- Facilitate advisory group meetings; and
- Summarize its findings in a rate study report.

An advisory group of waiver service providers from various geographic regions, service types, and agency sizes was convened in order to solicit feedback from a broad provider perspective. The group met regularly from March through October of 2020 and was used as a secondary data source to gather information on cost factors which cannot be determined using standard research methods, to validate rate model assumptions, to advise the Division on the necessary provider cost factors, and to recommend reimbursement policies which are consistent with typical practice and do not pose unnecessary obstacles to achieving the stated purpose of the waiver service.

In August 2020, all current and prospective waiver service providers were invited to participate in a cost survey to gather information regarding provider costs for delivering waiver services. The data from the cost survey was used as a primary data source to estimate certain cost factors and as a secondary source to validate other cost factor estimates determined through other data sources.

Also in August 2020, the Governor's Office and the Wyoming Department of Health announced difficult budget reduction actions necessary to respond to historic declines in state revenues. Reimbursement rates for most Medicaid services were reduced by 2.5%. The Governor's supplemental budget proposal submitted to the Wyoming Legislature in November 2020 also included an additional 2.5% reduction in those Medicaid service rates. In recognition of pending rate study results and to ensure continuity of care and access to critical community-based services, Community Choices Waiver service reimbursement rates were initially excluded from those budget reduction actions.

The rate study was completed and the summary report was finalized in November 2020. The Division accepts the report findings as a credible estimation of reimbursement rates which assure that its payments for services are consistent with the efficiency, economy, and quality of care and that those payments are sufficient to enlist enough providers so that waiver services are available to participants at least to the extent that those services are available to the general population. Therefore, the Division determined that the rates recommended by the Guidehouse report would be used as the basis for Community Choices Waiver rate rebasing. However, those services recommended by the study to receive significant increases were reduced by 5% in support of the Division's responsibility to deliver on its budget reduction obligations. Those services recommended by the study to receive a reduction or modest increase were not adjusted to include the 5% reduction.

The waiver's rate determination methods and the rebased maximum allowable reimbursement rates are effective upon the waiver program's renewal on July 1, 2021. Additional public input on the rate setting methods was obtained through the waiver renewal application process as described in Item 6-I of this application, and notice of significant changes to the Division's methods and standards for setting payment rates was given on February 28, 2021 in accordance with 42 CFR §447.205.

In June - August 2022, the Division contracted with Guidehouse to assist with determining reimbursement rates for five new services. Two of the new services, Transition Setup and Environmental Modification Services, align with the market rates approach described above. The Division's rate determination approach for the remaining three services relied upon aligning new services with similar, existing services for the following waiver services:
- Homemaker Services
- Case Management Services - Transition Intensive Case Management
- Independent Living Support (ILS)

The rates for Homemaker Services and Independent Living Support were determined by aligning with similar services (i.e., homemaker rate and individual habilitation training respectively) within the existing Comprehensive and Supports waivers due to similarities in service definitions and provider expectations. The existing Comprehensive and Supports waiver rates had been recently reviewed and updated in a SFY2023 Rate Study. The rate for Case Management Services - Transition Intensive Case Management was determined by aligning with CCW's existing case management rate due to similarities in service definitions and provider expectations, which was recently reviewed as part of a SFY2022 Rate Study.

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:*

Waiver services delivered under the participant-directed service delivery option are approved by the participant/designated employer of record and submitted to the Division's contracted Financial Management Services (FMS) agency for reimbursement. The FMS agency conducts payroll activities as described in Appendix E of this waiver application and submits claims for reimbursement directly to the Division's Medicaid Management Information System (MMIS).

For all other waiver services, claims for reimbursement are submitted by the service provider directly to the MMIS and are not routed through any other intermediary entity.

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 waiver services must be included in the participant's service plan. Participant service plans are maintained in the Division's case management information system which exchanges data with the Medicaid Management Information System (MMIS). The MMIS edits the service plan data for participant Medicaid eligibility, waiver program enrollment status, maximum allowable reimbursement rates, service provider enrollment status, and any other service line authorization edits and generates a prior authorization file. Once approved, service prior authorization data is transmitted from the MMIS to the Division's case management information system to confirm prior authorization of services included in the participant service plan. Providers are notified of waiver service prior authorization via an online provider portal and/or by mail.

All provider claims for reimbursement are submitted to the MMIS for processing. The MMIS is designed to meet federal certification requirements for claims processing, and submitted claims are adjudicated against MMIS edits prior to payment.

(a) An MMIS edit ensures that the waiver participant is eligible for Medicaid for the date(s) of service included on the claim. Claims submitted on behalf of individuals ineligible for Medicaid are denied.

(b) The MMIS validates the prior authorization of submitted claims. Claims for services submitted without prior authorization are denied.

(c) Providers must attest to the veracity of claims submitted for Medicaid reimbursement. Waiver services are subject to the same audit and post payment review activities as any other Medicaid service, and the accuracy of claim information is verified via the post payment audit processes described in Appendix I-1. These processes meet the program integrity standards established by 42 CFR §455, et seq., including the beneficiary verification procedures described at 42 CFR §455.20.

The Division's Fiscal Agent sends beneficiary verification letters to a sample of Medicaid members on a monthly basis. These letters request that the member review the services described on the letter and verify they were actually received by the member. The Fiscal Agent requests documentation from providers of those services identified by the member as not received. For those services which cannot be verified by provider documentation, the Fiscal Agent makes a referral to Division staff for further investigation. Division staff review the information provided and may contact the member and/or provider for more information. Those services which cannot be verified following Division staff review are referred to the Program Integrity Unit for potential recovery of overpayments.

Overpayments are recovered by the Division's Program Integrity Unit. Providers may return overpayments in full by check or by entering into a legally binding payment plan agreement in order to return overpayments in installment payments according to the timeline and terms established by that agreement. The Division may also use the MMIS to impose a credit balance on the provider's account and deduct all or a portion of the provider's future claims until the overpayments have been fully recovered. Federal Financial Participation (FFP) reimbursement and accounting is managed by the Program Integrity Unit in collaboration with the Wyoming Department of Health, Fiscal Services Unit.

The Program Integrity Unit uses the Division's Fraud, Waste, and Abuse information system to track identified overpayments, join them with MMIS claims data, and calculate the associated FFP amounts. The Program Integrity Unit shares this information with the Fiscal Services Unit which then reduces the FFP received by the Division through a CMS 64 Report adjustment in order to refund the federal share of overpayments.

In accordance with the provisions of the 21st Century Cures Act, Electronic Visit Verification (EVV) is required for personal support services to ensure payments are made only for services rendered.

Case managers must also conduct monthly service plan monitoring activities to ensure all services are delivered in accordance with the service plan. Monthly service plan monitoring activities are documented in the Division's case management information system. Service utilization data is available in the Division's case management information system as claims are submitted and reimbursed. Case managers monitor service utilization data and compare against the authorized amounts to identify any potential problems with service access or delivery and may follow up with service providers as necessary to support service plan implementation.

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.***
- [x] ***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:

County Public Health Nursing Agencies may be enrolled and reimbursed as a provider of any waiver service for which that agency is willing and qualified pursuant to the standards and processes detailed in Appendix C of this waiver application.

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:

- (●) ***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:*

The Division's rate setting methodology for assisted living facility services excludes costs for room and board. Waiver participants are responsible for reimbursing assisted living facilities for room and board costs pursuant to the provisions of the participant's lease or similarly enforceable residential agreement.

Reimbursement for respite services provided on a temporary basis in an approved assisted living or nursing care facility include costs for room and board in accordance with 42 CFR §441.310(a)(2).

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

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	11894.84	6206.79	18101.63	43118.36	1829.77	44948.13	26846.50
2	12107.71	6355.75	18463.46	43983.26	1862.66	45845.92	27382.46
3	12332.50	6508.29	18840.79	44867.06	1896.20	46763.26	27922.47
4	13986.43	6664.49	20650.92	45770.18	1930.41	47700.59	27049.67
5	14352.10	6824.44	21176.54	46693.07	1965.30	48658.37	27481.83

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:	
		Nursing Facility	
Year 1	3271		3271
Year 2	3464		3464
Year 3	3669		3669
Year 4	3886		3886
Year 5	4116		4116

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.*

To derive its Average Length of Stay (ALOS) estimates, the Division examined annual CMS 372(S) report data, reviewed its overall enrollment growth estimates, and calculated and analyzed the average annual growth rates for the unduplicated participant count and the total days of enrollment. The Division also considered historical program changes (i.e. elimination of the waiting list and the program's merger with the Assisted Living Facility (ALF) waiver program) as well as other external factors (e.g. the termination of the PACE program).

The Division chose the average annual ALOS growth rate (1.49%) as the basis for the ALOS growth trend. However, the Division reduced that figure by 0.5% in consideration of the asymptotic nature of that line as it approaches the 365 day limit. To forecast the ALOS for each waiver year, the Division used the standard linear regression function and applied its selected annual growth trend (.99%) to the ALOS data/estimate for the previous year.

As enrollment trends and data stabilize, the Division will monitor the actual ALOS. In future forecasts, the Division will likely adapt its ALOS derivation methods to independently forecast the total days of enrollment and then divide by the estimated unduplicated participant count.

Data source: The Division has developed a custom CMS 372(s) report template using IBM Cognos Analytics software. The report template extracts Medicaid Management Information System (MMIS) claims and enrollment data, compiles the data into the standard CMS 372(S) financial report format, can be easily adapted for ad-hoc reporting or custom reporting periods, and is updated regularly to incorporate program modifications (e.g. changes in covered services, procedure coding, or units of reimbursement). The Division used annual CMS 372(S) report data for the four state fiscal years ending June 30, 2020 as the basis for these estimates. However, the data used to in the derivation of these estimates differs from the data submitted through the annual CMS 372(S) lag reporting process in order to adjust for and incorporate historical program changes (e.g. the merger of the Long-Term Care and Assisted Living Facility waiver programs).

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:*

To inform the Division's estimates for the service utilization and cost factors associated with each waiver service, the Division examined historical growth rates, the proportion of the total waiver population that utilized each service, graphical trends, and other relevant data sources (e.g. as the utilization rates of comparable services in other states). Once the historical data was analyzed, the Division selected trend factors to independently forecast the number of users, the number of units per user, and the average cost per unit for each service. These forecasted factors were then multiplied together to calculate the total estimated expenditures for each service. The total expenditures for each service were added and then divided by the forecasted unduplicated participant count to derive the Factor D estimates.

The average annual growth rate for the four fiscal years ending June 30, 2020 was generally used as the basis for trending the number of users and units per user. For services with a single, fixed reimbursement rate, the Division generally selected a 0% growth trend as the reimbursement rates for this waiver were rebased in preparation for this renewal application and are not expected to change in the five year waiver period. A weighted average was used to estimate the cost per unit for services reimbursed using a variable reimbursement rate, e.g. skilled nursing services. The weighted average is based upon the expected mix of payment rates in accordance with the HCBS Technical Guide instructions for item J-2-c-i. When the average annual growth rate was unavailable or determined to be an unreliable indicator of future growth, the Division selected an alternative data source to predict the growth trend. The alternative data sources vary based upon the availability of data, nature of the service, or the specific circumstances which make the average annual growth rate an unreliable predictor.

Data source: The Division has developed a custom CMS 372(s) report template using IBM Cognos Analytics software. The report template extracts Medicaid Management Information System (MMIS) claims and enrollment data, compiles the data into the standard CMS 372(S) financial report format, can be easily adapted for ad-hoc reporting or custom reporting periods, and is updated regularly to incorporate program modifications (e.g. changes in covered services, procedure coding, or units of reimbursement). The Division used annual CMS 372(S) reports for the four state fiscal years ending June 30, 2020 as the primary data source for these estimates. However, the data used to calculate these estimates differs from the data submitted through the annual CMS 372(S) lag reporting process in order to adjust for and incorporate historical program changes.

DHCF identified case manager training as an area of focus for American Rescue Plan Act (ARPA), Section 9817 funding. DHCF will have an interagency agreement with the state UCEDD to develop and deliver this training. The Case Management – Certificate service utilization has been projected for Waiver Years 4 - 5 based on the timelines identified in this agreement, including the time needed to develop the training, the number of months it will take the case manager to complete the training, and number of case managers that are expected to take the training based on the current interest and historical participation in DHCF sponsored trainings. The projections also account for case managers billing for the typical and certificate level services in the same waiver year.

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:*

To inform the its estimates for Factor D', the Division analyzed historical growth rates of non-waiver Medicaid costs using CMS 372(S) Report data for the four state fiscal years ending June 30, 2020. The Division's forecast model independently forecasts the unduplicated waiver participant count and their associated non-waiver service costs for each waiver year. The Division selected an annual growth trend equal to the Medical Care Services Consumer Price Index (4.9%) as of September 2020 less 2.5% to account for rate reductions necessitated by state budget shortfall projections and implemented in August 2020.

In order to control for participant the growth which is expected to outpace the forecasted non-waiver service cost growth, the Factor D' estimates were not derived by dividing the forecasted non-waiver service costs by the forecasted number of unduplicated participants. Instead, the Division applied its selected annual growth trend (2.4%) to the data or estimates from the previous year using the standard linear regression function. Factor D' estimates do not include costs for prescribed drugs furnished to those waiver participants dually eligible for Medicare and Medicaid.

Data source: The Division has developed a custom CMS 372(s) report template using IBM Cognos Analytics software. The report template extracts Medicaid Management Information System (MMIS) claims and enrollment data, compiles the data into the standard CMS 372(S) financial report format, can be easily adapted for ad-hoc reporting or custom reporting periods, and is updated regularly to incorporate program modifications (e.g. changes in covered services, procedure coding, or units of reimbursement). The Division used annual CMS 372(S) reports for the four state fiscal years ending June 30, 2020 as the primary data source for these estimates. However, the data used to calculate these estimates differs from the data submitted through the annual CMS 372(S) lag reporting process in order to adjust for and incorporate historical program changes.

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:*

To inform the its estimates for Factor G, the Division analyzed historical growth rates of institutional costs for nursing facility residents using CMS 372(S) Report data for the four state fiscal years ending June 30, 2020. To forecast the total annual institutional costs, the Division selected an annual growth trend equal to the average annual growth rate for the four state fiscal years ending June 30, 2020 less 2.5% in order to account for rate reductions necessitated by state budget shortfall projections and implemented in August 2020. The Division selected an annual growth trend equal to the average annual growth rate for the three state fiscal years ending June 30, 2019 and removed state fiscal year 2020 as an outlier to forecast the total unduplicated number of nursing facility residents.

To calculate these estimates, the Division's selected growth trends were applied to the data or estimates from the previous year using the standard linear regression function. The total estimated institutional costs were then divided by the estimated number of unduplicated nursing facility residents to derive Factor G estimates.

Data source: The Division has developed a custom CMS 372(s) report template using IBM Cognos Analytics software. The report template extracts Medicaid Management Information System (MMIS) claims and enrollment data, compiles the data into the standard CMS 372(S) financial report format, can be easily adapted for ad-hoc reporting or custom reporting periods, and is updated regularly to incorporate program modifications (e.g. changes in covered services, procedure coding, or units of reimbursement). The Division used annual CMS 372(S) reports for the four state fiscal years ending June 30, 2020 as the primary data source for these estimates. However, the data used to calculate these estimates differs from the data submitted through the annual CMS 372(S) lag reporting process in order to adjust for and incorporate historical program changes.

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:*

To inform the its estimates for Factor G', the Division analyzed historical growth rates of non-institutional costs for nursing facility residents using CMS 372(S) Report data for the four state fiscal years ending June 30, 2020. To forecast the total annual non-institutional costs, the Division selected an annual growth trend equal to the Medical Care Services Consumer Price Index as of September 2020 (4.9%) less 2.5% in order to account for rate reductions necessitated by state budget shortfall projections and implemented in August 2020. The Division selected an annual growth trend equal to the average annual growth rate for the three state fiscal years ending June 30, 2019 and removed state fiscal year 2020 as an outlier to forecast the total unduplicated number of nursing facility residents.

To calculate these estimates, the Division's selected growth trends were applied to the data or estimates from the previous year using the standard linear regression function. The total estimated non-institutional costs were then divided by the estimated number of unduplicated nursing facility residents to derive Factor G' estimates. Factor G' estimates do not include costs for prescribed drugs furnished to those waiver participants dually eligible for Medicare and Medicaid.

Data source: The Division has developed a custom CMS 372(S) report template using IBM Cognos Analytics software. The report template extracts Medicaid Management Information System (MMIS) claims and enrollment data, compiles the data into the standard CMS 372(S) financial report format, can be easily adapted for ad-hoc reporting or custom reporting periods, and is updated regularly to incorporate program modifications (e.g. changes in covered services, procedure coding, or units of reimbursement). The Division used annual CMS 372(S) reports for the four state fiscal years ending June 30, 2020 as the primary data source for these estimates. However, the data used to calculate these estimates differs from the data submitted through the annual CMS 372(S) lag reporting process in order to adjust for and incorporate historical program changes.

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	
Homemaker	
Personal Support Services	
Respite	
Home Health Aide	
Skilled Nursing	
Assisted Living Facility Services	
Environmental Modification	
Home-Delivered Meals	
Independent Living Support	
Non-Medical Transportation	
Personal Emergency Response Systems (PERS)	
Transition Intensive Case Management	
Transition Setup	

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:						46318.72
Adult Day Services	1 Half-Day	14	103.39	32.00	46318.72	
Case Management Total:						6569999.76
Service Plan Development/Annual Update	Per Initial Plan/Annual	3271	1.00	507.81	1661046.51	
Monitoring	1 Month	3271	11.25	133.40	4908953.25	
Case Management - Certificate	1 Month	0	0.00	0.01	0.00	
Homemaker Total:						0.00
Homemaker	15 Minutes	0	0.00	0.01	0.00	
Personal Support Services Total:						10693423.76
Participant-Directed	15 Minutes	663	4096.15	3.80	10319840.31	
Agency-Based	15 Minutes	294	150.20	8.46	373583.45	
Respite Total:						104302.72
In-Home	15 Minutes	18	358.88	10.36	66923.94	
Facility-Based	1 Day	12	18.39	169.38	37378.78	
Home Health Aide Total:						7307435.74
Home Health Aide	15 Minutes	1174	600.81	10.36	7307435.74	
Skilled Nursing Total:						2670383.61
Skilled Nursing	15 Minutes	971	106.76	25.76	2670383.61	
Assisted Living Facility Services Total:						6625847.46
Assisted Living Facility Services	1 Day	397	283.31	58.91	6625847.46	
Environmental Modification Total:						0.00
Environmental					0.00	

GRAND TOTAL:	38908028.62
Total Estimated Unduplicated Participants:	3271
Factor D (Divide total by number of participants):	11894.84
Average Length of Stay on the Waiver:	306

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Modification (New)	Event	0	0.00	0.01		
Environmental Modification (Repair)	Event	0	0.00	0.01	0.00	
Home-Delivered Meals Total:						4012821.69
Home-Delivered Meals	1 Meal	2171	310.13	5.96	4012821.69	
Independent Living Support Total:						0.00
Independent Living Support	15 Minutes	0	0.00	0.01	0.00	
Non-Medical Transportation Total:						131494.14
Multipass	Per Purchase	39	6.00	45.00	10530.00	
Per Trip	1 Trip (One-Way)	316	72.09	5.31	120964.14	
Personal Emergency Response Systems (PERS) Total:						746001.02
Installation	1 Installation	463	1.00	63.41	29358.83	
Monitoring	1 Month	2046	9.50	36.87	716642.19	
Transition Intensive Case Management Total:						0.00
Transition Intensive Case Management	15 Minutes	0	0.00	0.01	0.00	
Transition Intensive Case Management - Certificate	15 Minutes	0	0.00	0.01	0.00	
Transition Setup Total:						0.00
Transition Setup	Event	0	0.00	0.01	0.00	
				GRAND TOTAL:		38908028.62
				Total Estimated Unduplicated Participants:		3271
				Factor D (Divide total by number of participants):		11894.84
				Average Length of Stay on the Waiver:		306

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:						85359.06
Adult Day Services	1 Half-Day	24	119.15	29.85	85359.06	
Case Management Total:						6957651.84
Service Plan Development/Annual Update	Per Initial Plan/Annual	3464	1.00	507.81	1759053.84	
Monitoring	1 Month	3464	11.25	133.40	5198598.00	
Case Management - Certificate	1 Month	0	0.00	0.01	0.00	
Homemaker Total:						0.00
Homemaker	15 Minutes	0	0.00	0.01	0.00	
Personal Support Services Total:						11348688.39
Participant-Directed	15 Minutes	667	4315.70	3.80	10938573.22	
Agency-Based	15 Minutes	303	159.99	8.46	410115.17	
Respite Total:						152335.95
In-Home	15 Minutes	19	362.47	10.36	71348.59	
Facility-Based	1 Day	26	18.39	169.38	80987.35	
Home Health Aide Total:						8022157.22
Home Health Aide	15 Minutes	1210	639.95	10.36	8022157.22	
Skilled Nursing Total:						2927389.55
Skilled Nursing	15 Minutes	1028	110.89	25.68	2927389.55	
Assisted Living Facility Services Total:						7214204.61
Assisted Living Facility Services	1 Day	418	292.97	58.91	7214204.61	
Environmental Modification Total:						0.00
Environmental Modification (New)	Event	0	0.00	0.01	0.00	
Environmental Modification (Repair)	Event	0	0.00	0.01	0.00	
Home-Delivered Meals Total:						4293301.97
Home-Delivered					4293301.97	

GRAND TOTAL:	41941113.70
Total Estimated Unduplicated Participants:	3464
Factor D (Divide total by number of participants):	12107.71
Average Length of Stay on the Waiver:	310

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Meals	1 Meal	2292	314.29	5.96		
Independent Living Support Total:						0.00
Independent Living Support	15 Minutes	0	0.00	0.01	0.00	
Non-Medical Transportation Total:						135743.76
Multipass	Per Purchase	41	6.00	45.00	11070.00	
Per Trip	1 Trip (One-Way)	295	79.59	5.31	124673.76	
Personal Emergency Response Systems (PERS) Total:						804281.37
Installation	1 Installation	473	1.00	63.41	29992.93	
Monitoring	1 Month	2165	9.70	36.87	774288.44	
Transition Intensive Case Management Total:						0.00
Transition Intensive Case Management	15 Minutes	0	0.00	0.01	0.00	
Transition Intensive Case Management - Certificate	15 Minutes	0	0.00	0.01	0.00	
Transition Setup Total:						0.00
Transition Setup	Event	0	0.00	0.01	0.00	
				GRAND TOTAL:		41941113.70
				Total Estimated Unduplicated Participants:		3464
				Factor D (Divide total by number of participants):		12107.71
				Average Length of Stay on the Waiver:		310

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:						161009.71
Adult Day Services	1 Half-Day	41	137.31	28.60	161009.71	
Case Management Total:						7369406.64
Service Plan Development/Annual Update	Per Initial Plan/Annual	3669	1.00	507.81	1863154.89	
Monitoring	1 Month	3669	11.25	133.40	5506251.75	
Case Management - Certificate	1 Month	0	11.25	203.17	0.00	
Homemaker Total:						0.00
Homemaker	15 Minutes	0	440.50	6.49	0.00	
Personal Support Services Total:						12043792.20
Participant-Directed	15 Minutes	671	4547.02	3.80	11593991.60	
Agency-Based	15 Minutes	312	170.41	8.46	449800.60	
Respite Total:						203564.67
In-Home	15 Minutes	20	366.09	10.36	75853.85	
Facility-Based	1 Day	41	18.39	169.38	127710.83	
Home Health Aide Total:						8806052.63
Home Health Aide	15 Minutes	1247	681.64	10.36	8806052.63	
Skilled Nursing Total:						3212288.42
Skilled Nursing	15 Minutes	1089	115.18	25.61	3212288.42	
Assisted Living Facility Services Total:						7852844.38
Assisted Living Facility Services	1 Day	440	302.96	58.91	7852844.38	
Environmental Modification Total:						0.00
Environmental Modification (New)	Event	0	1.00	5000.00	0.00	
Environmental Modification (Repair)	Event	0	1.00	5000.00	0.00	
Home-Delivered Meals Total:						4593789.20
Home-Delivered					4593789.20	

GRAND TOTAL:	45247945.48
Total Estimated Unduplicated Participants:	3669
Factor D (Divide total by number of participants):	12332.50
Average Length of Stay on the Waiver:	314

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Meals	1 Meal	2420	318.50	5.96		
Independent Living Support Total:						0.00
Independent Living Support	15 Minutes	0	1560.00	7.34	0.00	
Non-Medical Transportation Total:						138325.81
Multipass	Per Purchase	44	6.00	45.00	11880.00	
Per Trip	1 Trip (One-Way)	271	87.87	5.31	126445.81	
Personal Emergency Response Systems (PERS) Total:						866871.81
Installation	1 Installation	483	1.00	63.41	30627.03	
Monitoring	1 Month	2291	9.90	36.87	836244.78	
Transition Intensive Case Management Total:						0.00
Transition Intensive Case Management	15 Minutes	0	160.00	12.25	0.00	
Transition Intensive Case Management - Certificate	15 Minutes	0	160.00	12.86	0.00	
Transition Setup Total:						0.00
Transition Setup	Event	0	0.00	0.01	0.00	
				GRAND TOTAL:		45247945.48
				Total Estimated Unduplicated Participants:		3669
				Factor D (Divide total by number of participants):		12332.50
				Average Length of Stay on the Waiver:		314

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:						308710.42
Adult Day Services	1 Half-Day	70	158.24	27.87	308710.42	
Case Management Total:						10083080.23
Service Plan Development/Annual Update	Per Initial Plan/Annual	3886	1.00	507.81	1973349.66	
Monitoring	1 Month	984	11.25	133.40	1476738.00	
Case Management - Certificate	Monthly	2902	11.25	203.17	6632992.58	
Homemaker Total:						1946873.45
Homemaker	15 Minutes	681	440.50	6.49	1946873.44	
Personal Support Services Total:						12781167.55
Participant-Directed	15 Minutes	675	4790.74	3.80	12288248.10	
Agency-Based	15 Minutes	321	181.51	8.46	492919.45	
Respite Total:						261106.91
In-Home	15 Minutes	21	369.75	10.36	80442.81	
Facility-Based	1 Day	58	18.39	169.38	180664.10	
Home Health Aide Total:						9665613.23
Home Health Aide	15 Minutes	1285	726.05	10.36	9665613.23	
Skilled Nursing Total:						3526168.86
Skilled Nursing	15 Minutes	1154	119.64	25.54	3526168.86	
Assisted Living Facility Services Total:						8545088.14
Assisted Living Facility Services	1 Day	463	313.29	58.91	8545088.14	
Environmental Modification Total:						702020.00
Environmental Modification (New)	Event	220	1.00	3191.00	702020.00	
Environmental Modification (Repair)	Event	0	1.00	5000.00	0.00	
Home-Delivered Meals Total:						4915077.01
Home-Delivered					4915077.01	

GRAND TOTAL:	54351255.45
Total Estimated Unduplicated Participants:	3886
Factor D (Divide total by number of participants):	13986.43
Average Length of Stay on the Waiver:	318

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Meals	1 Meal	2555	322.77	5.96		
Independent Living Support Total:						**458016.00**
Independent Living Support	15 Minutes	40	1560.00	7.34	**458016.00**	
Non-Medical Transportation Total:						**137594.91**
Multipass	Per Purchase	46	6.00	45.00	**12420.00**	
Per Trip	1 Trip (One-Way)	243	97.01	5.31	**125174.91**	
Personal Emergency Response Systems (PERS) Total:						**934884.36**
Installation	1 Installation	494	1.00	63.41	**31324.54**	
Monitoring	1 Month	2424	10.11	36.87	**903559.82**	
Transition Intensive Case Management Total:						**50854.40**
Transition Intensive Case Management	15 Minutes	6	160.00	12.25	**11760.00**	
Transition Intensive Case Management - Certificate	15 Minutes	19	160.00	12.86	**39094.40**	
Transition Setup Total:						**35000.00**
Transition Setup	Event	25	1.00	1400.00	**35000.00**	
				GRAND TOTAL:		**54351255.45**
				Total Estimated Unduplicated Participants:		**3886**
				Factor D (Divide total by number of participants):		**13986.43**
				Average Length of Stay on the Waiver:		318

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:						595688.06
Adult Day Services	1 Half-Day	119	182.36	27.45	595688.06	
Case Management Total:						11264028.89
Service Plan Development/Annual Update	Per Initial Plan/Annual	4116	1.00	507.81	2090145.96	
Monitoring	1 Month	298	11.25	133.40	447223.50	
Case Management - Certificate	1 Month	3818	11.25	203.17	8726659.42	
Homemaker Total:						1946873.45
Homemaker	15 Minutes	681	440.50	6.49	1946873.44	
Personal Support Services Total:						13565013.37
Participant-Directed	15 Minutes	679	5047.52	3.80	13023611.10	
Agency-Based	15 Minutes	331	193.34	8.46	541402.27	
Respite Total:						278240.41
In-Home	15 Minutes	22	373.45	10.36	85116.72	
Facility-Based	1 Day	62	18.39	169.38	193123.69	
Home Health Aide Total:						10615775.45
Home Health Aide	15 Minutes	1325	773.35	10.36	10615775.45	
Skilled Nursing Total:						3867821.73
Skilled Nursing	15 Minutes	1222	124.27	25.47	3867821.73	
Assisted Living Facility Services Total:						9294430.40
Assisted Living Facility Services	1 Day	487	323.97	58.91	9294430.40	
Environmental Modification Total:						702020.00
Environmental Modification (New)	Event	220	1.00	3191.00	702020.00	
Environmental Modification (Repair)	Event	0	1.00	5000.00	0.00	
Home-Delivered Meals Total:						5257844.65
Home-Delivered					5257844.65	

GRAND TOTAL:	59073223.57
Total Estimated Unduplicated Participants:	4116
Factor D (Divide total by number of participants):	14352.10
Average Length of Stay on the Waiver:	322

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Meals	1 Meal	2697	327.10	5.96		
Independent Living Support Total:						**458016.00**
Independent Living Support	15 Minutes	40	1560.00	7.34	**458016.00**	
Non-Medical Transportation Total:						**133225.91**
Multipass	Per Purchase	49	6.00	45.00	**13230.00**	
Per Trip	1 Trip (One-Way)	211	107.10	5.31	**119995.91**	
Personal Emergency Response Systems (PERS) Total:						**1008000.45**
Installation	1 Installation	505	1.00	63.41	**32022.05**	
Monitoring	1 Month	2565	10.32	36.87	**975978.40**	
Transition Intensive Case Management Total:						**51244.80**
Transition Intensive Case Management	15 Minutes	2	160.00	12.25	**3920.00**	
Transition Intensive Case Management - Certificate	15 Minutes	23	160.00	12.86	**47324.80**	
Transition Setup Total:						**35000.00**
Transition Setup	Event	25	1.00	1400.00	**35000.00**	

GRAND TOTAL:	**59073223.57**
Total Estimated Unduplicated Participants:	**4116**
Factor D (Divide total by number of participants):	**14352.10**
Average Length of Stay on the Waiver:	322