Application for a Â§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 section 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 waiverï¿½s target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid state plan and other federal, state and local public programs as well as the supports that families and communities provide.

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

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

1. Request Information

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

B. Program Title:
Comprehensive Waiver

C. Waiver Number:WY.1061

D. Amendment Number:WY.1061.R02.02

E. Proposed Effective Date: (mm/dd/yy)
09/01/25

Approved Effective Date of Waiver being Amended: 04/01/24

2. Purpose(s) of Amendment

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

Federal funding related to the American Rescue Plan Act (ARPA) expired on March 31st, 2025. The Wyoming Department of Health used a portion of the ARPA funds to temporarily increase service reimbursement rates. Except for Case Management and CLS (basic) all other rates will return to their legislatively appropriated levels as the state cannot sustain rates at ARPA levels. Case Management and CLS (basic) will be sustained until June 30, 2026.

In addition to the rate changes, the amendment includes clarification of the conflict-free requirement for case managers serving as guardians, and updates the waiver to align with the recently approved CMS Waiver Application Technical Guide.

Please note that following the public comment period, the additional provision regarding the conflict-free requirement for case managers serving as guardians is removed. Please refer to Section Main 6. and Main B. Optional for a summary of comments received.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☐ Waiver Application	
☐ Appendix A ? Waiver Administration and Operation	
☐ Appendix B ? Participant Access and Eligibility	
☒ Appendix C ? Participant Services	C-1/C-3, C-5, C-2-g
☒ Appendix D ? Participant Centered Service Planning and Delivery	D-1-d-ii
☐ Appendix E ? Participant Direction of Services	
☐ Appendix F ? Participant Rights	
☐ Appendix G ? Participant Safeguards	
☐ Appendix H	
☐ Appendix I ? Financial Accountability	
☒ Appendix J ? Cost-Neutrality Demonstration	J-2-d-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:

The state adjusted cost projections in Appendix J to reflect the decrease in provider rates due to ARPA funding expiration. Updated the appropriate sections to align with new waiver application requirements.

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 section 1915(c) of the Social Security Act (the Act).

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

Comprehensive Waiver

C. Type of Request: amendment

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

○ **3 years** ◉ **5 years**

Waiver Number:WY.1061.R02.02
Draft ID: WY.015.02.02

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 04/01/24
Approved Effective Date of Waiver being Amended: 04/01/24

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: July 31, 2027). The time required to complete this information collection is estimated to average 163 hours per response for a new waiver application and 78 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 in 42 CFR § 440.160**

☒ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR § 440.40 and 42 CFR § 440.155**

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

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

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

☒ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR § 440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

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

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of section 1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under section 1915(b) of the Act.**

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

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

☐ **section 1915(b)(1) (mandated enrollment to managed care)**

☐ **section 1915(b)(2) (central broker)**

☐ **section 1915(b)(3) (employ cost savings to furnish additional services)**

☐ **section 1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under section 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 section 1915(i) of the Act.**

☐ **A program authorized under section 1915(j) of the Act.**

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

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

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

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

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

3. Components of the Waiver Request

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

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

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

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

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

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

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

F. Participant Rights. Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

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

H. Quality Improvement Strategy. Appendix H contains the quality improvement strategy for this waiver.

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

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

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in section 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 section 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 section 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 section 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 section 1915(b) or another provision of the Act.

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

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and

improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the quality improvement strategy specified in **Appendix H**.

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

The public comment period for the Comprehensive Waiver opened May 23rd and closed June 23rd, 2025. DHCF collaborated with the Wyoming Governor's Council on Developmental Disabilities (WGCDD) to promote the public comment period. The WGCDD promoted the public comment period through the email lists and social media outlets available to them. Communications were sent to the Division's Developmental Disability (DD) distribution lists on May 23rd, June 5th, June 16th, and June 23rd. A public forum was conducted via phone conference on Thursday, June 12th, 2025 from 12:30 pm-1:30 pm. Case managers were encouraged and reminded to ensure that participants and families were aware of the public comment period, and provided information on where the documents and other relevant information could be found.

A summary of the proposed changes, the proposed fee schedule, frequently asked questions, and the full waiver application were published to the DHCF website at https://health.wyo.gov/healthcarefin/hcbs/hcbs-public-notices/ on May 23, 2025. A public notification was published to the Casper Star Tribune May 24, 2025 and June 7, 2025 and the Wyoming Tribune Eagle on May 26, 2025 and June 2, 2025. The text of the public notice was also posted on the DHCF website.

DHCF also distributed a Notice of Intent to Amend to Tribal Governments on May 23, 2025. The notice invited Tribal Governments to submit written comments and/or request additional consultation within 30 days of the notice. The Tribal Governments were also invited and encouraged to attend the public forum and submit public comments through the broader public comment period as well.

DHCF received a total of 31 comments during the public comment period. The summary of comments and the Division's responses are below:

REGARDING C1/C3 - CONFLICT FREE CASE MANAGEMENT FOR CASE MANAGERS SERVING AS GUARDIANS
Limiting Participant Choice of Providers: The proposed rule will limit participants' choice by limiting the selection of providers. In smaller communities there are a limited quantity of available providers. With a limited number of providers and case managers, and the possibility of participants having to choose a new case manager or provider, a participant may need to relocate to other communities or find other jobs. The feasibility of implementing such a rule contradicts the principle of person-centered service plans, autonomy, and participant choice. Number of comments received: 8

Detriment of Inconsistency and Disruption to Long-Standing Relationships: The stability and progress of participants facing the loss of a case manager or guardian they have relied on for nearly 30 years would have detrimental impacts if the new conflict of interest rule passes. The rule could lead to participants losing long-term providers and case managers, disrupting continuity of established care, and in some cases, result in moving and a need to change residences. Number of comments received: 5

Costs of Implementation: Participants may incur costs for hiring a paid guardian or paying to change the guardianship order limiting participant's discretionary income. Case managers are not compensated for their guardianship duties. Case Managers would face financial hardship when choosing between case management duties and guardian responsibilities. The administrative burden to transition that amount of participants would be nearly impossible and business could not be sustained. Number of comments received: 8

Unnecessary due to Established Rules: Chapter 45 rules already address conflict of interest issues and specifically state that case management agencies cannot make financial or health-related decisions for participants (including guardianships) and cannot have a financial interest or relationship with providers. This is an overreach of the Federal Conflict-free Rule (42 CFR 441.301(c)(1)(vi)) and the Home and Community-Based Services (HCBS) Settings Rule regarding person-centered service plans and choice in providers. Being a guardian is a personal choice driven by care, and professional case managers should be able to manage potential conflicts of interest professionally rather than face State-imposed, blanket restrictions. Number of comments received: 4

Ambiguity: The language used and broad definition of "associated with providers of their ward" is ambiguous, overly inclusive and could potentially create conflicts for case managers or guardians through incidental social relationships (e.g., attending the same church, volunteering for the same agency). Number of comments received: 4

Exemption for Parents and Current Case Managers Serving as Guardians: It is recommended that the HCBS waiver

include a provision to exempt parents of participants who are also case managers and grandfather in current case managers who already serve as guardians for waiver participants. Number of comments received: 2

REGARDING APPENDIX J: ARPA EXPIRATION RATE ADJUSTMENTS AND LACK OF SERVICE FUNDING Concern about Institutionalization: We are concerned about further potential cuts to the Wyoming Waiver program and the reduced support that could lead to institutionalization for our child/adult child with developmental disabilities. Number of comments received: 2

Quality and Quantity of Services: Rate reductions and the expiration of APRA, will compromise a providers' ability to sustain essential services, especially in light of increasing living costs. Current allowances are inadequate to cover essential needs for participants as it is. Direct Support Professionals (DSPs) will face even more personal financial sacrifices and participants will be impacted. Number of comments received: 3

Lack of Adequate Services: As a resident in Wyoming there is a lack of appropriate support and resources compared to most other states. Number of comments received: 1

See Main B-Optional for additional information.

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: Walsh

First Name: Dawn

Title: Communications Analyst

Agency: Division of Healthcare Financing

Address: 122 W. 25th Street, 4 West

Address 2:

City: Cheyenne

State: **Wyoming**

Zip:

82002

Phone:

(307) 777-8761 **Ext:** **TTY**

Fax:

(307) 777-8685

E-mail:

dawn.walsh@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 section 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: Matt Crandall

07/01/2025

State Medicaid Director or Designee

Submission Date: Jul 1, 2025

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

Last Name: Crandall

First Name: Matthew

Title: Policy and Communications Unit Manager

Agency: Wyoming Department of Health

Address: 122 W 25th St, 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

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:

Case Managers will have 12 months from the time this waiver amendment is approved to come into compliance with the added conflict-free case management requirements.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Additional EVV information needed in Appendix I-1:

These solutions electronically validate visits and personal care services as they are provided to participants. Providers billing services for which EVV is required must submit claims through the State's procured EVV system. The information captured is as follows:
* Type of service provided;
* Participant receiving the service;
* Caregiver providing the service;
* Date of service;
* Location of service;
* Start time of the service (Check-in); and
* Time the service ends (Check-out).

The participant attests to the visit through the caregiver's mobile device on the vendor system's mobile app or they can call the Interactive Voice Response (IVR) Line if caregivers do not have a smartphone. Participants can also review their service history within the vendor's member portal and attest to visits as another option. Requiring billing through the use of EVV in combination with the required data elements that are collected for each service instance strengthens the State's accountability efforts and provides greater visibility into the details of services rendered.

Virtual Support
Virtual support is available to participants who are 18 years or older, and who receive Community Living Services at the Basic 15-minute or Basic Daily tier. 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 IPC 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 IPC. 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 IPC 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 may not be inclined to attend in-person, but must still 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 remote monitoring 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 remote monitoring. 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.
- In accordance with Chapter 45, Section 13(h)(xii), providers must not use video monitoring in participant bedrooms or bathrooms. Other forms of remote monitoring, remote support, or sensors may be used where appropriate, and must be documented in the participant's IPC. Adherence to these requirements is observed during regular on-site visits conducted by the Division, as well as during monthly case manager visits.

Remote Monitoring

Remote Monitoring is available to participants who are 18 years or older, and who receive Community Living Services (CLS) at the Basic Daily Level, Level 3, or Level 4 tier. Remote monitoring is the use of communication and non-invasive monitoring technologies to assist participants in attaining or maintaining independence in their homes while minimizing the need for onsite staff presence and intervention. Remote monitoring is intended to decrease the participant's dependence on staff support during round-the-clock services while providing needed services in the least restrictive environment.

This service delivery model must promote community integration. By implementing remote monitoring, in-person staff time should be focused on supporting individuals with accessing their community, and with activities of daily living and instrumental activities of daily living. Remote monitoring will be available during times when the participant is typically quiet or sleeping, in order to facilitate the participant living in their own apartment rather than a congregate setting.

Remote monitoring is available to participants who choose this option, have completed a Remote Monitoring Risk Assessment to identify potential risks and mitigation of those risks, and have provided informed consent. At a minimum, the remote monitoring delivery option must meet the following requirements:

- The participant must have an informed choice between in person and remote support services;
- The participant must choose service delivery through remote monitoring, and that choice must be documented in the participant's IPC, and demonstrated through a signed consent form.
- Remote monitoring must fit within the scope and definition of the community living service being received.
- A participant specific remote monitoring protocol that outlines how the remote monitoring will be implemented must be developed and adequately support the supervision needs of the participant. The participant's IPC 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 remote monitoring technology, and follow up with the provider to ensure the concerns are addressed.
- The participant must have full control of remote monitoring devices, and have the ability to turn off the device and end services any time they wish.
- Informed consent of other individuals who may be affected by the remote monitoring must be obtained at least annually during their annual IPC review.
- The participant's services may not be delivered remotely 100% of the time. There must always be an option for in-person services available. Remote monitoring is not intended to replace provider presence during times a participant needs in-person support or supervision.
- If remote monitoring does not facilitate the wishes and desires of a participant, it is not an option.
- Remote monitoring 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.
- The use of the remote monitoring option must not block, prohibit or discourage the use of in-person services or access to the community. Participants must be encouraged to engage with friends and family and actively participate in their community.

Remote Monitoring Devices

Remote monitoring devices will belong to the participant, and may be paid through Specialized Equipment Services, as long as the equipment meets the participant's needs as indicated in the participant's Remote Monitoring Risk Assessment. The devices must meet the service definition, cannot exceed the Specialized Equipment Services cap, and must fit within the participant's individual budget amount (IBA). Continuous live audio/video feed and recorded audio/video feed are not acceptable forms of remote support.

The following device categories will be authorized for remote monitoring:
(a) Door, motion, stove, and bed sensors
(b) Panic buttons and pendants
(c) Fire/carbon monoxide alerts and monitoring - This category is specific to devices that will send notification to a remote monitor when triggered and does not include typical fire and carbon monoxide detectors.
(d) Strobe lighting for visual alerts
(e) Assistive technology such as calendars and alarms
(f) Staff check-in buttons
(g) Cues to prompt independence, such as recorded reminders when a participant enters or exits a room.
(h) Smart thermostats, lightbulbs, door openers, automated door locks, outlet switches, and mechanical faceplate light switches
(i) Doorbell integration
(j) 24/7 Response Center option

Provider Standards for Remote Monitoring
All providers that deliver services using the remote monitoring option must meet all Division requirements established for remote monitoring. At a minimum:
- Providers must have written policies that assure the participant's right to privacy.
- Providers that deliver remote monitoring services must use a HIPAA-compliant telehealth service delivery platform approved by the Division. During the provider certification renewal process, providers that deliver remote monitoring 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 remote monitoring. 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 remote monitoring 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, remote monitoring equipment, disengaging the system, and responding to system failure. Provider policies must be approved before they will be certified to provide remote monitoring services.
- Providers will be ultimately responsible for the remote monitoring activity. All monitoring must be conducted in real time and provided by an individual who is awake. As identified in the corresponding service tier, on-call 24 hour support or a contingency plan for emergency situations must be outlined in the participant's IPC. The provider must be available to respond as outlined in the participant's remote support protocol, which may include in-person response within specific time-frames.
- As part of the established remote monitoring standards, providers must have safeguards and backup systems (i.e., battery backup, generator) in place at the remote monitoring base and participant living sites in the event of electrical outages. In addition to backup systems, the provider must have an established process for ensuring appropriate on-site staff support in such an event. Additional participant specific information related to how the provider should support the participant in such an event must be included in the participant's remote monitoring protocol. Backup systems will be discussed as part of the provider's ongoing certification renewal.
- In accordance with Chapter 45, Section 13(h)(xii), providers must not use video monitoring in participant bedrooms or bathrooms. Other forms of remote monitoring, remote support, or sensors may be used where appropriate, and must be documented in the participant's IPC. Adherence to these requirements is observed during regular on-site visits conducted by the Division, as well as during monthly case manager visits.

Initial and Ongoing Assessment of Remote Monitoring
The participant and plan of care team are required to conduct the Remote Monitoring Risk Assessment in order to identify potential risks, and plan the participant's remote monitoring in a way that addresses these risks. The plan of care team must develop an individualized remote monitoring protocol that includes the participant's response needs, contact and emergency data, and other pertinent information. The remote monitoring protocol will be uploaded in EMWS as part of the IPC.

Initially, the plan of care team must assess and determine if continued usage of remote monitoring will facilitate the health and welfare of the participant at the three month and six month milestone. After the first six months, the plan of care team must assess the appropriateness of continued usage at least every six months. A review of the Remote Monitoring Risk Assessment, remote monitoring protocol, and all incident reports and other relevant documentation, to include alert, response, and staff response logs, must be part of these assessments. Team notes, updated remote monitoring protocols, and updated Remote Monitoring Risk Assessments must be uploaded in EMWS.

In the event the participant chooses to discontinue remote monitoring services, the provider and plan of care team must transition the participant to traditional community living services within 30 calendar days. Providers must develop and implement a policy that addresses a participant's immediate transition from remote monitoring services if a health or safety need is identified that overrides the 30 calendar day transition timeline.

The participant, legally authorized representative, if applicable, and plan of care team members must sign the Remote Monitoring Risk Assessment, indicating that they agree or disagree that remote monitoring is an appropriate option for the participant. All parties must be educated on how the remote monitoring system works and be made aware of both its benefits and risks, and the participant must sign an informed consent form that indicates they understand the parameters of remote monitoring. This informed consent form must be maintained in EMWS. Updated informed consent forms must be obtained annually on the Remote Monitoring Risk Assessment.

*****I-2-d continuation
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.

As additional program safeguards, case managers are required to perform quarterly service observations of every participant they serve. If there are any issues with services provided or services not being provided to the participant, DHCF is notified as well as Medicaid Program Integrity, if necessary.

The following services are subject to EVV:
- Personal Care
- Child Habilitation 0-12
- Child Habilitation 13-17
- Companion Individual
- Companion (Group up to 3)
- Respite (Individual)
- Respite (Group of 2)
- Respite Daily (Individual)
- Respite Daily (Group of 2)
- Skilled Nursing

For participant directed services EVV is used to verify information during the shift submission and pre-payment validation process for Payroll by the FMS. If there are shift entry exceptions noted, they are highlighted within the ACES$ NOTES portal. Based on the PD exception policy, if there are over a certain number of exceptions within a month, there are increasing levels of technical support provided beginning with mandatory refresher training and client support, through recommendation by the program of removal of the employer role or the employee if there are continued issues noted.

For agency providers using EVV claim information is submitted through the EVV solution aggregator in order for payment to be authorized. EVV pre-payment review occurs in the EVV aggregator solution prior to the claim submission.

Main:6-I Continued -
Based on public comment, the Division will not move forward with the additional provision regarding the conflict-free requirement for case managers serving as guardians in the case management service definition. The Division also received comments regarding the rate reduction, however, Wyoming State Agencies are required to follow the budget approved by the Wyoming Legislature which does not include funding for rates at the current ARPA levels contained in the current waiver.

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 (DHCF)

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the state Medicaid agency. Thus this section does not need to be completed.

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

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the state. Thus, this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

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

Level of Care Evaluation
DHCF 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 DHCF's case management information system. DHCF establishes the level of care evaluation criteria and retains the authority to make final level of care determinations.

Quality Assurance and Quality Improvement Activities
DHCF 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 DHCF. 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.

Benefits Management System (BMS)
DHCF contracts with a private corporation to act as its Fiscal Agent and to maintain the Benefits Management System (BMS), 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.

Qualified Provider Enrollment
DHCF contracts with a private corporation to enroll qualified providers and maintain documentation in relation to provider enrollment. Duties of this contract include:

- Processing all provider enrollment applications through an online portal;
- Conducting an initial screening of provider qualifications;
- Searching 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);
- Obtaining confirmation from DHCF that the applicant/provider meets all applicable provider qualifications as specified in the waver application;
- Notifying applicant/provider of approval/disapproval;
- Enrolling approved providers in BMS

Financial Management Services
DHCF has a contract with a private Financial Management Services (FMS) organization to support participants or their designated employers of record in participant-directed waiver services by performing financial administrative activities on the participant's behalf. The contracted entity verifies self-directed caregiver qualifications by gathering and maintaining initial employment information, facilitating background investigations, requesting and filing employment related IRS information and documents. The FMS provides an electronic visit verification (EVV) solution for participant directed employers and their individual caregivers which is used to verify service delivery and visit information in order to process and provide payroll to the participant directed caregiver.

EVV
DHCF has a contract with a private corporation for the implementation and compliance of the 21st Century Cures Act EVV requirements. This contractor ensures all EVV - qualifying services are recorded through the proper system and ensures prebilling review to ensure the following elements are captured:

- Date of the service delivery
- Start and end time of the service delivery
- Identification of the caregiver delivering the service

- Starting and ending location of the service delivery
- Type of service performed
- Identification of the individual receiving the service

Establishment of Statewide Rate Methodology
DHCF maintains a contract with a consulting agency for the purpose of conducting regular provider reimbursement rate studies and establishing or refreshing the statewide rate methodology. This rate study supports the requirement of WY Stat § 42-4-120 (g),which requires DHCF to rebase provider reimbursement rates every two to four years.

○ **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.* Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	☒	☐
Waiver enrollment managed against approved limits	☒	☐
Waiver expenditures managed against approved levels	☒	☐
Level of care waiver eligibility 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 state's quality improvement strategy, provide information in the following fields to detail the state's 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 - Number and percent of contract deliverables met for all contracted functions of the Benefits Management System contract. Numerator:# of contract deliverables met Denominator:# of contract deliverables

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
A.a2 - Number and percent of contract deliverables met for all contracted functions of the Utilization Review and Quality Assurance contract. Numerator:# of contract deliverables met Denominator:# of contract deliverables

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measure:
A.a3 - Number and percent of contract deliverables met for all contracted functions of the Financial Management Services contract. Numerator:# of contract deliverables met Denominator:# of contract deliverables

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

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

	Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
A.a4 - Percentage of contract deliverables met for all contracted functions of the Level of Care Evaluation contract. Numerator:# of contract deliverables met Denominator:# of contract deliverables

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
A.a5 - Percentage of contract deliverables met for all contracted functions of the Electronic Visit Verification contract. Numerator:# of contract deliverables met Denominator:# of contract deliverables

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
A.a6 - Number and percent of contract deliverables met for all contracted functions of the Establishment of Statewide Rate Methodology contract. Numerator:# of contract deliverables met Denominator:# of contract deliverables

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

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

	Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
A.a7 - Number and percent of contract deliverables met for all contracted functions of the Enrollment of Qualified Providers contract. Numerator:# of contract deliverables met Denominator:# of contract deliverables

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

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. 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 Performance Review Committee assures accountability to the Division’s stakeholders and provides oversight of quality improvement activities, including regular monitoring of QIP effectiveness.

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

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

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

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

In order to be eligible for the Comprehensive waiver, an individual must meet the eligibility criteria established in Chapter 46 of Wyoming Medicaid Rules and (a) experience a situation that meets the criteria for emergency services, as outlined in Chapter 46, or (b) qualify for a reserved capacity slot, as established in Appendix B-3-c of this application. Funding for emergency situations and reserved capacity must be approved by the Extraordinary Care Committee (ECC). Once a person is placed on the Comprehensive Waiver, ongoing participation is presumed unless they no longer meet the eligibility requirements, or are denied for other reasons established in Chapter 46.

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

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

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

- (●) **Not applicable. There is no maximum age limit**
- ( ) **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

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

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

- (●) **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ( ) **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

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

- ( ) **A level higher than 100% of the institutional average.**

  Specify the percentage:

- ( ) **Other**

  Specify:

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

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

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

The 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	1850
Year 2	1850
Year 3	1850
Year 4	1850
Year 5	1850

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	1840
Year 2	1840
Year 3	1840
Year 4	1840
Year 5	1840

Appendix B: Participant Access and Eligibility

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

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

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

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

Purpose(s) the state reserves capacity for:

Purposes	
ICF-Eligible Children Aging Out of State Custody	
Emergency Cases	
Transitions from a state-funded institution	
Eligible Dependents of Qualified Military Service Members	

Appendix B: Participant Access and Eligibility

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

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

ICF-Eligible Children Aging Out of State Custody

Purpose *(describe):*

The Department annually reserves 15 spots for ICF-Eligible Children Aging Out of State Custody on an individuals 18th birthday. The department will collaborate with the department of family services regarding eligible cases, assessments, and service plan coordination.

Describe how the amount of reserved capacity was determined:

The Department collaborated with the Department of Family Services to estimate the number of current individuals in a foster home care setting who may be eligible for comprehensive waiver while estimating potential future needs.

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

Waiver Year	Capacity Reserved
Year 1	15

Waiver Year	Capacity Reserved
Year 2	15
Year 3	15
Year 4	15
Year 5	15

Appendix B: Participant Access and Eligibility

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

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

Emergency Cases

Purpose *(describe):*

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

Describe how the amount of reserved capacity was determined:

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

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

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

Appendix B: Participant Access and Eligibility

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

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

Transitions from a state-funded institution

Purpose *(describe):*

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

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

Describe how the amount of reserved capacity was determined:

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

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

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

Appendix B: Participant Access and Eligibility

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

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

Eligible Dependents of Qualified Military Service Members

Purpose *(describe):*

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

Describe how the amount of reserved capacity was determined:

Information was derived from the Wyoming Military Department.

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

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

Appendix B: Participant Access and Eligibility

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

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

- (●) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

- (●) **Section 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)

- [ ] **Parents and Other Caretaker Relatives (42 CFR § 435.110)**
- [ ] **Pregnant Women (42 CFR § 435.116)**
- [ ] **Infants and Children under Age 19 (42 CFR § 435.118)**

☒ **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 section 1902(a)(10)(A)(ii)(XIII)) of the Act)**

☒ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in section 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 section 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 section 1902(e)(3) of the Act)**

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

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

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

Specify:

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

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

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

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

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

Select one:

- (●) **300% of the SSI Federal Benefit Rate (FBR)**
- ( ) **A percentage of FBR, which is lower than 300% (42 CFR § 435.236)**

  Specify percentage: [ ]
- ( ) **A dollar amount which is lower than 300%.**

  Specify dollar amount: [ ]

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

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

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

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

Select one:

- ( ) **100% of FPL**
- ( ) **% of FPL, which is lower than 100%.**

  Specify percentage amount: [ ]

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the period beginning January 1, 2014 and extending through September 30, 2027 (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 section 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 section 1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or section 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 period after September 30, 2027 (or other date as required by law).

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law) (select one).

- (●) **Spousal impoverishment rules under section 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 section 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 (Section 1634 State/SSI Criteria 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 section 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 period after September 30, 2027 (or other date as required by law).

b. Regular Post-Eligibility Treatment of Income: Section 1634 State and SSI Criteria State after September 30, 2027 (or other date as required by law).

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 section 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 period after September 30, 2027 (or other date as required by law).

c. Regular Post-Eligibility Treatment of Income: 209(b) State or after September 30, 2027 (or other date as required by law).

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 period after September 30, 2027 (or other date as required by law).

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules after September 30, 2027 (or other date as required by law)

The state uses the post-eligibility rules of section 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 section 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 or 42 CFR § 435.735:

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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

e. Regular Post-Eligibility Treatment of Income: Section 1634 State or SSI Criteria State – January 1, 2014 through September 30, 2027 (or other date as required by law).

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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

f. Regular Post-Eligibility Treatment of Income: 209(b) State ? January 1, 2014 through September 30, 2027 (or other date as required by law).

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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules – January 1, 2014 through September 30, 2027 (or other date as required by law).

The state uses the post-eligibility rules of section 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 an entity under contract with the Medicaid agency.**

Specify the entity:

- ( ) **Other**

Specify:

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

Individuals performing the initial evaluation are required to have the training and experience equivalent to a bachelor's degree in business or public administration, social services, psychology, counseling or education, PLUS two years of professional work experience in training, counseling, or planning, or administering services for persons in a developmental disability or acquired brain injury.

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

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

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

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

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

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

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the state plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

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

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

The reevaluation process includes the annual LOC assessment using the LT-104 or LT-101, which verifies that the person continues to meet the level of care for the demographic. The LT-104 and LT-101 gathers information on an individual as described in B-6-d.

A Public Health Registered Nurse is responsible for arranging the assessment and gathering the information for the LT-101. Case management providers are responsible for arranging the assessment and gathering information for the LT-104.

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

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

- ( ) **Every three months**
- ( ) **Every six months**
- (●) **Every twelve months**
- ( ) **Other schedule**

  Specify the other schedule:

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

- (●) **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial**

evaluations.

○ **The qualifications are different.**
Specify the qualifications:

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

DHCF's case management information system automatically generates a reevaluation referral to the Public Health Nursing County Offices and Case Management Providers for active waiver participants 60 days prior to the expiration of the annual service plan. Reevaluation timeliness is monitored by DHCF staff, the Public Health Nursing County Offices, and the Public Health Division through automated alerts, task lists, and reports generated by the DHCF's case management information system. DHCF 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 DHCF'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 state's quality improvement strategy, provide information in the following fields to detail the state's 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 - Number and Percent of initial applicants who had a level of care assessment prior to eligibility determination in accordance with DHCF standards and the approved waiver. Numerator:# of initial applicants with LOC assessment completed prior to eligibility determination in accordance with DHCF standards and the approved waiver Denominator: total # of initial applicants

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:
B.c1 - Number and Percent of annual level of care assessments conducted for each

eligible participant in accordance with DHCF standards and the approved waiver. Numerator:# of eligible participants with an LOC assessment conducted in accordance with DHCF standards and the approved waiver Denominator:# of all eligible participants)

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

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

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

Original source data is stored on EMWS or its successor

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Adult Day Services**		
Statutory Service	**Case Management**		
Statutory Service	**Community Living Services**		
Statutory Service	**Community Support Services**		
Statutory Service	**Homemaker**		
Statutory Service	**Personal Care**		
Statutory Service	**Respite**		
Statutory Service	**Supported Employment**		
Extended State Plan Service	**Dietician Services**		
Extended State Plan Service	**Occupational Therapy**		
Extended State Plan Service	**Physical Therapy**		
Extended State Plan Service	**Skilled Nursing**		
Extended State Plan Service	**Speech, Hearing and Language Services**		
Other Service	**Behavioral Support Services**		
Other Service	**Child Habilitation Services**		
Other Service	**Cognitive Retraining**		
Other Service	**Companion Services**		
Other Service	**Crisis Intervention Support**		
Other Service	**Environmental Modification**		
Other Service	**Individual Habilitation Training**		
Other Service	**Special Family Habilitation Home**		
Other Service	**Specialized Equipment**		
Other Service	**Transportation**		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04060 adult day services (social model)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

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

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

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

Services During Acute Care Hospital Stays
As authorized in 42 U.S.C 1396a(h), this service may be provided in an acute care hospital and billed at the existing rate if the services are:
(A) identified in the participant's IPC;
(B) provided to meet needs of the participant that are not met through the provision of acute care hospital services;
(C) are in addition to and not a substitute for services that the acute care hospital is obligated to provide through its conditions of participation or under Federal
or State law, or under another applicable requirement; and
(D) designed to ensure smooth transitions between the acute care setting and the home and community-based settings, and to preserve the individual's functional
abilities.

Case managers and providers must coordinate with hospital staff and plan of care team members in order to ensure that the participant's transition from a temporary hospital stay to their home is seamless.

Adult day services is billed as a 15 minute rate.

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

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

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

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

Virtual Support
Virtual support is available to participants who are 18 years or older, and who receive Adult Day Services at the Basic Level of Care tier. 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 IPC 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 IPC. 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 IPC 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 may not be
  inclined to attend in-person, but must still 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 Supports
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 remote monitoring 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 remote monitoring. 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.
- In accordance with Chapter 45, Section 13(h)(xii), providers must not use video monitoring in participant bedrooms or bathrooms. Other forms of remote monitoring, remote support, or sensors may be used where appropriate, and must be documented in the participant's IPC. Adherence to these requirements is observed during regular on-site visits conducted by the Division, as well as during monthly case manager visits.

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

Adult day services are available to individuals who are 18 years of age or older. This is not a habilitation service.

Approved units will be based on individual level of support need and must fit within the assigned budget.

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

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

A participant's IPC may include two or more types of non-residential services as long as service times do not overlap.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Services

Provider Category:

Agency

Provider Type:

Agency certified by DHCF to provide service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider that employs one or more individuals other than themselves, and otherwise does not meet the definition of an individual provider. An agency provider is required to attain and maintain a certification for this service from DHCF, and demonstrate the legal payment of employee compensation (e.g., IRS Form 1096 that proves the issuance of one or more Form 1099, IRS Form W-3 that proves the issuance of one or more Form W-2) upon request. If a provider meets the criteria outlined in Section 25 of Chapter 45 of Wyoming Medicaid Rules, it must attain and maintain accreditation by a nationally recognized accreditation entity for human services as specified.

Other Standard *(specify):*

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Services

Provider Category:

Individual

Provider Type:

Independent Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider who does not designate wages and does not employ staff members other than themselves. This provider typically does not have a business tax identification number, but instead uses their social security number as a business tax identification number. An individual provider is required to attain and maintain a certification for this service from DHCF. If an individual provider meets the criteria outlined in Section 25 of Chapter 45 of Wyoming Medicaid Rules, they must attain and maintain accreditation by a nationally recognized accreditation entity for human services as specified.

Other Standard *(specify):*

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

A provider must ensure that services occur in settings that are community based, and facilitate opportunities for participants to access the community and community resources to the same degree as people who do not receive HCBS. A participant must have choice in with whom they spend their time, the activities and events in which they are involved, and from whom they receive assistance and support. A participant must have choice and decision making authority over how they budget, manage, and spend money. A participant must be treated with dignity and respect, have their privacy respected to the extent possible for health and safety, and be free from coercion and restraint. Any restriction of a participant's rights must meet federal requirements and include an assessed need and a restoration plan.
s and include an assessed need and a restoration plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

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

Service Definition *(Scope):*

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

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

Case managers are responsible for conducting the following functions:
- Assessing and reassessing a participant's need for waiver services;
- Initiating a participant's level of care evaluation and re-evaluation process;
- Linking a participant to other federal, state, and local programs;
- Providing choice of services and providers;
- Developing person centered IPCs in accordance with DHCF policies and procedures;
- Coordinating multiple services and providers;
- Coordinating participant transitions between providers, services, and settings;
- Monitoring the implementation of participant's PCs in accordance with Chapter 45 and 46 of Wyoming Medicaid Rules;
- Monitoring the participant's IBA to assure that services are provided within the IBA, and addressing identified concerns;
- Verifying EVV service deliver documentation for applicable providers;
- Monitoring participant health and welfare, and addressing identified concerns;
- Monitoring compliance with HCBS Settings criteria;
- Responding to participant crises;
- Reporting and follow-up on critical incidents;
- Conducting semi-annual service observations of each non-habilitative service received;
- Conducting quarterly service observations of each habilitation service received, and
- When a participant chooses the participant-directed service delivery model:
  (A) Completing referral forms and submit all required information to the Financial Management Services Agent (FMS);
  (B) Interacting with the FMS to assist participants with enrollment in participant-direction;
  (C) Assisting the employer of record (EOR) with completing employee paperwork, and addressing questions or issues that arise.
  (D) Work with the assigned DHCF staff member on appropriate solution when non compliance is discovered.

Monthly requirements
Each month, the case manager must:
- Maintain direct contact with the participant and legally authorized representative (if applicable), which may include the

visit to the participant's place
of residence, service observations, and virtual or in-person interactions.
- Follow-up on concerns or questions raised by the participant, legally authorized representative, or plan of care team, or identified through incident
reports, complaints, or service observations.
- Review service utilization and documentation of traditional and participant-directed services to assure the amount, frequency, and duration of services is
appropriate.
- Monitor and evaluate the positive behavior support plan, as applicable, and complete follow-up on concerns.
- Evaluate the use of restraints and complete follow-up on concerns.
- When a participant chooses the participant-directed service delivery model, use the FMS portal to review provider time sheets, determine budget usage, and
provide ongoing monitoring of the participant's budget, and report improper budget usage to the assigned DHCF staff member.

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

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

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

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

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

Monthly Unit
The monthly unit shall be billed on or after the last day of the month. A minimum of two hours of billable services shall be documented in order to bill, but all billable services shall be documented each month.

- A monthly visit to the participant's place of residence, with the participant present, is required to monitor the participant's health and welfare, as well as to discuss satisfaction with services and needed changes to the IPC.
- At least one hour of person to person contact with the participant or legally authorized representative is required to bill a monthly unit.

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

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

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

Agency certified BY DHCF to provide service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider that employs one or more individuals other than themselves, and otherwise does not meet the definition of an individual provider. A case management agency is required to attain and maintain a certification for this service from DHCF, and demonstrate the legal payment of employee compensation (e.g., IRS Form 1096 that proves the issuance of one or more Form 1099, IRS Form W-3 that proves the issuance of one or more Form W-2) upon request. If a case management agency meets the criteria outlined in Section 25 of Chapter 45 of Wyoming Medicaid Rules, it must attain and maintain accreditation by a nationally recognized accreditation entity for case management services.

The case management agency is eligible to bill the Case Management - Certificate rate for case managers who can demonstrate completion of DHCF sponsored training on person-centered planning and case management best practices.

Other Standard *(specify):*

A case management agency must meet the requirements in Chapter 45 of Wyoming Medicaid Rules. Requirements for case managers employed by a case management agency include, but are not limited to: a successful criminal history background screening; a current CPR and First Aid certification; a current Medication Assistance certification for case managers assisting participants with medications; and a current driver's license and vehicle insurance, if providing transportation. Agencies must ensure that all case managers meet the training, education, experience, and conflict of interest requirements established in Appendix D-1-a of this Application.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Individual

Provider Type:

Independent Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

An independent case manager is required to attain and maintain a certification for this service from DHCF. If the case manager meets the criteria outlined in Section 25 of Chapter 45 of Wyoming Medicaid Rules, they must attain and maintain

accreditation by a nationally recognized accreditation entity for case management services.

Case managers who can demonstrate completion of DHCF sponsored training on person-centered planning and case management best practices are eligible to bill the Case Management - Certificate rate.

The case management agency is eligible to bill the Case Management - Certificate rate for case managers who can demonstrate completion of DHCF sponsored training on person-centered planning and case management best practices.

Other Standard *(specify):*

An independent case manager must meet the requirements in Chapter 45 of Wyoming Medicaid Rules. Requirements for case managers include, but are not limited to: a successful criminal history background screening; a current CPR and First Aid certification; a current Medication Assistance certification for case managers assisting participants with medications; and a current driver's license and vehicle insurance, if providing transportation. An independent case manager must meet the training, education, experience, and conflict of interest requirements established in Appendix D-1-a of this Application.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

Community Living Services

HCBS Taxonomy:

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

Service Definition *(Scope):*

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

- CLS is reimbursed based on the participant's Level of Service (LOS) score, and includes some level of ongoing 24-hour support (e.g., 24-hour on-call support) by a provider, as defined in the level of service and outlined in the participant's IPC.
- A participant who lives in a setting that is owned or leased by a provider, the participant, or the participant's family may receive the level of CLS that aligns with their level of service score and can be supported by their IBA. A participant who is living with their family is only eligible to receive CLS - Basic to the extent that the service can be supported by their IBA.
- A participant who receives CLS must have one primary residence. CLS may be provided in the participant's primary residence or in other community settings the participant chooses.
- Provider owned or leased settings where CLS is furnished must be fully accessible to the participants living in that setting.
- With the exception of host homes, CLS may be delivered through participant-direction.
- Transportation between the participant's residence, other service sites, or places in the community is included in the rate.
- CLS is a habilitation service. This means training on objectives is expected as part of the provision of services, and the participant's progress must be documented and made available to the participant, legally authorized representative, and case manager each month.
- Participants are encouraged to take vacations and travel. If a participant takes a trip outside of CLS, the provider may be reimbursed on the days the participant leaves for and returns from that trip if they provide services to the participant on those days. If a participant takes a vacation while receiving CLS, the provider must adhere to all supervision and support requirements identified in the service definition and the participant's IPC. If service definitions and supervision levels cannot be met, case managers must work with the plan of care team to identify an alternative waiver or non-waiver service.
- Health related services may be provided after staff are trained by the appropriate trainer or medical professional, and documentation of training is evident.

As authorized in 42 U.S.C 1396a(h), CLS may be provided in an acute care hospital if the services are:
- Identified in the participant's IPC;
- Provided to meet needs of the participant that are not met through the provision of acute care hospital services;
- Are in addition to, and may not be a substitute for services that the acute care hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and
- Designed to ensure smooth transitions between the acute care setting and the home and community-based settings, and to preserve the individual's functional abilities.

Case managers and providers must coordinate with hospital staff and plan of care team members in order to ensure that the participant's transition from a temporary hospital stay to their home is seamless.

Host Home

Host home services consist of participant specific, individually designed and coordinated services within a family (other than biological, step or adoptive parents) host home environment. Host homes differ from other community living settings by featuring one sponsor working with one participant living together in the sponsor's home. A sponsor is defined as an individual who is an independent certified provider to one participant in their home. The sponsor is the only residential provider for the participant, does not employ staff, and is not a subcontractor. This service is not open to new participants without going through the Extraordinary Care Committee (ECC) approval process for an out of home placement. The sponsor is the primary caregiver and assumes 24-hour care of the participant. Relative providers (defined as biological, step, or adoptive parents) cannot provide this service. Host home services cannot be participant-directed.

Tiered Levels
A participant receives a tiered service approved in the IPC based upon need, according to the following tiers descriptions. Tier levels for this service align with the participant's assessed LOS, and the expectations of the service as specified in the definition. All supervision and support must align with the participant's IPC, and meet the needs of each participant present as appropriate to assure health and safety.

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

This service may be provided through virtual supports, as described below. The participant and legally authorized representative must have a choice in where and how the service will be received, and it must be documented in the participant's IPC. Documentation must demonstrate that opportunities for community integration, support for employment, and social interactions are still incorporated in the participant's life. If virtual support does not facilitate the wishes and desires of a participant, it is not an option.

Level 3 – Due to the participant's moderate functional limitations in activities of daily living, and possible behavioral support needs, this tier requires regular staff availability within hearing distance of the participant, and meeting periodically with the participant on each day billed for general supervision, support, personal care, positive behavior support, monitoring, and training. Behavioral and medical supports are not intense and may be provided in a shared staffing setting. Staff support must be available through the night, and overnight expectations must be stipulated in the IPC.

Level 4 – Due to the participant's significant functional limitations and medical or behavioral support needs, this tier requires full-time staff to be available when the participant is in this service, with regular personal attention given throughout the day for training, personal care, reinforcement, positive behavior support, and community or social activities. Behavioral and medical supports are not generally intense and may be provided in a shared staffing setting. There must be staff support through the night as indicated in the IPC, and overnight expectations must be stipulated in the IPC.

Level 5 – Due to the participant's significant and somewhat intensive functional limitations and medical or behavioral support needs, this tier requires one or more full-time staff support to be in close proximity during most awake hours when the participant is in this service, with frequent personal attention given throughout the day for training, personal care, reinforcement, and community or social activities. Behavioral and medical supports and personal care may be somewhat intense, but service may be provided in a shared staffing setting. There must be in-person staff support throughout the night, as indicated in the IPC. Participants who receive this service tier are not eligible for remote monitoring.

Level 6 – Due to the participant's high medical, behavioral, or personal care needs, this tier requires frequent personal support and supervision with full-time staff within immediate proximity during most awake hours. The expectation is that the participant will receive the personal attention of at least one staff person unless otherwise outlined in the IPC and approved by DHCF. Occasional 2:1 support is included in this rate, and must be specified in the IPC. There must be in-person staff support available to the participant through the night, as indicated in the IPC. Participants who receive this service tier are not eligible for remote monitoring.

Information for Remote Monitoring and Virtual Support can be found in the Option Section of this Waiver.

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

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

Community living is a 24 hour service. The following requirement must be met in order for payment to be allowed:
- Basic daily rate – a minimum of 4 hours of documented service per calendar day. Providers are required to provide overnight and crisis support as indicated in
  the participant's IPC.
- Levels 3-6 daily rate – a minimum of 8 hours of documented provider support in a 24 hour period (from 12:00am-11:59pm) unless the participant is leaving for or
  returning from a vacation outside of waiver services. Providers are required to provide overnight support as indicated in the participant's IPC.

CLS basic services may be billed as a 15 minute unit for a maximum of 5,475 units per plan year for individual services, or for a maximum of 5,475 per plan year for group services. The 15 minute unit and daily rate cannot be billed for a participant on the same day.

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

Support with personal care needs is a component of CLS , so service times for CLS and personal care services cannot overlap. Payment will not be made for the cost of room and board, including the cost of building maintenance, upkeep, and improvement. The method by which the costs of room and board are excluded from payment for CLS is specified in Appendix I-5 of this Application.

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

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

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Community Living Services

Provider Category:

Individual

Provider Type:

Individual hired by the participant for service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Prior to providing services, and individual being hired by the participant shall:

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent- Financial Management Service

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Community Living Services

Provider Category:

Agency

Provider Type:

Agency certified by DHCF to provide service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider that employs one or more individuals other than themselves, and otherwise does not meet the definition of an individual provider. An agency provider is required to attain and maintain a certification for this service from DHCF, and demonstrate the legal payment of employee compensation (e.g., IRS Form 1096 that proves the issuance of one or more Form 1099, IRS Form W-3 that proves the issuance of one or more Form W-2) upon request. If a provider meets the criteria outlined in Section 25 of Chapter 45 of Wyoming Medicaid Rules, it must attain and maintain accreditation by a nationally recognized accreditation entity for human services as specified.

Other Standard *(specify):*

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

A provider must ensure that services occur in settings that are community based and facilitate opportunities for participants to access the community and community resources to the same degree as people who do not receive HCBS. A participant must have choice in with whom they spend their time, the activities and events in which they are involved, and from whom they receive assistance and support. A participant must have choice and decision making authority over how they budget, manage, and spend money. A participant must be treated with dignity and respect, have their privacy respected to the extent possible for health and safety, and be free from coercion and restraint. Any restriction of a participant's rights must meet federal requirements and include an assessed need and a restoration plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Community Living Services

Provider Category:

Individual

Provider Type:

Independent Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider who does not designate wages and does not employ staff members other than themselves. This provider typically does not have a business tax identification number, but instead uses their social security number as a business tax identification number. An individual provider is required to attain and maintain a certification for this service from DHCF. If an individual provider meets the criteria outlined in Section 25 of Chapter 45 of Wyoming Medicaid Rules, they must attain and maintain accreditation by a nationally recognized accreditation entity for human services as specified.

Other Standard *(specify):*

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

A provider must ensure that services occur in settings that are community based, and facilitate opportunities for participants to access the community and community resources to the same degree as people who do not receive HCBS. A participant must have choice in with whom they spend their time, the activities and events in which they are involved, and from whom they receive assistance and support. A participant must have choice and decision making authority over how they budget, manage, and spend money. A participant must be treated with dignity and respect, have their privacy respected to the extent possible for health and safety, and be free from coercion and restraint. Any restriction of a participant's rights must meet federal requirements and include an assessed need and a restoration plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

Community Support Services

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Community Support Services (CSS) offer assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills. Services include activities designed to keep participants engaged in their environment, develop and maintain relationships, and build on previously learned skills. Services must be furnished in accordance with the participant's IPC and include full access to the community to the same degree as community members who do not receive HCBS. Supporting the participant in adult educational pursuits is an approved activity of this service.

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

CSS should focus on enabling the participant to attain or maintain their maximum functional level and should serve to reinforce skills or lessons taught in other settings, including skills learned during therapy services.

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

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

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

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

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

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

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

Approved units must be based on the participant's needed level of support and must fit within the participant's assigned budget. CSS is reimbursed at a 15 minute unit.

The CSS high level of care tier is available to participants who want help building meaningful relationships and social connections in the community with a more individualized approach from the provider. A participant with any LOS score

may add the high level of care tier for this service to their IPC for individual services with up to one other waiver participant where the entire time is spent solely in the community and not in a provider setting.

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

Support with personal care needs, including medication assistance, is a component of the service, but cannot comprise more than 20% of the service. Personal care services must not be billed at the same time as this service. Participants cannot be paid for work activities performed during this service.

A participant's IPC may include two or more types of non-residential services as long as service times do not overlap. Non-residential services must not exceed an average weekly amount of 35 hours if the participant receives Community Living Services levels 3-6.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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	Independent Provider
Agency	Agency certified by DHCF to provide service

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Community Support Services

Provider Category:

Individual

Provider Type:

Independent Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider who does not designate wages and does not employ staff members other than themselves. This provider typically does not have a business tax identification number, but instead uses their social security number as a business tax identification number. An individual provider is required to attain and maintain a certification for this service from DHCF. If an individual provider meets the criteria outlined in Section 25 of Chapter 45 of Wyoming Medicaid Rules, they must attain and maintain accreditation by a nationally recognized accreditation entity for human services as specified.

Other Standard *(specify):*

A provider of this service must meet the requirements in Chapter 45 of Wyoming Medicaid Rules. Requirements for providers include, but are not limited to: a successful criminal history background screening; a current CPR and First Aid

certification; a current Medication Assistance certification for assisting participants with medications; a current crisis intervention and restraint usage certification, if applicable; and a current driver's license and vehicle insurance, if providing transportation. A provider must complete participant specific training prior to providing services to the participant. In addition to Chapter 45 requirements, providers must adhere to the standards and requirements of all applicable Medicaid rules and regulations, all sub-regulatory guidance, and the Wyoming Medicaid Provider Agreement.

A provider must ensure that services occur in settings that are community based, and facilitate opportunities for participants to access the community and community resources to the same degree as people who do not receive HCBS. A participant must have choice in with whom they spend their time, the activities and events in which they are involved, and from whom they receive assistance and support. A participant must have choice and decision making authority over how they budget, manage, and spend money. A participant must be treated with dignity and respect, have their privacy respected to the extent possible for health and safety, and be free from coercion and restraint. Any restriction of a participant's rights must meet federal requirements and include an assessed need and a restoration plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Community Support Services

Provider Category:

Agency

Provider Type:

Agency certified by DHCF to provide service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider that employs one or more individuals other than themselves, and otherwise does not meet the definition of an individual provider. An agency provider is required to attain and maintain a certification for this service from DHCF, and demonstrate the legal payment of employee compensation (e.g., IRS Form 1096 that proves the issuance of one or more Form 1099, IRS Form W-3 that proves the issuance of one or more Form W-2) upon request. If a provider meets the criteria outlined in Section 25 of Chapter 45 of Wyoming Medicaid Rules, it must attain and maintain accreditation by a nationally recognized accreditation entity for human services as specified.

Other Standard *(specify):*

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

A provider must ensure that services occur in settings that are community based and facilitate opportunities for participants to access the community and community resources to the same degree as people who do not receive HCBS. A participant

must have choice in with whom they spend their time, the activities and events in which they are involved, and from whom they receive assistance and support. A participant must have choice and decision making authority over how they budget, manage, and spend money. A participant must be treated with dignity and respect, have their privacy respected to the extent possible for health and safety, and be free from coercion and restraint. Any restriction of a participant's rights must meet federal requirements and include an assessed need and a restoration plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

HCBS Taxonomy:

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

Service Definition *(Scope):*

Homemaker services consist of chore-type activities such as meal preparation and routine household care. Services are available when the individual who is regularly responsible for these activities is temporarily unavailable or unable to manage the home and care for him or herself or others in the home.

Examples of covered tasks include but are not limited to 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.

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

This service is not available to participants who receive Special Family Habilitation Home, Host Home Services or CLS level 3-6.

A provider must not bill for two participants during the same time frame.

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Individual

Provider Type:

Individual hired by the participant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Prior to providing services, and individual being hired by the participant shall:

- Be at least 18 years of age;
- Successfully pass a criminal history background screening;
- Be able to effectively communicate with the participant and other stakeholders;
- Be able to complete record keeping as required by the employer

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent- Financial Management Service

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Agency certified by DHCF to provide service

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

A provider that employs one or more individuals other than themselves, and otherwise does not meet the definition of an individual provider. An agency provider is required to attain and maintain a certification for this service from DHCF, and demonstrate the legal payment of employee compensation (e.g., IRS Form 1096 that proves the issuance of one or more Form 1099, IRS Form W-3 that proves the issuance of one or more Form W-2) upon request.

Other Standard *(specify):*

A provider of this service must meet the requirements in Chapter 45 of Wyoming Medicaid Rules. In addition to Chapter 45 requirements, providers must adhere to the standards and requirements of all applicable Medicaid rules and regulations, all sub-regulatory guidance, and the Wyoming Medicaid Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Individual

Provider Type:

Independent Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider who does not designate wages and does not employ staff members other than themselves. This provider typically does not have a business tax identification number, but instead uses their social security number as a business tax identification number. An individual provider is required to attain and maintain a certification for this service from DHCF.

Other Standard *(specify):*

A provider of this service must meet the requirements in Chapter 45 of Wyoming Medicaid Rules. In addition to Chapter 45 requirements, providers must adhere to the standards and requirements of all applicable Medicaid rules and regulations, all sub-regulatory guidance, and the Wyoming Medicaid Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

HCBS Taxonomy:

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

Service Definition *(Scope):*

Personal Care Services (PCS) consist of a range of assistance to enable participants to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may include hands-on assistance or prompting the participant to perform a task. PCS may be provided on an episodic or on a continuing basis. Health-related services that may be provided include care relating to medical or health protocols, medication assistance or administration, and range of motion exercises. Health related services may be provided after staff are trained by the appropriate trainer or medical

professional, and documentation of training is evident.

PCS may include assistance in performing activities of daily living (ADLs) (e.g., bathing dressing, personal hygiene, bathroom assistance, transferring, maintaining continence) and more complex instrumental activities of daily living (IADLs) on the participant's property (e.g., light housework, laundry, meal preparation exclusive of the cost of the meal, medication and money management).

The participant must be physically present during this service. PCS must be provided in the participant's home or on their property. PCS must be essential to the health and welfare of the participant rather than that participant's family.

As authorized in 42 U.S.C 1396a(h), CLS may be provided in an acute care hospital if the services are:
- Identified in the participant's IPC;
- Provided to meet needs of the participant that are not met through the provision of acute care hospital services;
- Not a substitute for services that the acute care hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and
- Designed to ensure smooth transitions between the acute care setting and the home and community-based settings, and to preserve the individual's functional abilities.

Case managers and providers must coordinate with hospital staff and plan of care team members in order to ensure that the participant's transition from a temporary hospital stay to their home is seamless.

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

PCS is available to all ages and is a 1:1 service. The number of units authorized by DHCF are based on the participant's extraordinary care needs as specified in their IPC and other assessments, and shall not exceed 7,280 units.

PCS is included in ADS, Companion, Child Habilitation, CSS, Supported Employment, and CLS, and cannot be billed during the same time frame as these services, which is subject to audit by the Program Integrity Unit within the Single State Medicaid Agency. PCS cannot be provided on the same IPC as special family habilitation home and host home services.

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

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

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

A legally authorized representative of a participant under the age of 18 may provide PCS to their ward if they meet the restrictions noted above. A legally authorized representative will not be authorized to provide PCS to a participant who is 18 years of age or older.

If a legally authorized representative is providing PCS to their minor ward, the IPC must be developed and monitored by a case manager without a conflict of interest to ensure the services are in the best interest of the participant.

Relative providers and legally authorized representatives cannot provide this service through participant-direction.

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

Transportation costs are not included as part of this service.

This service is subject to electronic visit verification.

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:

Individual

Provider Type:

Individual hired by the participant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Prior to providing services, and individual being hired by the participant shall:

- Be at least 18 years of age;
- Successfully pass a criminal history background screening;

- Be able to effectively communicate with the participant and other stakeholders;
- Be able to complete record keeping as required by the employer;
- Hold a current driver's license and automobile insurance, if providing transportation during the provision of services;
- Hold a current CPR and First Aid certification;
- Hold a current Medications Assistance Training certification, if applicable; and
- Hold a certificate in crisis intervention and restraint usage (CPI, Mandt), if applicable for the participant's needs.

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent- Financial Management Service

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:

Agency

Provider Type:

Agency certified by DHCF to provide service

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

A provider that employs one or more individuals other than themselves, and otherwise does not meet the definition of an individual provider. An agency provider is required to attain and maintain a certification for this service from DHCF, and demonstrate the legal payment of employee compensation (e.g., IRS Form 1096 that proves the issuance of one or more Form 1099, IRS Form W-3 that proves the issuance of one or more Form W-2) upon request. If a provider meets the criteria outlined in Section 25 of Chapter 45 of Wyoming Medicaid Rules, it must attain and maintain accreditation by a nationally recognized accreditation entity for human services as specified.

Other Standard *(specify):*

A provider of this service must meet the requirements in Chapter 45 of Wyoming Medicaid Rules. Requirements for providers and provider direct care staff include, but are not limited to: a successful criminal history background screening; a current CPR and First Aid certification; a current Medication Assistance certification for direct care staff assisting participants with medications; a current crisis intervention and restraint usage certification, if applicable; and a current driver's license and vehicle insurance, if providing transportation. Direct care staff must complete participant specific

training prior to providing services to the participant. In addition to Chapter 45 requirements, providers must adhere to the standards and requirements of all applicable Medicaid rules and regulations, all sub-regulatory guidance, and the Wyoming Medicaid Provider Agreement.

A provider must ensure that services occur in settings that are community based and facilitate opportunities for participants to access the community and community resources to the same degree as people who do not receive HCBS. A participant must have choice in with whom they spend their time, the activities and events in which they are involved, and from whom they receive assistance and support. A participant must have choice and decision making authority over how they budget, manage, and spend money. A participant must be treated with dignity and respect, have their privacy respected to the extent possible for health and safety, and be free from coercion and restraint. Any restriction of a participant's rights must meet federal requirements and include an assessed need and a restoration plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:

Individual

Provider Type:

Independent Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider who does not designate wages and does not employ staff members other than themselves. This provider typically does not have a business tax identification number, but instead uses their social security number as a business tax identification number. An individual provider is required to attain and maintain a certification for this service from DHCF. If an individual provider meets the criteria outlined in Section 25 of Chapter 45 of Wyoming Medicaid Rules, they must attain and maintain accreditation by a nationally recognized accreditation entity for human services as specified.

Other Standard *(specify):*

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

A provider must ensure that services occur in settings that are community based, and facilitate opportunities for participants to access the community and community resources to the same degree as people who do not receive HCBS. A participant must have choice in with whom they spend their time, the activities and events in which they are involved, and from whom they receive assistance and support. A participant must have choice and decision making authority over how they budget, manage, and spend money. A participant must be treated with dignity and respect, have their privacy respected to the extent possible for health and safety, and be free from coercion and restraint. Any restriction of a participant's rights must meet

federal requirements and include an assessed need and a restoration plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

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

Service Definition *(Scope):*

Respite services are intended to be utilized on a short-term basis to provide relief for an unpaid caregiver from the daily burdens of care. Respite includes assistance with personal care and activities of daily living, medication assistance if needed, and supervision.

Respite may be provided in the caregiver's home, the provider's home, the participant's home, or in community settings. Therespite setting and services must support the identified needs of the participant. Respite cab only be provided for up to two participants at the same time. Three participants may be supported in this service if they are family members, live in the same household, and can be safely supported by one provider. A provider may also supervise other children under the age of 12, or other individuals requiring support and supervision, but must limit the total combined number of people under their care to no more than three, unless approved by DHCF. The provider must adhere to the supervision levels identified in each

participant's IPC.

Routine transportation is included in the service rate

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

Respite must not be used to substitute care while the primary caregiver is at work, or during services otherwise available through public education programs including education activities, after school supervision, daytime services when the school is not in session, or services to preschool age children. The participant may choose to receive a more appropriate service, such as Child Habilitation or Companion Services, for support and supervision while their primary caregiver is working. Respite cannot be used to relieve any paid providers, including providers of Community Living, Community Supports, or Adult Day Services.

Respite cannot be provided to individuals under the age of 18 and individuals 18 and older at the same time, unless participants are members of the same family and the situation has been approved by DHCF, In these situations, a detailed description of how Respite will be provided must be included in each participant's IPC.
- Respite is billed at a 15 minute or daily unit. The 15 minute and daily unit cannot be billed on the same day. Any use of respite over nine (9) hours a day must
be billed as a daily unit.
- There is an annual cap of 5616 individual 15-minute units. Each daily unit counts as 37 units against the 5616 individual 15-minute units.
- Approved service units are based upon the participant's need and budget limit.
- Relative providers (defined as biological, adoptive, or step parents) cannot provide this service.
- Respite services cannot be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the Single
State Medicaid Agency. This prohibition includes billing for or providing Respite on the same day the participant receives a daily unit of CLS.

This service is subject to electronic visit verification.

FFP may not be claimed for room and board when respite is provided in the participant's home or place of residence.

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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	Independent Provider
Agency	Agency certified by DHCF to provide service
Individual	Individual hired by the participant

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Independent Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider who does not designate wages and does not employ staff members other than themselves. This provider typically does not have a business tax identification number, but instead uses their social security number as a business tax identification number. An individual provider is required to attain and maintain a certification for this service from DHCF. If an individual provider meets the criteria outlined in Section 25 of Chapter 45 of Wyoming Medicaid Rules, they must attain and maintain accreditation by a nationally recognized accreditation entity for human services as specified.

Other Standard *(specify):*

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

A provider must ensure that services occur in settings that are community based, and facilitate opportunities for participants to access the community and community resources to the same degree as people who do not receive HCBS. A participant must have choice in with whom they spend their time, the activities and events in which they are involved, and from whom they receive assistance and support. A participant must have choice and decision making authority over how they budget, manage, and spend money. A participant must be treated with dignity and respect, have their privacy respected to the extent possible for health and safety, and be free from coercion and restraint. Any restriction of a participant's rights must meet federal requirements and include an assessed need and a restoration plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Agency certified by DHCF to provide service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider that employs one or more individuals other than themselves, and otherwise does not meet the definition of an individual provider. An agency provider is required to attain and maintain a certification for this service from DHCF, and demonstrate the legal payment of employee compensation (e.g., IRS Form 1096 that proves the issuance of one or more

Form 1099, IRS Form W-3 that proves the issuance of one or more Form W-2) upon request. If a provider meets the criteria outlined in Section 25 of Chapter 45 of Wyoming Medicaid Rules, it must attain and maintain accreditation by a nationally recognized accreditation entity for human services as specified.

Other Standard *(specify):*

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

A provider must ensure that services occur in settings that are community based and facilitate opportunities for participants to access the community and community resources to the same degree as people who do not receive HCBS. A participant must have choice in with whom they spend their time, the activities and events in which they are involved, and from whom they receive assistance and support. A participant must have choice and decision making authority over how they budget, manage, and spend money. A participant must be treated with dignity and respect, have their privacy respected to the extent possible for health and safety, and be free from coercion and restraint. Any restriction of a participant's rights must meet federal requirements and include an assessed need and a restoration plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Individual hired by the participant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Prior to providing services, and individual being hired by the participant shall:

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent- Financial Management Service

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

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

Service Definition *(Scope):*

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

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

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

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

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

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

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

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

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

SEFA reimbursable activities include:

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

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

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

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

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

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

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

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

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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	Independent Provider
Individual	Individual hired by the participant
Agency	Agency certified BY DHCF to provide service

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Individual

Provider Type:

Independent Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider who does not designate wages and does not employ staff members other than themselves. This provider typically does not have a business tax identification number, but instead uses their social security number as a business tax identification number. An individual provider is required to attain and maintain a certification for this service from DHCF. If an individual provider meets the criteria outlined in Section 25 of Chapter 45 of Wyoming Medicaid Rules, they must attain and maintain accreditation by a nationally recognized accreditation entity for human services as specified.

Other Standard *(specify):*

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

A provider must ensure that services occur in settings that are community based, and facilitate opportunities for participants to access the community and community resources to the same degree as people who do not receive HCBS. A participant must have choice in with whom they spend their time, the activities and events in which they are involved, and from whom they receive assistance and support. A participant must have choice and decision making authority over how they budget, manage, and spend money. A participant must be treated with dignity and respect, have their privacy respected to the extent possible for health and safety, and be free from coercion and restraint. Any restriction of a participant's rights must meet federal requirements and include an assessed need and a restoration plan.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Individual

Provider Type:

Individual hired by the participant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Prior to providing services, and individual being hired by the participant shall:

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent – Financial Management Service

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

Agency certified BY DHCF to provide service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider that employs one or more individuals other than themselves, and otherwise does not meet the definition of an individual provider. An agency provider is required to attain and maintain a certification for this service from DHCF, and demonstrate the legal payment of employee compensation (e.g., IRS Form 1096 that proves the issuance of one or more Form 1099, IRS Form W-3 that proves the issuance of one or more Form W-2) upon request. If a provider meets the criteria outlined in Section 25 of Chapter 45 of Wyoming Medicaid Rules, it must attain and maintain accreditation by a nationally recognized accreditation entity for human services as specified.

Other Standard *(specify):*

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

A provider must ensure that services occur in settings that are community based and facilitate opportunities for participants to access the community and community resources to the same degree as people who do not receive HCBS. A participant must have choice in with whom they spend their time, the activities and events in which they are involved, and from whom they receive assistance and support. A participant must have choice and decision making authority over how they budget, manage, and spend money. A participant must be treated with dignity and respect, have their privacy respected to the extent possible for health and safety, and be free from coercion and restraint. Any restriction of a participant's rights must meet federal requirements and include an assessed need and a restoration plan.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Dietician Services

HCBS Taxonomy:

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

Service Definition *(Scope):*

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

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

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

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

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

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

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Agency certified by DHCF to provide service

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

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

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Occupational Therapy

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Occupational Therapy (OT) Services consist of the full range of activities, which include assessing needs, developing a treatment plan, determining therapeutic intervention, and training and assisting with adaptive aids. OT Services through the waiver may be used for maintenance and the prevention of regression of skills.

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

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

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

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

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

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Agency certified by DHCF to provide service

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

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

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Physical Therapy

HCBS Taxonomy:

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

Service Definition *(Scope):*

Physical Therapy (PT) Services consist of the full range of activities that preserve and improve a participant's abilities for independent function such as range of motion, strength, tolerance, and coordination. It may also prevent, insofar as possible, progressive disabilities through the use of assistive and adaptive devices, positioning, and sensory stimulation.

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

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

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

Relative providers (defined as biological, adoptive, or step parents) cannot provide this service.
Services are available as an individual 15 minute unit or as a group session unit, which requires a minimum of 30 minutes in service in order to bill.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Agency certified by DHCF to provide service

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

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

Other Standard *(specify):*

A provider of this service must meet the requirements in Chapter 45 of Wyoming Medicaid Rules. Requirements for providers and provider direct care staff include, but are not limited to: a successful criminal history background screening; a current CPR and First Aid certification; a current Medication Assistance certification for direct care staff assisting participants with medications; a current crisis intervention and restraint usage certification, if applicable; and a current

driver's license and vehicle insurance, if providing transportation. Staff providing PT Services must complete participant specific training prior to providing services to the participant. In addition to Chapter 45 requirements, providers must adhere to the standards and requirements of all applicable Medicaid rules and regulations, all sub-regulatory guidance, and the Wyoming Medicaid Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Skilled Nursing

HCBS Taxonomy:

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

Service Definition *(Scope):*

Skilled Nursing Services are medical services delivered on an intermittent or part time basis to participants who have complex chronic medical conditions. Skilled Nursing Services are performed within the Nurses' scope of practice as defined by Wyoming's Nurse Practice Act, and include:

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

Services must require a level of expertise that is undeliverable by non-medically trained individuals. Services must be supported by an order from a licensed medical professional. The referral and any claims billed for this service must include the referring entity's NPI number. A Request for Prior Authorization of Skilled Nursing Services form must be submitted to

the DHCF contractor that approves Skilled Nursing Services, and a prior authorization must be obtained before services can be added to the participant's IPC.

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

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

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

Skilled Nursing Services are an extension of the Medicaid State Plan. Skilled nursing services may be used when Medicaid State Plan services have been exhausted, are not available in the participant's area, or the participant's needs cannot be met by the home health agency.

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

This service is subject to electronic visit verification

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Agency certified by DHCF to provide service

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

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

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Speech, Hearing and Language Services

HCBS Taxonomy:

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

Service Definition *(Scope):*

Speech, Hearing, and Language Services consist of a full range of activities that include screening and evaluation of participants with respect to speech function; development of therapeutic treatment plans; direct therapeutic intervention; selection, assistance, and training with augmentative communication devices, and the provision of ongoing therapy.

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

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

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

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

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

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Speech, Hearing and Language Services

Provider Category:

Agency

Provider Type:

Agency certified by DHCF to provide service

Provider Qualifications

License *(specify):*

If the agency is a Home Health Agency, it must be fully licensed in the State of Wyoming. Staff providing Speech, Hearing, and Language Services must have a current license to practice from the Wyoming State Board of Speech Pathology and Audiology.

Certificate *(specify):*

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

Other Standard *(specify):*

A provider of this service must meet the requirements in Chapter 45 of Wyoming Medicaid Rules. Requirements for providers and provider direct care staff include, but are not limited to: a successful criminal history background screening; a

current CPR and First Aid certification; a current Medication Assistance certification for direct care staff assisting participants with medications; a current crisis intervention and restraint usage certification, if applicable; and a current driver's license and vehicle insurance, if providing transportation. Staff providing Speech, Hearing, and Language Services must complete participant specific training prior to providing services to the participant. In addition to Chapter 45 requirements, providers must adhere to the standards and requirements of all applicable Medicaid rules and regulations, all sub-regulatory guidance, and the Wyoming Medicaid Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Behavioral Support Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10040 behavior support
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Behavioral Support Services are used to develop and implement individualized behavior plans based on behavioral sciences that focus on positive behaviors and identified challenges to improve a variety of well-defined skills. This service includes development of a functional behavior analysis, positive behavior support plan, training in appropriate expression of emotions and desires through the implementation of positive behavior support, and interventions to increase adaptive replacement behaviors. Behavioral Support Services can also be accessed for the purpose of reducing the use of restrictions and restraints within a participant's current IPC.

Activities required for reimbursement:
- Direct contact and observation with the participant (and collaterals as necessary) for the purposes of baseline determinations and positive behavior support plan (PBSP)
development, which must comply with Chapter 45, Section 17 of Wyoming Medicaid Rules.
- Completing a functional behavior analysis and developing a PBSP and subsequent revisions utilizing positive behavior supports and interventions.
- Conducting participant training to support effective implementation of an individual's desired outcomes through comprehensive Positive Behavior Support.
- Creating templates and providing training and technical assistance with primary caregiver(s) on the implementation of the participant's PBSP.
- Documenting work completed, including case notes on training provided to primary caregivers and participants.
- Regularly reviewing the effectiveness of the PBSP with the participant and team.
- Generating summary documents to include baseline data regarding the behaviors, any progress has been made, intervention strategies have been implemented, and identified
barriers that may inhibit progress

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

Behavioral Support Services are available for participants who are 21 and older. Participants under the age of 21 can access this service through early education programs, school programs, and the Medicaid State Plan (for individuals with an Autism diagnosis).

Behavioral Support Services require a service request form, are subject to prior authorization by DHCF, and are not be covered under any billable service through the Medicaid State Plan.

A maximum of 120 units per plan year are available at the BCBA/BCaBA levels for initial assessment, completion of a functional behavior analysis, and PBSP development. A maximum of 960 units per year are available at the RBT level for measurement assessment, skill acquisition, behavior reduction, and documentation and reporting.

Documentation must be submitted to substantiate the need for continued Behavioral Support Services on subsequent plans as this service isn't meant to be a continuous long term service.

Activities that are not allowed under this service:
- Aversive techniques or any other technique not approved by the participant's person centered planning team and the provider's human rights committee, if applicable.
- Restrictive interventions described in Chapter 45 of Wyoming Medicaid Rules.
- Direct care services.
- Counseling, therapy, or other services covered under the Medicaid State Plan.

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

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Support Services

Provider Category:

Agency

Provider Type:

Agency certified by DHCF to provide service

Provider Qualifications

License *(specify):*

Agencies offering this service must ensure that the practicing provider of Behavioral Support Services follows the requirements and certifications established by the Board of Certified Behavior Analysts, per https://www.bacb.com. Each individual providing this service must meet the certification standards for the service that is being provided.

Certificate *(specify):*

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

Other Standard *(specify):*

A provider of this service must meet the requirements in Chapter 45 of Wyoming Medicaid Rules. Requirements for providers and clinicians include, but are not limited to: a successful criminal history background screening; a current CPR and First Aid certification; a current driver's license and vehicle insurance, if providing transportation. Clinicians must complete participant specific training prior to providing services to the participant. In addition to Chapter 45 requirements, providers must adhere to the standards and requirements of all applicable Medicaid rules and regulations, all sub-regulatory guidance, and the Wyoming Medicaid Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Support Services

Provider Category:

Individual

Provider Type:

Independent Provider

Provider Qualifications

License *(specify):*

A provider of Behavioral Support Services must follow the requirements and certifications established by the Board of Certified Behavior Analysts, per https://www.bacb.com.

Certificate *(specify):*

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

Other Standard *(specify):*

A provider of this service must meet the requirements in Chapter 45 of Wyoming Medicaid Rules. Requirements for providers and clinicians include, but are not limited to: a successful criminal history background screening; a current CPR

and First Aid certification; a current driver's license and vehicle insurance, if providing transportation. Clinicians must complete participant specific training prior to providing services to the participant. In addition to Chapter 45 requirements, providers must adhere to the standards and requirements of all applicable Medicaid rules and regulations, all sub-regulatory guidance, and the Wyoming Medicaid Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

DHCF will initially certify a new provider for one year. Renewal of that certification will be conducted at least once every three (3) years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Child Habilitation Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Child Habilitation Services provide regularly scheduled activities and supervision to children for a portion of their day. Services include training, coordination, and intervention directed at skill development and maintenance, physical health promotion and maintenance, language development, cognitive development, socialization, social and community integration, and domestic and economic management. This includes services not otherwise available through public education programs in the participant's local school district, including after school supervision, daytime services when school is not in session, and services to preschool age children. This service excludes any services available through public education programs funded under the Individuals with Disabilities Education Act (IDEA).

Services may be provided at various times of the day in multiple settings, when other waiver services would not be more appropriate, such as Respite or Personal Care. Service may occur in a single physical environment or in multiple environments, including settings in the community.

For children ages 0-12, this service includes the provision of supplementary staffing necessary to meet the child's exceptional care needs in a daycare setting. This service does not include the basic cost of child care, which is the rate charged by and paid to a child care center or worker for children who do not have special needs.

For children ages 13-17, this service is available for the cost of child care, which is no longer required after age 12. Transportation is included in the reimbursement rate.

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

Child Habilitation Services are limited to children under age 18. Approved services must be based on assessed need and fit within the participant's assigned budget.

A provider of Child Habilitation Services may receive reimbursement for up to two (2) participants at one time, but must limit the total combined number of people to whom they are providing services to no more than three, unless approved by DHCF. The provider must adhere to the supervision levels identified in each participant's IPC.
A relative provider (defined as a biological, adoptive, or step parent) cannot provide this service. Child Habilitation Services cannot be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the State Medicaid Agency.

Support with personal care needs, including medication assistance, is a component of the service, but may not comprise the entirety of the service. Personal Care Services cannot be billed at the same time as Child Habilitation Services.

This service is subject to electronic visit verification.

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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	Independent Provider
Agency	Agency certified by DHCF to provide service
Individual	Individual hired by the participant

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Child Habilitation Services

Provider Category:

Individual

Provider Type:

Independent Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider who does not designate wages and does not employ staff members other than themselves. This provider typically does not have a business tax identification number, but instead uses their social security number as a business tax identification number. An individual provider is required to attain and maintain a certification for this service from DHCF. If an individual provider meets the criteria outlined in Section 25 of Chapter 45 of Wyoming Medicaid Rules, they must attain and maintain accreditation by a nationally recognized accreditation entity for human services as specified.

Other Standard *(specify):*

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

A provider must ensure that services occur in settings that are community based, and facilitate opportunities for participants to access the community and community resources to the same degree as people who do not receive HCBS. A participant must have choice in with whom they spend their time, the activities and events in which they are involved, and from whom they receive assistance and support. A participant must have choice and decision making authority over how they budget, manage, and spend money. A participant must be treated with dignity and respect, have their privacy respected to the extent possible for health and safety, and be free from coercion and restraint. Any restriction of a participant's rights must meet federal requirements and include an assessed need and a restoration plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Child Habilitation Services

Provider Category:

Agency

Provider Type:

Agency certified by DHCF to provide service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider that employs one or more individuals other than themselves, and otherwise does not meet the definition of an individual provider. An agency provider is required to attain and maintain a certification for this service from DHCF, and demonstrate the legal payment of employee compensation (e.g., IRS Form 1096 that proves the issuance of one or more Form 1099, IRS Form W-3 that proves the issuance of one or more Form W-2) upon request. If a provider meets the criteria outlined in Section 25 of Chapter 45 of Wyoming Medicaid Rules, it must attain and maintain accreditation by a nationally recognized accreditation entity for human services as specified.

Other Standard *(specify):*

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

A provider must ensure that services occur in settings that are community based and facilitate opportunities for participants to access the community and community resources to the same degree as people who do not receive HCBS. A participant must have choice in with whom they spend their time, the activities and events in which they are involved, and from whom they receive assistance and support. A participant must have choice and decision making authority over how they budget, manage, and spend money. A participant must be treated with dignity and respect, have their privacy respected to the extent possible for health and safety, and be free from coercion and restraint. Any restriction of a participant's rights must meet federal requirements and include an assessed need and a restoration plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Child Habilitation Services

Provider Category:

Individual

Provider Type:

Individual hired by the participant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Prior to providing services, and individual being hired by the participant shall:

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

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

received training on the following DHCF policies and procedures:

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent- Financial Management Service

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Cognitive Retraining

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11120 cognitive rehabilitative therapy
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Cognitive retraining provides training and rehabilitation services to the participant and family members that assists in the restoration of cognitive function (e.g. ability or skills for learning, analysis, memory, attention, concentration, orientation,

and information processing) in accordance with the IPC. This service is specifically for individuals with an acquired brain injury (ABI), who meet the criteria outlined in Chapter 46, Section 5 of Wyoming Medicaid Rules.

Activities include:
- Direct contact and observation with the participant (and collaterals as necessary) for the purposes of baseline determinations and treatment plan development.
Treatment may focus on safety in the community, interacting with others, initiation and goal setting and money management skills. Vocational evaluation and
training may also be a component of this service.
- Conducting participant training to support effective implementation of an individual's desired outcomes. Training generally focuses on developing higher level
motor, social, and cognitive skills in order to prepare and support the participant to return to independent living and potentially to work.
- Creating templates and providing training and technical assistance with primary caregiver(s) on the implementation of the participant’s treatment plan.
- Documenting work completed, including case notes on training provided to primary caregivers and participants.
- Regularly reviewing the effectiveness of the treatment plan with the participant and team.
- Generating summary documents to include baseline data, progress made, intervention strategies that have been implemented, and identified barriers that may inhibit
progress.

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

Cognitive Retraining Services are available for participants who are 21 and older and have an acquired brain injury.

Documentation that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 (Vocational Rehabilitation or Workforce Services) must be maintained in the case manager and provider file. A third party liability form may be required by DHCF.

A maximum of 520 units per plan year are available. Documentation must be submitted to substantiate the need for continued Cognitive Retraining Services on subsequent plans as this service isn’t meant to be a continuous long term service.

Activities that are not allowed under this service:
- Aversive techniques or any other technique not approved by the participant’s person centered planning team.
- Restrictive interventions described in Chapter 45 of Wyoming Medicaid Rules.
- Direct care services.
- Counseling, therapy, or other services covered under the Medicaid State Plan.

Relative providers (defined as biological, step, or adoptive parents), spouses, and legally authorized representatives cannot provide this service.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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	Independent Provider
Agency	Agency certified by DHCF to provide service

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Cognitive Retraining

Provider Category:

Individual

Provider Type:

Independent Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider who does not designate wages and does not employ staff members other than themselves. This provider typically does not have a business tax identification number, but instead uses their social security number as a business tax identification number. An individual provider is required to attain and maintain a certification for this service from DHCF. An individual providing this service must be:
- Certified in cognitive retraining from an accredited institution of higher learning;
- Be a certified Brain Injury Specialist through the Brain Injury Association of America (https://www.biausa.org/professionals/acbis/certified-brain-injury-specialist/cbis-information-eligibility);
- Be a licensed professional with one year of acquired brain injury training; or
- Have a Bachelor's degree in a related field and three (3) years of experience in working with people with acquired brain injuries.

Other Standard *(specify):*

A provider of this service must meet the requirements in Chapter 45 of Wyoming Medicaid Rules. Requirements for providers include, but are not limited to: a successful criminal history background screening and a current CPR and First Aid certification. Providers must complete participant specific training prior to providing services to the participant. In addition to Chapter 45 requirements, providers must adhere to the standards and requirements of all applicable Medicaid rules and regulations, all sub-regulatory guidance, and the Wyoming Medicaid Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Cognitive Retraining

Provider Category:

Agency

Provider Type:

Agency certified by DHCF to provide service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider that employs one or more individuals other than themselves, and otherwise does not meet the definition of an individual provider. To be able to provide this service, an agency provider is required to attain and maintain a certification for this service from the DHCF, and demonstrate the legal payment of employee compensation (e.g., IRS Form 1096 that proves the issuance of one or more Form 1099, IRS Form W-3 that proves the issuance of one or more Form W-2) upon request. Agencies are required to verify that the staff member providing the service is:
- Certified in cognitive retraining from an accredited institution of higher learning;
- Is a certified Brain Injury Specialist through the Brain Injury Association of America (https://www.biausa.org/professionals/acbis/certified-brain-injury-specialist/cbis-information-eligibility);
- Is a licensed professional with one year of acquired brain injury training; or
- Has a Bachelor's degree in a related field and three (3) years of experience in working with people with acquired brain injuries.

Other Standard *(specify):*

A provider of this service must meet the requirements in Chapter 45 of Wyoming Medicaid Rules. Requirements for providers and staff members include, but are not limited to: a successful criminal history background screening and a current CPR and First Aid certification. Providers and affected staff members must complete participant specific training prior to providing services to the participant. In addition to Chapter 45 requirements, providers must adhere to the standards and requirements of all applicable Medicaid rules and regulations, all sub-regulatory guidance, and the Wyoming Medicaid Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Companion Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08040 companion
Category 2:	**Sub-Category 2:**

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Companion Services include supervision, socialization, and assistance for a participant to maintain safety in the home and community, and to enhance independence. Companions may assist or supervise the participant with tasks such as meal preparation, laundry, and shopping, but do not perform these activities as discrete services. Companions may also perform light housekeeping tasks that are incidental to the care and supervision of the participant. The provision of Companion Services does not entail hands-on nursing care, but does include personal care, such as medication assistance, and assistance iwith activities of daily living, as needed, during the provision of services. Routine transportation is included in the reimbursement rate.

As authorized in 42 U.S.C 1396a(h), CLS may be provided in an acute care hospital if the services are:
- Identified in the participant's IPC;
- Provided to meet needs of the participant that are not met through the provision of acute care hospital services;
- Not a substitute for services that the acute care hospital is obligated to provide through its conditions of participation or under Federal or State law, or
under another applicable requirement; and
- Designed to ensure smooth transitions between the acute care setting and the home and community-based settings, and to preserve the individual's functional
abilities.

Case managers and providers must coordinate with hospital staff and plan of care team members in order to ensure that the participant's transition from a temporary hospital stay to their home is seamless.

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

This service is subject to electronic visit verification.

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

This service is available to participants ages 18 and up. It is reimbursed at a 15-minute unit and is available as a 1:1 service or as a group service 2 or 3 people. Service can be provided for no more than nine (9) hours a day except for special events or out of town trips. This service cannot be used to provide monitoring while a participant sleeps.

Companion Services provided to participants ages 18 through 21 must not duplicate or replace services that are covered under IDEA. Providers cannot serve children and adults at the same time unless authorized in advance by DHCF. Services cannot be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit.

A participant’s IPC may include two or more types of non-residential services as long as service times do not overlap. Non-residential services must not exceed an average weekly amount of 35 hours if the participant receives Community Living Services levels 3-6.

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

This service is subject to electronic visit verification.

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Companion Services

Provider Category:

Individual

Provider Type:

Individual hired by the participant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Prior to providing services, and individual being hired by the participant shall:

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent- Financial Management Service

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Companion Services

Provider Category:

Individual

Provider Type:

Independent Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider who does not designate wages and does not employ staff members other than themselves. This provider typically does not have a business tax identification number, but instead uses their social security number as a business tax identification number. An individual provider is required to attain and maintain a certification for this service from DHCF. If an individual provider meets the criteria outlined in Section 25 of Chapter 45 of Wyoming Medicaid Rules, they must attain and maintain accreditation by a nationally recognized accreditation entity for human services as specified.

Other Standard *(specify):*

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

A provider must ensure that services occur in settings that are community based, and facilitate opportunities for participants to access the community and community resources to the same degree as people who do not receive HCBS. A participant must have choice in with whom they spend their time, the activities and events in which they are involved, and from whom they receive assistance and support. A participant must have choice and decision making authority over how they budget, manage, and spend money. A participant must be treated with dignity and respect, have their privacy respected to the extent possible for health and safety, and be free from coercion and restraint. Any restriction of a participant's rights must meet federal requirements and include an assessed need and a restoration plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Companion Services

Provider Category:

Agency

Provider Type:

Agency certified by DHCF to provide service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider that employs one or more individuals other than themselves, and otherwise does not meet the definition of an individual provider. An agency provider is required to attain and maintain a certification for this service from DHCF, and demonstrate the legal payment of employee compensation (e.g., IRS Form 1096 that proves the issuance of one or more Form 1099, IRS Form W-3 that proves the issuance of one or more Form W-2) upon request. If a provider meets the criteria outlined in Section 25 of Chapter 45 of Wyoming Medicaid Rules, it must attain and maintain accreditation by a nationally recognized accreditation entity for human services as specified.

Other Standard *(specify):*

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

A provider must ensure that services occur in settings that are community based and facilitate opportunities for participants to access the community and community resources to the same degree as people who do not receive HCBS. A participant must have choice in with whom they spend their time, the activities and events in which they are involved, and from whom they receive assistance and support. A participant must have choice and decision making authority over how they budget, manage, and spend money. A participant must be treated with dignity and respect, have their privacy respected to the extent possible for health and safety, and be free from coercion and restraint. Any restriction of a participant's rights must meet federal requirements and include an assessed need and a restoration plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Crisis Intervention Support

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
10 Other Mental Health and Behavioral Services	10030 crisis intervention
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Crisis Intervention Services are available for situations in which a participant's tier level may not provide sufficient support for specific activities, medical conditions, or occurrences of behaviors or crisis, but extensive supervision is not needed at all times. Crisis Intervention provides funding for extra staff support in order to supervise a participant during times of periodic behavioral episodes when a participant is a danger to themselves or others, or if the participant has an occasional or temporary medically fragile situation and is at risk of imminent harm without the extra staff support. Intervention for behavioral purposes is not intended for monitoring the participant should the behavior occur, but for the purpose of supporting the participant when the need arises, using positive behavior supports and interventions outlined in the IPC to de-escalate a situation, teach appropriate behaviors, and keep the participant safe until they are stable.

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

Crisis Intervention can only be provided to a participant who is age 18 or older in a habilitation day service.

Crisis Intervention units are based on the participant's verified need and evidence of the diagnosis or condition requiring this service. Documentation of progress and data on behaviors and outcome of the intervention services must be submitted to the case manager and DHCF at the frequency specified in the IPC.

Relatives (defined as biological, adoptive, or step parents) cannot provide this service.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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	Independent Provider

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Crisis Intervention Support

Provider Category:

Individual

Provider Type:

Independent Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider who does not designate wages and does not employ staff members other than themselves. This provider typically does not have a business tax identification number, but instead uses their social security number as a business tax identification number. An individual provider is required to attain and maintain a certification for this service from DHCF. If an individual provider meets the criteria outlined in Section 25 of Chapter 45 of Wyoming Medicaid Rules, they must attain and maintain accreditation by a nationally recognized accreditation entity for human services as specified.

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Crisis Intervention Support

Provider Category:

Agency

Provider Type:

Agency certified by DHCF to provide service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider that employs one or more individuals other than themselves, and otherwise does not meet the definition of an individual provider. An agency provider is required to attain and maintain a certification for this service from DHCF, and demonstrate the legal payment of employee compensation (e.g., IRS Form 1096 that proves the issuance of one or more Form 1099, IRS Form W-3 that proves the issuance of one or more Form W-2) upon request. If a provider meets the criteria outlined in Section 25 of Chapter 45 of Wyoming Medicaid Rules, it must attain and maintain accreditation by a nationally recognized accreditation entity for human services as specified.

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Modification

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

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

Service Definition *(Scope):*

Environmental modifications include functionally necessary physical adaptations to the participant's residence, as outlined in the participant's IPC, that are necessary to ensure the health, welfare, and safety of the participant or that enable the participant to function with greater independence in the home. Adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are needed for the welfare of the participant.

All services must 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 $30,000 per family per any current or previous DHCF waiver will be calculated for purchases made after July 1, 2013. A request that addresses a critical health or safety need and exceeds the lifetime cap is subject to available funding and approval by the ECC.

Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). Adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant are excluded.

Modifications of rented or leased homes must be extraordinary alterations that are uniquely needed by the individual, and for which the property owner would not ordinarily be responsible.

Adaptations that are covered by the Medicaid State Plan, a state Independent Living Center, or Vocational Rehabilitation are excluded. 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 Waiver is the payor of last resort. Environmental Modifications cannot be used to modify settings that are owned or leased by providers of waiver services.

Pursuant to Chapter 44 of Wyoming Medicaid Rules, the case manager should not obtain quotes until the overall scope of the project is approved by DHCF. DHCF may use a third party to conduct an on-site visit to assess the proposed modification and need for the modification to ensure cost effectiveness.

Sale of environmental modifications cannot profit the participant or family.

Relative providers (defined as biological, adoptive, or step parents) may provide this service in accordance with Chapter 45 of Wyoming Medicaid Rules, and must adhere to the following requirements:
- They must be a certified Environmental Modification provider; and
- At least one other bid must be submitted to ensure cost effectiveness.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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	Independent Provider
Agency	Agency certified by DHCF to provide service

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modification

Provider Category:

Individual

Provider Type:

Independent Provider

Provider Qualifications

License *(specify):*

Provider must have the applicable building, electrical, plumbing, or contractor's license, as required by local and state regulations

Certificate *(specify):*

A provider who does not designate wages and does not employ staff members other than themselves. This provider typically does not have a business tax identification number, but instead uses their social security number as a business tax identification number. An individual provider is required to attain and maintain a certification for this service from DHCF

Other Standard *(specify):*

A provider of this service must meet the requirements in Chapter 45 of Wyoming Medicaid Rules. In addition to Chapter 45 requirements, providers must adhere to the standards and requirements of all applicable Medicaid rules, sub-regulatory guidance, and the Wyoming Medicaid Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modification

Provider Category:

Agency

Provider Type:

Agency certified by DHCF to provide service

Provider Qualifications

License *(specify):*

Provider must have the applicable building, electrical, plumbing, or contractor's license, as required by local and state regulations.

Certificate *(specify):*

A provider that employs one or more individuals other than themselves, and otherwise does not meet the definition of an individual provider. An agency provider is required to attain and maintain a certification for this service from DHCF, and demonstrate the legal payment of employee compensation (e.g., IRS Form 1096 that proves the issuance of one or more

Form 1099, IRS Form W-3 that proves the issuance of one or more Form W-2) upon request.

Other Standard *(specify):*

A provider of this service must acknowledge their duty to report the suspected abuse, neglect, and exploitation of participants in accordance with W.S. 14-3-205 and W.S. 35-20-103, and must adhere to the standards and requirements of all applicable Medicaid rules, sub-regulatory guidance, and the Wyoming Medicaid Provider Agreement. Providers must sign an acknowledgement of confidentiality and duty to report abuse, neglect, and exploitation.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Individual Habilitation Training

HCBS Taxonomy:

Category 1:	Sub-Category 1:
13 Participant Training	13010 participant training
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Individual Habilitation Training is a specialized 1:1 intensive training service to assist a participant with the acquisition or improvement in skills that will lead to more independence and a higher level of functioning. Individual Habilitation Training services are available for participants who live with unpaid caregivers or who need less than 24-hour paid supervision and support.

- Training objectives are required, must be meaningful to the participant, and may include: adaptive skill development; assistance and training on activities of daily

living; transportation safety and navigation; building social capital and connections; and hobby skill development for work on fine or gross motor skills.
- Objectives must be specific and measurable, and data must be tracked and analyzed for trends. Summary reports on progress or lack of progress must be provided to the
case manager and participant or legally authorized representative monthly. Objectives must be revised as needed when skills are acquired or the objective is not
yielding any progress.
- Services may be provided in the participant's home, a provider setting, or in the community.
- Services may include supporting the participant to be included and involved in associations and community groups, and a broad range of community activities including
opportunities to pursue social and cultural interests, choice making, and volunteering.
- Transportation relating to the participant's training objective must be provided by the service provider and is included in the rate for the service.
- This service includes services not otherwise available through IDEA or other public education programs in the participant's local school district, including after
school supervision, daytime services when school is not in session, and services to preschool age children

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

Individual Habilitation Training is an intensive training service; therefore, it is expected that training is occurring at all times this service is being provided. If the participant is unable to sustain intensive training, the IPC must identify an alternate service to be used during times in which supervision is provided but training is not conducted.

Individual Habilitation Training is a 1:1 service. It is available to participant's ages 0 through 20, and must be provided based upon the participant's needs and IBA. Individual Habilitation Training is limited to 4 hours a day. Individual Habilitation Training cannot be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the State Medicaid Agency

Relative providers (defined as a biological, adoptive, or step parent) cannot provide this service.

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Individual Habilitation Training

Provider Category:

Individual

Provider Type:

Individual hired by the participant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Prior to providing services, and individual being hired by the participant shall:

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

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

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

Within a year of being certified in this service, and annually thereafter, the provider or staff providing the service must successfully complete at least eight (8) hours of continued education in any of the following areas: specific disabilities or diagnosed conditions relating to the population s/he serves, writing measurable objectives, gathering and using data to develop better training programs, or training modules posted by the Division.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent- Financial Management Service

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Individual Habilitation Training

Provider Category:

Agency

Provider Type:

Agency certified by DHCF to provide service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider that employs one or more individuals other than themselves, and otherwise does not meet the definition of an individual provider. An agency provider is required to attain and maintain a certification for this service from DHCF, and demonstrate the legal payment of employee compensation (e.g., IRS Form 1096 that proves the issuance of one or more Form 1099, IRS Form W-3 that proves the issuance of one or more Form W-2) upon request. If a provider meets the criteria outlined in Section 25 of Chapter 45 of Wyoming Medicaid Rules, it must attain and maintain accreditation by a nationally recognized accreditation entity for human services as specified.

Other Standard *(specify):*

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

A provider must ensure that services occur in settings that are community based and facilitate opportunities for participants to access the community and community resources to the same degree as people who do not receive HCBS. A participant must have choice in with whom they spend their time, the activities and events in which they are involved, and from whom they receive assistance and support. A participant must have choice and decision making authority over how they budget, manage, and spend money. A participant must be treated with dignity and respect, have their privacy respected to the extent possible for health and safety, and be free from coercion and restraint. Any restriction of a participant's rights must meet federal requirements and include an assessed need and a restoration plan.

Within a year of being certified in this service, and annually thereafter, the provider must successfully complete at least eight (8) hours of continued education in any of the following areas: specific disabilities or diagnosed conditions relating to the population they serve, writing measurable objectives, gathering and using data to develop better training programs. This can include the ECHO training offered by the Wyoming Institute for Disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Individual Habilitation Training

Provider Category:

Individual

Provider Type:

Independent Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider who does not designate wages and does not employ staff members other than themselves. This provider typically does not have a business tax identification number, but instead uses their social security number as a business tax identification number. An individual provider is required to attain and maintain a certification for this service from DHCF. If an individual provider meets the criteria outlined in Section 25 of Chapter 45 of Wyoming Medicaid Rules, they must attain and maintain accreditation by a nationally recognized accreditation entity for human services as specified.

Other Standard *(specify):*

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

A provider must ensure that services occur in settings that are community based, and facilitate opportunities for participants to access the community and community resources to the same degree as people who do not receive HCBS. A participant must have choice in with whom they spend their time, the activities and events in which they are involved, and from whom they receive assistance and support. A participant must have choice and decision making authority over how they budget, manage, and spend money. A participant must be treated with dignity and respect, have their privacy respected to the extent possible for health and safety, and be free from coercion and restraint. Any restriction of a participant's rights must meet federal requirements and include an assessed need and a restoration plan.

Within a year of being certified in this service, and annually thereafter, the provider must successfully complete at least eight (8) hours of continued education in any of the following areas: specific disabilities or diagnosed conditions relating to the population they serve, writing measurable objectives, gathering and using data to develop better training programs. This can include the ECHO training offered by the Wyoming Institute for Disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Special Family Habilitation Home

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

02 Round-the-Clock Services	02031 in-home residential habilitation

Category 2: **Sub-Category 2:**

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

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

Service Definition *(Scope):*

Special family habilitation home (SFHH) services consist of participant specific, individually designed and coordinated services within a family (other than biological, step, or adoptive parents) host home environment. Services are only available to children ages 0 – 17.

Special family habilitation home services are available until another residential option is available to the child, subject to involvement from the Department of Family Services, Department of Education, Office of the Attorney General, and the Wyoming Department of Health. DHCF will work with the Department of Family Services and the Department of Education in order to help the child receive residential services if they are determined to be the last resort for the minor child. When a child on this service turns 18, s/he may transition to the appropriate community living service.

• Transportation between the participant's place of residence, other service sites, or places in the community is included in the rate.
• Providers are responsible for both formal and informal training opportunities. Participant schedules must be individualized and objectives must be meaningful. Training on
objectives is expected as part of the provision of services, and progress shall be documented and made available to the participant, legally authorized representative, and case
manager each month.
• The SFHH provider is the primary caregiver and assumes 24-hour care of the individual. The provider must be in the participant's residence, providing services during both awake
and sleeping time for a minimum of eight (8) hours in a twenty-four (24) hour period (from 12:00am – 11:59pm), in order to be reimbursed.
• Family visits and trips are encouraged. The provider shall be reimbursed on the days the participant leaves for and returns from a trip.

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

• This service is not open to new participants without going through the Extraordinary Care Committee (ECC) approval process for an out of home placement.
• This service cannot be used in conjunction with individual habilitation training services.
• SFHH services include personal care needs, so IPCs with both SFHH and personal care services will not be approved.
• Relative providers (defined as biological, step, or adoptive parents) shall not provide this service.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Special Family Habilitation Home

Provider Category:

Agency

Provider Type:

Agency certified by DHCF to provide service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider that employs one or more individuals other than themselves, and otherwise does not meet the definition of an individual provider. To be able to provide this service, an agency provider is required to attain and maintain a certification for this service from the DHCF, and demonstrate the legal payment of employee compensation (e.g., IRS Form 1096 that proves the issuance of one or more Form 1099, IRS Form W-3 that proves the issuance of one or more Form W-2) upon request. If a provider meets the criteria outlined in Section 25 of Chapter 45 of the Department of Health's Medicaid Rules, it shall attain and maintain accreditation by a nationally recognized accreditation entity for human services as specified.

Other Standard *(specify):*

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Special Family Habilitation Home

Provider Category:

Individual

Provider Type:

Independent Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider who does not designate wage rates and does not employ staff members other than themselves. This provider typically does not have a business tax identification number, but instead uses their social security number as a business tax identification number. To be able to provide this service, an individual provider is required to attain and maintain a certification for this service from DHCF. If an individual provider meets the criteria outlined in Section 25 of Chapter 45 of the Department of Health's Medicaid Rules, they shall attain and maintain accreditation by a nationally recognized accreditation entity for human services as specified.

Other Standard *(specify):*

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Specialized Equipment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Specialized Equipment includes:
- Devices, controls, or appliances that enables a participants to increase their ability to perform activities of daily living;
- Devices, controls, or appliances that enable a participant to perceive, control, or communicate with the environment or community in which they live;
- Approved remote monitoring equipment;
- Items necessary for life support or to address physical conditions, including ancillary supplies and equipment necessary for the proper functioning of such items;
- Other durable and non-durable medical equipment not available under the Medicaid State Plan or IEP that is necessary to address participant functional limitations;
and,
- Necessary medical supplies not available under the Medicaid State Plan or other insurance held by the participant. Items reimbursed with waiver funds are in
addition to any medical equipment and supplies furnished under the Medicaid State Plan and exclude those items that are not of direct medical or remedial benefit
to the participant. All items shall meet applicable standards of manufacture, design and installation.

The participant's IPC must reflect the need for equipment, how the equipment addresses health, safety, or accessibility needs of the participant or allows them to function with greater independence, and specific information on how often and where the equipment is used. Criteria for approval, allowable items, and limitations of this service are outlined in Chapter 44 of Wyoming Medicaid Rules.

Specialized Equipment must be functionally necessary and meet at least two of the following criteria, and is subject to DHCF approval:
- Be necessary to increase the participant's ability to perform activities of daily living or to perceive control, or communicate with the environment in which the
participant lives;
- Be necessary to enable the participant to function with greater independence and without which the participant would require institutionalization; or
- Be necessary to ensure the participant's health, welfare, and safety.

Relative providers (defined as biological, adoptive, and step parents) may provide this service if they meet the following requirements:

- They are a certified Specialized Equipment provider;
- They do not impose a mark-up to the total cost of the equipment when providing this service to their relative (unless they operate a non-profit corporation); and
- At least one other bid for the equipment is submitted to ensure cost effectiveness.

Case managers are responsible for searching and coordinating the purchasing of specialized equipment according to the service definition.

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

Specialized Equipment has a $4,000 annual limit and is subject to prior authorization through DHCF. The cost of the assessment must be funded as a part of the $4,000 cap.

Case managers are responsible for checking with Medicaid, Medicare, and a participant's other insurance carrier, as applicable, to see if the requested equipment is covered under their plans. The provider must then sign a third party verification form indicating that the Comprehensive Waiver is the payor of last resort.

If the participant has an Individualized Education Plan or Individualized Family Service Plan, the case manager is required to submit a copy of that document, along with documentation as to why the equipment is not available through those services.

The purchase of electronic technology devices is allowed once every five (5) years, and like items cannot be purchased during those five (5) years unless the device is used as a primary means for communication and the request is accompanied by a letter of necessity from a Speech Language Pathologist. DHCF will limit the purchase of general items (i.e., iPad, electronic tablet), and requires a written recommendation by a Certified Specialized Equipment professional before such an item is approved

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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	Independent Provider
Agency	Agency certified by DHCF to provide service

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Equipment

Provider Category:

Individual

Provider Type:

Independent Provider

Provider Qualifications

License *(specify):*

Provider shall have the applicable building, electrical, plumbing, or contractor's license, as required by local or state

regulations

Certificate *(specify):*

A provider who does not designate wages and does not employ staff members other than themselves. This provider typically does not have a business tax identification number, but instead uses their social security number as a business tax identification number. An individual provider is required to attain and maintain a certification for this service from DHCF. A case management provider cannot charge a markup for the service.

Other Standard *(specify):*

A provider of this service must meet the requirements in Chapter 45 of Wyoming Medicaid Rules. In addition to Chapter 45 requirements, providers must adhere to the standards and requirements of all applicable Medicaid rules, sub-regulatory guidance, and the Wyoming Medicaid Provider Agreement. Providers offering repair services (e.g., Wheelchair repair) must have the requisite certification necessary to complete the repair.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

DHCF will initially certify a new provider for one year. Renewal of that certification will be conducted at least once every three (3) years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Equipment

Provider Category:

Agency

Provider Type:

Agency certified by DHCF to provide service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider that employs one or more individuals other than themselves, and otherwise does not meet the definition of an individual provider. An agency provider is required to attain and maintain a certification for this service from DHCF, and demonstrate the legal payment of employee compensation (e.g., IRS Form 1096 that proves the issuance of one or more Form 1099, IRS Form W-3 that proves the issuance of one or more Form W-2) upon request. A case management provider cannot charge a markup for the service.

Other Standard *(specify):*

A provider of this service must adhere to the standards and requirements of all applicable Medicaid rules, sub-regulatory guidance, and the Wyoming Medicaid Provider Agreement. Providers offering repair services (e.g., wheelchair repair) must have the requisite certification necessary to complete the repair.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transportation

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
15 Non-Medical Transportation	15010 non-medical transportation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

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 IPC. 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:

Services are reimbursed by trip. A trip may be rounded up to 5 miles if at least 2 miles are traveled. A trip may be rounded up to 10 miles if at least 7 miles are traveled. Service is capped at $2,000 per year.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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	Independent Provider
Agency	Senior Center
Agency	Public Transit Agency
Agency	Contract Motor Carrier
Agency	Agency certified by DHCF to provide services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:

Individual

Provider Type:

Independent Provider

Provider Qualifications

License *(specify):*

Providers must have a current drivers license pursuant to State requirements.

Certificate *(specify):*

A provider who does not designate wages and does not employ staff members other than themselves. This provider typically does not have a business tax identification number, but instead uses their social security number as a business tax identification number. An individual provider is required to attain and maintain a certification for this service from DHCF.

Other Standard *(specify):*

A provider of this service must meet the requirements in Chapter 45 of Wyoming Medicaid Rules. Requirements for providers include, but are not limited to: a successful criminal history background screening; a current CPR and First Aid certification; vehicle insurance; and additional liability insurance for transporting people for business purposes. A provider must complete participant specific training prior to providing services to the participant. In addition to Chapter 45 requirements, providers must adhere to the standards and requirements of all applicable Medicaid rules, sub-regulatory guidance, and the Wyoming Medicaid Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

DHCF will initially certify a new provider for one year. Renewal of that certification will be conducted at least once every three (3) years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: 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:

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: 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:

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: 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:

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: Transportation

Provider Category:

Agency

Provider Type:

Agency certified by DHCF to provide services

Provider Qualifications

License *(specify):*

Agency providers must ensure that individuals who provide transportation have a current drivers license pursuant to State requirements.

Certificate *(specify):*

A provider that employs one or more individuals other than themselves, and otherwise does not meet the definition of an individual provider. An agency provider is required to attain and maintain a certification for this service from DHCF, and demonstrate the legal payment of employee compensation (e.g., IRS Form 1096 that proves the issuance of one or more Form 1099, IRS Form W-3 that proves the issuance of one or more Form W-2) upon request.

Other Standard *(specify):*

A provider of this service must meet the requirements in Chapter 45 of Wyoming Medicaid Rules. Requirements for providers include, but are not limited to: a successful criminal history background screening; a current CPR and First Aid certification; vehicle insurance; and additional liability insurance for transporting people for business purposes. A provider must complete participant specific training prior to providing services to the participant. In addition to Chapter 45 requirements, providers must adhere to the standards and requirements of all applicable Medicaid rules, sub-regulatory guidance, and the Wyoming Medicaid Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 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.*
- ☐ **As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management).** *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 and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

d. Remote/Telehealth Delivery of Waiver Services. Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

No services selected for remote delivery

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Providers and provider staff members who deliver direct waiver services, including managers, supervisors, direct care staff, participant employees hired through self-direction, and any other person who may have unsupervised access to participants, shall complete and pass 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.

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

DHCF requires the provider and all staff members to submit a background screening before they can provide waiver services. When a participant, or their representative, hires a new employee under the participant-directed service deliver option, the Financial Management Service shall assure the background screening is submitted before the employee can receive reimbursement for working for the participant.

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

DHCF requires a full subsequent background screening every 5 years. Additionally, providers and any person with an ownership or control interest or who is an agent or managing employee of the provider shall undergo subsequent monthly OIG screenings.

Providers are responsible for ensuring results of background screenings are maintained in the provider or staff file. DHCF completes a staff file review of provider agencies during the provider certification renewal process to assure background checks have been completed and to verify that staff meet the background check requirements to provide waiver services. DHCF also oversees the Financial Management Service provider to assure background checks are completed before employees of participants who are self-directing services begin working with the participant.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- ○ **No. The state does not conduct abuse registry screening.**
- ◉ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Wyoming Department of Family Services (DFS) maintains the Central Registry of child and disabled adult protection cases, as authorized in Wyoming State Statute W.S. §7-19-201. All providers and provider staff members who provide direct waiver services, including managers, supervisors, direct care staff, participant employees hired through participant direction, and any other person who may have unsupervised access to participants, shall submit a Central Registry Disclosure Form for screening by DFS to ensure they are not listed on the DFS central registry, per Chapter 45 of Wyoming Medicaid Rules.

Providers are responsible for ensuring results of the DFS central registry screening are maintained in the provider or staff file. DHCF completes a staff file review of provider agencies during the provider certification renewal process to assure central registry screenings have been completed and to verify that staff meet the requirements to provide waiver services. DHCF also oversees the Financial Management Service (FMS) provider. The FMS provider assures central registry screenings are completed before employees of participants who are self-directing services begin working with the participant.

DHCF requires a subsequent Central Registry Screening every five (5) years.

Appendix C: Participant Services

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

Note: Required information from this page 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 or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *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 types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is ***"extraordinary care"***, exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

Wyoming State Statute 42-4-102(a)(ii) provides the statutory authority to allow payments to legally responsible individuals as described in this section.

1. Children under the age of 18 may receive Personal Care Services from a legally responsible individual for services that are deemed extraordinary care, if
the legally responsible individual is the biological, adoptive, or step parent of a minor child, or the legally authorized representative of a minor
child.
2. The legally responsible individual(s) must be a certified Medicaid provider, establish a Limited Liability Company or a Corporation, and meet the
qualifications as specified in Chapter 45 of Wyoming Medicaid Rules.
3. The need for Personal Care Services must meet the service definition for personal care as described in Appendix C-1/C-3. Criteria for extraordinary care
shall meet the requirements specified below, and must be documented in the participant's IPC:
a. The participant's Adaptive Behavior Quotient is 0.35 or lower on the ICAP assessment; and
b. The participant needs assistance with ADLs or IADLs exceeding the range of expected activities that a legally responsible individual would
ordinarily perform in the household on behalf of a person of the same age without a disability or chronic illness, and which are necessary to assure
the health and welfare of the participant and avoid institutionalization. (Example: a 12 year old needing assistance with dressing and bathing, whereas
a typical 12 year old does not.); or
c. The participant requires care from a person with specialized medical skills relating to the participant's diagnosis or medical condition as determined
appropriate by the participant's licensed medical professional and DHCF.
4. Personal Care Services for extraordinary care paid to a legally responsible individual can't exceed four (4) hours per day per participant. Additional
units needed beyond 4 hours a day can only be approved by the Extraordinary Care Committee (ECC).
5. To ensure the provision of services is in the best interest of the participant, the IPC must be developed and monitored by a case manager without a
conflict of interest. The IPC must demonstrate that services do not duplicate similar services, natural supports, or services otherwise available to the
participant.
6. Personal Care Services are subject to prior authorization by DHCF and must be based on the participant's individual extraordinary care needs as specified
in the IPC and other assessments. Documentation of services provided are reviewed by the case manager on a monthly basis to verify that services delivered
align with the approved IPC.

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 types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

◉ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

DHCF recognizes that there are certain circumstances in which paying a relative to provide essential waiver services is the most efficient, cost effective, and beneficial to participants. These circumstances may include:
• A lack of available non-related providers in remote geographic regions that can furnish services at necessary times and places;
• A participant's extraordinary care needs; or
• The need for specialized medical skills acquired by relatives.

However, it is important to ensure that there are systems in place to guard against conflicts of interest, inadvertent limits on participant choice, and potential fraud.

1. A relative is defined as a biological, adoptive, or step parent who:
   a. Has established a LLC or other corporation;
   b. Is a certified Medicaid provider, or an employee of a certified Medicaid provider, and meets the qualifications specified in Chapter 45 of the
      Department of Health's Medicaid Rules; and
   c. Is not the spouse or legally authorized representative of the participant.
2. Relatives may furnish Community Living, Community Support, Personal Care, Environmental Modification, and Specialized Equipment.
   a. Specific limitations for relatives providing these services are outlined in Appendix C1.
3. Documentation of services provided must be reviewed by the case manager on a monthly basis to verify that services delivered align with the approved
   IPC.
4. Relatives paid to provide services as outlined above must meet the same requirements and qualifications as other providers and provider staff, and are
   subject to the same oversight levels as outlined in the waiver and applicable regulations and policies. All claims are subject to post-payment
   validation.
5. Relatives can't provide services through participant-direction.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR § 431.51:

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 DHCF 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 DHCF or its agent. Service providers qualified by the DHCF 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 Wyoming Medicaid Rules.

g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act. Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one*:

○ **No, the state does not choose the option to provide HCBS in acute care hospitals.**

◉ **Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions.** *By checking the boxes below, the state assures:*

☒ **The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;**

☒ **The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;**

☒ **The HCBS must be identified in the individual's person-centered service plan; and**

☒ **The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.**

And specify: **(a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting;(b) How the 1915(c) HCBS will assist the individual in returning to the community; and(c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.**

Adult Day Service (ADS), Community Living Support (CLS), Companion, and Personal Care services may be provided by HCBS waiver providers in Acute Care Hospitals. The need for HCBS services to be provided in Acute Care Hospitals must be identified through the participant's Individual Plan of Care (IPC). HCBS services cannot substitute for services that the acute care hospital is obligated to provide through its conditions of participation, or under Federal or State law, or under other applicable requirements. HCBS services can only be used to meet the needs of the participant that are not being met through Acute Care. The participant's plan of care team is responsible for ensuring a smooth transition back into the community. The case manager and CLS provider (when applicable) is responsible for facilitating team meetings, for meeting with acute care hospital personnel to discuss seamless transitions, and for ensuring necessary supports are in place to support the participant once they return to community services. There is no difference in the rate paid to providers.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's 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 - Number and Percent of waiver providers that initially met all state certification requirements. Numerator: # of waiver providers that initially met all state certification requirements Denominator: # of providers initially certified to provide waiver services

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

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

Data Aggregation and Analysis:

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

Performance Measure:
C.a2 - Number and Percent of waiver providers that obtained certification renewal prior to certification expiration. Numerator: # of waiver providers that obtained certification renewal prior to certification expiration Denominator: # of providers recertified

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
Information Management for Providers (IMPROV) system, or its successor

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

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

Data Aggregation and Analysis:

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

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 - Number and Percent of non-certified self-directed employees who met minimum requirements outlined in Wyoming rule and regulation. Numerator: # of non-certified participant-directed employees who met minimum requirements Denominator: total # of non-certified participant-directed employee

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

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

Data Aggregation and Analysis:

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

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
C.c1 - Number and Percent of enrolled waiver providers that met all state initial training requirements. Numerator: # of enrolled waiver providers that met all state initial training requirements Denominator: total # of enrolled waiver provders

Data Source (Select one):
Other
If 'Other' is selected, specify:
IMPROV, or its successor

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **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:
C.c2 - Number and Percent of enrolled providers that met all state ongoing training requirements. Numerator: # of enrolled providers that met all state ongoing training requirements Denominator: # of enrolled providers required to complete ongoing training

Data Source (Select one):
Other
If 'Other' is selected, specify:
Improv, or its successor

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **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 state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The anticipated outcome for this data collection is ensuring that the state has designed and implemented an adequate system for assuring that qualified providers deliver waiver services to participants. The state will review the performance measure data for this assurance on a quarterly basis. If, during a quarterly review, there are areas that do not meet anticipated outcomes, DHCF will ensure that issues caused by failure to follow process or policy are remedied through technical assistance and re-education at an individual level, and, where possible, through statewide training. Individual remediation activity requires follow up from DHCF to determine that the provider successfully completed the required corrective action. Corrective action plans, sanctions, and decertification may occur if a provider fails to meet remediation efforts. Remediation strategies include training, revision of administrative processes and procedures, administrative rule revisions, and waiver amendments. These strategies will be used based on the results of the discovery and analysis of the related performance measure. If compliance with the performance measure falls below 86%, a request for a corrective action plan, including activities and time lines for completion and follow-up, will be required. Follow-up will include a discovery process using a valid random sample.

On a quarterly basis, DHCF will review performance measures, corrective action, and other meaningful data listed above.

Processes for such review will be studied, and possibly adjusted on an annual basis.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

○ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

◉ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based

on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☒ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

A. The waiver services to which the limit applies:

The individual budget amount (IBA) assigned to a participant applies to any of the waiver services they choose to have on the IPC. Levels 3 - 6 of Community Living Services are not open to new participants without going through the Extraordinary Care Committee (ECC) approval process for an out of home placement.

B. The basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject:

DHCF uses a methodology for assessing need and determining budgets which provides a stable and equitable foundation on which to build a stronger, more person-centered waiver system that promotes greater community integration, employment support, and independence.

The IBA methodology uses the nationally recognized Inventory for Client and Agency Planning (ICAP) to determine budgets based on a participant's assessed needs. The ICAP is been applied to each applicant, and the assessment determines an individual's level of functioning for broad independence and general maladaptive factors. The sub-scores of the ICAP also measure a person's functioning in the areas of social and communication skills, personal living skills, motor skills, and community living skills.

A participant's IBA is determined by three (3) factors:

1. Level of Service score (LOS) (continuous scale between 1 – 6), assigned to a person based on independent assessments of need, including their ICAP scores,
supplemental assessments, and prior service utilization;
2. Living Situation: family home, independently or semi-independently, or in community living services; and
3. Age: over 21 or under 21 and in school.

Assessing the Level of Service Need
For each participant on the Comprehensive Waiver, the IBA algorithm uses three (3) separate 'passes' to assess the level of need on a continuous scale between 1 and 6.

The first pass determines a level based on the overall ICAP service score alone. The second pass considers the ICAP sub-scores corresponding most closely to overall behavioral and medical needs (general maladaptive score and personal living domain score, respectively). The highest of the first and second passes is chosen. The third pass, based on generated flags, considers other independent assessment information on the participant, based on specific assessment questions and prior service utilization. These flags may result in an adjustment of the final LOS, necessitating an adjusted budget in order to properly reflect the participant's assessed needs.

C. How the limit will be adjusted over the course of the waiver period:
DHCF reviews the methodology and algorithm used to set budgets each year to determine if the IBAs assigned are reflective of the assessed service needs of the participants. DHCF also reviews the IBA adjustments requests that have been submitted (whether approved or denied) in order to analyze the reasons for adjustment requests and determine whether a factor in the model is missing or incorrectly weighted.

D. Provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state:
If a participant's plan of care team believes a participant's IBA does not reflect the participant's assessed needs, they may request a review by the ECC. The request must accompany additional information on other assessed needs the plan of care team believes are inaccurately captured in the ICAP. The ECC process is outlined in Chapter 46, of Wyoming Medicaid Rules.

If a person needs a budget in excess of their approved IBA any budget increase must be approved by the ECC. DHCF will also work with the participant's team on other treatment, behavior or medical support services, and other service options to try to improve the person's condition and lower the cost of services over time.

E. The safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs:

DHCF reserves a portion of the waiver budget for emergency increases to an IBA. If a participant needs an IBA that exceeds the cost limit for the waiver, the participant and their plan of care team may receive an increased IBA for a period of one (1) to two (2) years, and may also be notified of other waiver options and programs in the state for which they are possibly eligible, in order to meet the person's health and safety needs.

Funding requests that are modified or denied are eligible for a fair hearing, and the participant is notified of this right. After approving additional funding, DHCF may complete follow-up monitoring to assure the funds are being utilized appropriately and the assessed need continues to exist for the participant.

F. How participants are notified of the amount of the limit:
Upon initial placement on the waiver, and prior to each annual IPC renewal, the case manager is notified of the participant's assigned IBA. The case manager is responsible for communicating the IBA to the participant and legally authorized representative in order to plan services. Any adjustments to IBAs based on legislative decisions or other factors will go through the same notification process.

The IBA Methodology is available for review on the DHCF website.

☐ **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 in which 1915(c) HCBS are recieved. *(Specify and describe the types of settings in which waiver services are received.)*

All Supports waiver services are provided in the participant's home and community. Specific setting types include all residential and non-residential settings, and include the following services, which are re-assessed during regular provider certification renewals: Adult Day Services, Child Habilitation Services, Community Living Services, Community Support Services, Companion Services, Individual Habilitation Training Services, Respite Services, and Supported Employment Services.

Settings in which HCBS are provided comport with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, including those requirements applicable to provider-owned or controlled settings. Exceptions to these requirements are made only when supported by the participant's assessed need and specified in the person-centered IPC.

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 in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)*

Participant goals and objectives, along with needed supports and progress made, are established through the person-centered planning process and documented in the participant's IPC. The person-centered planning process addresses the participant's opportunity to seek employment and work in competitive integrated settings, engage in community life, and control personal resources, based on their needs and preferences. Services are provided in a manner that ensures the participant's right to privacy, dignity, respect, and freedom from coercion and restraint, and optimize individual initiative, autonomy, and independence in making life choices.

Each provider must complete certification to become a Supports Waiver provider. This certification process ensures the provider's initial compliance with the federal HCBS Settings Rule, and is repeated every one to three years to ensure ongoing compliance. Additionally, HCBS Settings Rule language is included in Wyoming Medicaid rules that govern the Comprehensive (Supports) Waiver program.

Case managers review participant satisfaction each month, and conduct service observations to ensure services are delivered in alignment with the participant's IPC, are non-institutional in nature, and are consistent with the requirements and objectives of the HCBS Settings Rule. An assessment of participant experience is conducted as part of the National Core Indicators Adult In-Person Survey. This survey measures experience data such as the participant's level of awareness of and access to rights provided in the HCBS Settings Rule, freedom to make informed decisions, community integration, privacy and confidentiality, and other individual experience expectations outlined in the HCBS Settings Rule.

DHCF reviews all incidents and complaints, and conducts investigations as necessary to address concerns related to abuse, neglect, exploitation, and rights restrictions. All rights restrictions must be designed and approved in accordance with Chapter 45 of Wyoming Medicaid Rules and the HCBS Settings Rule. If the restriction has not gone through the modification process and is not supported in the participant's IPC, DHCF works with the participant's case manager and plan of care team to mitigate the concern.

3. *By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:*

- ☒ **The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.**
- ☒ **The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.** ***(see Appendix D-1-d-ii)***
- ☒ **Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.**
- ☒ **Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.**
- ☒ **Facilitates individual choice regarding services and supports, and who provides them.**
- ☒ **Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.**

Provider-owned or controlled residential settings. (*Specify whether the waiver includes provider-owned or controlled settings.*)

- ○ **No, the waiver does not include provider-owned or controlled settings.**
- ◉ **Yes, the waiver includes provider-owned or controlled settings.** (By checking each box below, the state assures that each setting, *in addition to meeting the above requirements, will meet the following additional conditions*):
  - ☒ **The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the**

state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

☒ **Each individual has privacy in their sleeping or living unit:**

- ☒ **Units have entrance doors lockable by the individual.**
- ☒ **Only appropriate staff have keys to unit entrance doors.**
- ☒ **Individuals sharing units have a choice of roommates in that setting.**
- ☒ **Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.**

☒ **Individuals have the freedom and support to control their own schedules and activities.**

☒ **Individuals have access to food at any time.**

☒ **Individuals are able to have visitors of their choosing at any time.**

☒ **The setting is physically accessible to the individual.**

☒ **Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan*(see Appendix D-1-d-ii of this waiver application).***

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Individualized Plan of Care (IPC)

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. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. *(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:

A case manager shall have one (1) of the following qualifications:

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

• Counseling;
• Education;
• Gerontology;
• Human Services;
• Nursing;
• Psychology;
• Rehabilitation;
• Social Work;
• Sociology; or
• A related degree, as approved by DHCF; or

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

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

☐ **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. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *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.** ***Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:***

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a process in place to ensure:*

- ☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**
- ☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**
- ☐ **Direct oversight of the process or periodic evaluation by a state agency;**
- ☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**
- ☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

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.

The following is how participants are supported during the Service Plan development.

(a) Individuals who are interested in applying for the Supports Waiver program can find all of the necessary guides and documents on the HCBS Section website, or can contact the area Benefits and Eligibility Specialist (BES) for assistance. The BES will walk the applicant through the Support Waiver Application Guide, which provides step by step instructions on completing the application and waiver eligibility process and the roles and responsibilities of the participant, legally authorized representative, and participant. A list of qualified case managers is also provided. The applicant is encouraged to interview case managers to find the case manager with whom they are comfortable. Once selected, the case manager will assist the applicant in completing the case manager selection form and Supports Waiver application, and help them through the rest of the application and waiver eligibility process.

(b) As part of person-centered planning, the participant and legally authorized representative, as appropriate, determines who to involve or exclude for the plan development process. DHCF offers a Planning Workbook to support the participant and their plan of care team in developing a person-centered plan.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. i. 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; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The IPC is generated by Care Case Management System (CCMS). The logic and prompts within CCMS, in addition to a team meeting checklist utilized by case managers during each team meeting, promote a person centered planning approach which is in compliance with 42 CFR §441.301(c)(2) and Chapter 45 of Wyoming Medicaid Rules.

(a) A participant's IPC is developed by the case manager, with input from the participant, legally authorized representative (if applicable), and the plan of care team. The plan of care team is comprised of representatives from each service provider and other stakeholders the participant or legally authorized representative chooses to involve, including therapists, employers, family members, friends, or other people important in the participant's life. The IPC is renewed annually, and all sections of the IPC are formally reviewed at least once every six (6) months. Plan of care meetings are scheduled at a place and time that is convenient for the participant or the legally authorized representative. Plan of care team members are typically notified at least twenty (20) days prior to the meeting date.

(b) CCMS is designed to collect information specific to a participant's preferences, support needs, goals, and health status.
• The Individual Preferences section requires that questions regarding a participant's desired accomplishments for the coming year, personal preferences, and important
things to know about the participant be addressed.
• The Needs and Risks section lists the areas of need that should be addressed (i.e., communication, mobility, personal care), and includes a space for any necessary
protocols to be uploaded into the system and included in the IPC document.
• The Circle of Supports section identifies non-waiver services that are available to the participant.
• The Medical section is a comprehensive compilation of medical information including medical appointments (dental, vision, counseling, specialists), allergies, medical
conditions and protocols, and how to assist the participant while at an appointment.

(c) The Comprehensive and Supports Waiver Service Index, which is located shall be found at https://health.wyo.gov/healthcarefin/hcbs/servicesandrate, is an extensive list of services available on Comprehensive and Supports Waivers, and is available to participants, legally authorized representatives, plan of care team members, and case managers. The case manager is responsible for reviewing the services available with the participant and legally authorized representative prior to the IPC meeting. If the participant or legally authorized representative requests a change in services, the case manager must work with them to identify providers that offer the service using the provider list maintained by DHCF, and schedule provider interviews, if requested. Changes are documented in team meeting or case management notes. A change in services or providers can be made at any time during the plan year.

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

The case manager develops the IPC from the information gathered through the person-centered planning process and confirms there is agreement from the plan of care team on the participant's goals, strengths, preferences, needs, and risks. The participant is encouraged and supported to direct the service planning process to the maximum extent possible. The case manager provides information and options as needed to assist the participant in determining which services and supports will be included in their IPC. Upon completion of the IPC, the case manager has all identified team members sign the team signature form approving the IPC. The case manager gives copies of the IPC to all providers listed on the IPC.

The IPC 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 or other natural supports; 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.

(e) The case manager is responsible for identifying waiver and non-waiver services, and coordinating all services and

supports included in the participant's IPC. All providers are required to sign the Team Signature and Verification form, indicating that they agree to the IPC that was developed. The participant's written informed consent is obtained on the Participant and Legally Authorized Representative Verification Form, which is downloaded from CCMS. The participant and legally authorized representative are required to answer questions about their involvement in the IPC planning process, their understanding of and agreement to any rights restrictions, and their choice in services and providers.

(f) The case manager has specific monitoring responsibilities to ensure the IPC is implemented appropriately and to identify possible changes needed in the plan. Responsibilities include:
• Monthly – A home visit, with the participant present, to monitor the participant's health and welfare, as well as assess participant satisfaction with both waiver and non-
waiver services.
• Monthly – A review of critical incidents to identify trends and concerns.
• Monthly – A review of goal progress.
• Monthly – A review of restraint usage.
• Monthly – A review of service utilization and documentation.
• Monthly – A review of documentation and progress on all self-directed services, if applicable.
• Quarterly – Observation, with participant present, of all services delivered.
• Quarterly – A review of health information to identify possible changes in health status.

(g) A participant's IPC must be reviewed at least semi-annually, when a participant's circumstances or needs change significantly, or at the request of the participant or any team member. IPCs may be revised when there is a reassessment of functional need or as the need arises.

ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

☒ **The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.**

☒ **For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:**

- ☒ **A specific and individualized assessed need for the modification.**
- ☒ **Positive interventions and supports used prior to any modifications to the person-centered service plan.**
- ☒ **Less intrusive methods of meeting the need that have been tried but did not work.**
- ☒ **A clear description of the condition that is directly proportionate to the specific assessed need.**
- ☒ **Regular collection and review of data to measure the ongoing effectiveness of the modification.**
- ☒ **Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.**
- ☒ **Informed consent of the individual.**
- ☒ **An assurance that interventions and supports will cause no harm to the individual.**

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The IPC is developed in collaboration with the participant's team, and must include input from the participant and legally authorized representative to determine risks and develop mitigation plans. Mitigation of risk factors is addressed by the participant and team. Training and goals related to the mitigation of risk is given a very high priority during the planning process.

The needs and risk section of the IPC addresses areas of potential risk. In this section, the type of support needed, a description of what the support should look like, and a space for relevant protocols is included. Per the IPC meeting checklist, these areas must be addressed, at a minimum, during the annual IPC meeting and the 6 month plan review meeting. The IPC is revised when necessitated by changes in the participant's health, wellness, or other risk factors.

The individual preferences section of the IPC outlines the participant's preference and any additional support the participant may need. During the IPC meeting, the case manager facilitates the conversation to address unhealthy habits, risky behavior, and important changes the participant wants to make in their life. To further expand on the input from the participant, legally authorized representative, and team members, the medical and behavioral support sections of the IPC address risk in these specific areas.

Risks that result in a rights restriction must be noted in the IPC and address the eight areas specified in CFR 441.301, including a restoration plan that includes the specific strategies that the participant will use to build the skills necessary to reinstate the right over time.

The circle of supports section of the plan addresses the specific back up supports the participant needs. This includes emergency contacts, back up case management services, and other supports in the person life. This section also identifies the main contact people for the participant's routine activities and environments, in case an incident arises. For individuals who live more independently, a more detailed action plan for on call or emergency situations is developed. All providers of community living services are expected to address or provide 24 hour emergency support.

All provider staff are mandatory reporters of suspected abuse, neglect, and exploitation.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Participants and legally authorized representatives shall have free choice of providers and may request a change of providers at any time during the plan year.

DHCF reviews information on institutional and community services available, provider choice, and participant-directed options when the person first applies for services. A case manager list is provided, as well as tips and tools for interviewing and selecting a case manager. Once a case manager is selected, eligibility is determined, and a funding opportunity is available, the case manager reviews the choice of services and providers available for the services selected, assists with scheduling interviews or visits, and convenes the plan of care team based on the participant's choices.

Services and provider choice shall be formally reviewed at the 6 month review and annual plan of care meetings. The Participant and Legally Authorized Representative Verification Form shall be signed, indicating that the participant and legally authorized representative had choice in service providers.

Satisfaction with current providers and services is reviewed during home visits. A provider list, searchable by service and location, is available on the DHCF website and can be accessed at any time. The case manager is responsible for providing this information if it is requested by the participant or legally authorized representative.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the

service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR § 441.301(b)(1)(i):

The IPC is generated within CCMS. The logic and prompts within CCMS ensure the IPC is developed in accordance with DHCF requirements. In accordance with the IPC Review Process, IPC review is conducted through a process flow outlined in CCMS that utilizes a defined set of criteria to identify IPCs that require a manual review performed by DHCF staff. Other IPCs do not receive manual review.

In order to assure that the quality of the IPC is maintained, a random sampling of IPCs is reviewed by DHCF each month. The review methodology can be found in the Quality Improvement Review Process.

Appendix D: Participant-Centered Planning and Service Delivery

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

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update, when the individual's circumstances or needs change significantly, or at the request of the individual, 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, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The case manager is responsible for monitoring the implementation of the IPC and participant health and welfare. Monitoring activities include:
• A monthly home visit, with the participant present, to monitor the participant's health and welfare, discuss satisfaction with both waiver and non-waiver services, and
identify changes needed in the IPC.
• Quarterly service observations.
• A monthly review of critical incidents, goal progress, and backup plans to identify trends and concerns.
• A monthly review of the implementation and effectiveness of the positive behavior support plan and restraint usage, and conducting follow-up as needed.
• A monthly review of utilization of services, and documentation of service delivery.
• Quarterly review of specific health information to identify possible changes in health status.

Per Chapter 45 of Wyoming Medicaid Rules, case managers are required to report concerns with IPC implementation and participant health and safety to DHCF each quarter, using the incident reporting or complaint process. The case manager is required to report significant concerns to DHCF immediately.

b. Monitoring Safeguards. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

◉ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.** *(Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation).*

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. *By checking each box, the state attests to having a process in place to ensure:*

☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**

☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**

☐ **Direct oversight of the process or periodic evaluation by a state agency;**

☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**

☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's 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 participantsï?½ 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 - Number and Percentage of IPCs with participant and/or legally authorized representative (LAR) signature verifying the participant and/or LAR participated in the development of the plan. Numerator: # of plans with signature verifying the participant and/or LAR participated in the development of the plan Denominator: total # of IPC's

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
D.a2 - Number and Percentage of IPCs with participant and/or legally authorized representative signature verifying that the plan met the participant's assessed needs and goals. Numerator: # of plans with signature verifying the plan met the participant's assessed needs and goals Denominator: total # of IPC's

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

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

Data Aggregation and Analysis:

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

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: Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.***

Performance Measures

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

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

c. ***Sub-assurance: 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.c1 - Number and Percent of IPCs that were revised to address changing needs. Numerator # of IPCs revised to address changing needs Denominator: # of IPCs requiring a revision due to a change in participant's needs

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

Responsible Party for	**Frequency of data**	**Sampling Approach**

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

Data Aggregation and Analysis:

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

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

Performance Measure:
D.c2 - Number and percent of IPCs that were updated/revised every 12 months. Numerator: # of IPCs that were updated or revised every 12 months Denominator: # of IPCs

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

d. ***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.d1 - Number and percent of services delivered in accordance with the IPC, including the type, scope, amount, duration and frequency. Numerator: # of services

delivered in accordance with the IPC, including the type, scope, amount, duration, and frequency Denominator: # services delivered

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

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:

e. ***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:
D.e1 - Number and percent of IPCs stating participants/legally authorized representatives were given a choice of services. Numerator: # of IPCs containing verified choice of services in the plan of care documentation Denominator: total # of IPC's

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
D.e2 - Number and percent of IPCs stating participants/legally authorized representatives were given a choice of providers. Numerator: # of IPCs containing verified choice of providers in the plan of care documentation Denominator: total # of IPC's

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The anticipated outcome for this data collection is ensuring that the state has designed and implemented an adequate system for assuring that participants receive services in accordance with their plan. The state will review the performance measure data for this assurance on a quarterly basis. If, during a quarterly review, there are areas that do not meet anticipated outcomes, DHCF will ensure that issues caused by failure to follow process or policy are remedied through technical assistance and re-education at an individual level and, where possible, through statewide training. Individual remediation activity requires follow up from DHCF to determine that the party in need of remediation (case manager etc.) successfully completed the required corrective action. Remediation strategies include training, revision of administrative processes and procedures, administrative rule revisions, and waiver amendments. These strategies will be used based on the results of the discovery and analysis of the related performance measure. If compliance with the performance measure falls below 86%, a request for a corrective action plan, including activities and time lines for completion and follow-up, will be required.

DHCF will, on a quarterly basis, review performance measures, corrective action, and other meaningful data listed above. Processes for such review will be studied, and possibly adjusted on an annual basis.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Waiver participants have the option to receive support services provided by qualified HCB Medicaid waiver providers certified by DHCF, support services through participant-direction, or a combination of both participant-directed and traditional support services.

If self-directing one or more of their services, participants or their legally authorized representative act as the employer of record. This option gives participants the authority and responsibility to recruit, hire, schedule, evaluate, and supervise their workers, and gives the participant budgetary authority.

Participants choosing to be the employer of record will receive assistance with the self-direction process from the Fiscal/Employer agent (FMS) and case manager.

The 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.

The case manager will assist the participant with the self-direction process, and is responsible for the following:
• Completing the referral form tp FMS and assisting with other required FMS documents
• Submitting the Individual Plan of Care (IPC)
• Monitoring implementation of, and conducting follow up on concerns found with the implementation of the IPC
• Providing Information to the EOR on how complete and submit employment paperwork
• Conducting ongoing monitoring of the participant's budget

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☒ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

  Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ◉ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The case manager is responsible for providing initial information on participant-directed services, which includes:
1) An overview of self-determination and participant-directing services, including the principles of self-determination (Freedom, Authority, Support, Responsibility, and Confirmation).
2) The benefits of participant-directing, including enhanced choice and control over services and how the budget is spent.
3) The responsibilities involved in participant-directing services, including hiring, training, and firing workers, managing the budget, and approving workers' timecards.
4) The potential liabilities of participant-directing services, including liabilities that may occur as the common law employer when hiring or firing staff, managing the budget, and approving timecards.

Once the participant chooses participant-direction, the FMS provides information on the role of the FMS, the employer of record, and the direct support worker. The participant and legally authorized representative can contact the case manager or FMS for questions related to self-directed services. DHCF staff located throughout the state also serve as ongoing resources if questions or concerns arise about participant-directing services.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

- ○ **The state does not provide for the direction of waiver services by a representative.**
- ◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

- ☒ **Waiver services may be directed by a legal representative of the participant.**

☐ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Companion Services	☒	☒
Child Habilitation Services	☒	☒
Respite	☒	☒
Supported Employment	☒	☒
Personal Care	☒	☒
Homemaker	☒	☒
Individual Habilitation Training	☒	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Financial Management Services are provided by a contractor using the Fiscal/Employer Agent Model. The FMS vendor is chosen through a competitive bid process which includes a request for proposal, and fair proposal evaluation by staff and subject matter experts which results in an executed contract. Contract lengths vary at the Department's discretion with the option to extend contracts for additional years. The State pays the award FMS vendor an agreed upon per member per month (PMPM) administrative cost in exchange for the administration of the contracted FMS services.

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

The FMS is compensated for administrative activities based upon a PMPM reimbursement method.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☒ **Assist participant in verifying support worker citizenship status**

☒ **Collect and process timesheets of support workers**

☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**

☐ **Other**

Specify:

Supports furnished when the participant exercises budget authority:

☒ **Maintain a separate account for each participant's participant-directed budget**

☒ **Track and report participant funds, disbursements and the balance of participant funds**

☒ **Process and pay invoices for goods and services approved in the service plan**

☒ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other services and supports**

Specify:

Additional functions/activities:

☐ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**

☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**

☒ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

State Medicaid Agency and DHCF Policy for Monitoring the FMS:

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

The contract with the FMS vendor outlines the requirements of the FMS to act on behalf of the employer/participant in gathering and maintaining relevant employee information; maintaining employment files with necessary tax, IRS, and payroll information; providing a system for payment of services rendered (payroll to direct support worker) that takes into account applicable Department of Employment, Labor, and waiver specific restrictions (e.g.: service overlap, service caps, 40 hours work-week limit per employee, over budget) verifying submitted electronic visit information against these expectations, to be compiled and processed for payroll to the employee.

Policy Provisions:
DHCF issues policy, procedure manuals, memorandums, instructions, and other correspondence to interpret and implement the approved waivers, including information on the roles and responsibilities of the FMS, responsibilities of the case manager in the monthly monitoring of employer of record, and monitoring responsibilities of DHCF. and the Medicaid Program Integrity Unit (PI). DHCF conducts quarterly on-site audits to verify compliance with all contractual requirements, responsibilities and obligations, which includes a complete review of all FMS policies and procedures annually, and verification of required content within a random sample of employment files. Per program guidance provided to the vendor, the FMS will develop and complete a corrective action plan, for any item that is determined to be out of compliance with the contractual requirements, responsibilities, or obligations of the FMS vendor, at the time the non-compliance issue is communicated to the vendor. The contract includes clauses for termination of the contract if serious concerns are identified. The FMS shall submit a corrective action plan as outlined in Chapter 45 of the Department of Health’s Medicaid Rules for each area of non-compliance identified in the quarterly contractual compliance audit. DHCF reviews and approves the corrective action plan according to Medicaid Rules, and monitor implementation of the corrective action plan to assure areas of non-compliance are adequately addressed.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

The case manager provides information to participants or legally authorized representatives on traditional service delivery and participant-direction.

Case managers provide assistance in support of participant-direction at the time an applicant receives a funding opportunity, twice a year during home visits or team meetings, or as requested or needed.

The case manager will assist the participant with the participant-direction process, and is responsible for the following:

- Completing and submitting the referral form and other required documents to the FMS
- Submitting the IPC
- Monitoring implementation of, and conducting follow up on concerns found with the implementation of the IPC
- Assisting the EOR with information on how to complete employment paperwork
- Conducting ongoing monitoring of the participant's budget

☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Special Family Habilitation Home	☐
Adult Day Services	☐
Dietician Services	☐
Companion Services	☐
Specialized Equipment	☐
Transportation	☐
Child Habilitation Services	☐
Cognitive Retraining	☐
Skilled Nursing	☐
Physical Therapy	☐
Community Living Services	☐
Respite	☐
Community Support Services	☐
Case Management	☒
Supported Employment	☐
Speech, Hearing	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
and Language Services	
Environmental Modification	☐
Personal Care	☐
Homemaker	☐
Crisis Intervention Support	☐
Occupational Therapy	☐
Individual Habilitation Training	☐
Behavioral Support Services	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

◉ **No. Arrangements have not been made for independent advocacy.**

○ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

A participant may voluntarily move off of participant-direction at any time during their plan year. When a participant voluntarily moves off of participant-direction, the participant works with the case manager who follows the DHCF transition process to move away from the participant-direction service model.

The transition process includes a transition team meeting to assure the team, including all providers, has current information on the changes being made to the IPC. During the transition team meeting, the case manager revises the IPC to reflect the changes in services and service providers. The IPC is submitted to DHCF for review before the transitions occur. DHCF has seven (7) calendar days to review the revised IPC.

The case manager works with the participant or their legally authorized representative to notify the FMS of the termination of self-directed services, and assists the participant in completing any required paperwork.

DHCF has an emergency transition process in place if there are significant health and welfare concerns that may require a quicker transition off of participant-directed services. This transition process requires DHCF staff to be involved in the transition process so DHCF can assure the new services and service providers meet the needs of the participant, and to assure the participant's health and welfare needs are met during the transition from participant-direction. The case manager submits the revised IPC to DHCF, which can review the revised plan within one (1) business day if an emergency situation exists. Once a participant has chosen to voluntarily terminate participant-direction, they cannot choose the participant-directed service model until their semi-annual or annual plan of care meeting, which will assure that the participant and team have an opportunity to carefully plan the transition back to the use of participant direction.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Situations that may result in involuntary termination are described in Chapter 46, Section 12 of the Department of Health's Medicaid Rules.

DHCF can involuntarily terminate the use of participant direction when the following situations occur:

1) A participant or their representative is not managing the budget appropriately.
DHCF has processes in place to identify mismanagement of a budget, including budget oversight and reporting by the FMS and review of monthly budget reports by the participant's case manager. DHCF works with the participant's case manager and the FMS to provide additional training, education, and support to help the participant understand their responsibilities with managing the budget. However, if mismanagement of the budget continues, DHCF can involuntarily terminate the use of self-direction.

2) A participant's health and welfare needs are not adequately met.
DHCF has processes in place to identify when a participant's health and welfare needs are not adequately being met, including oversight by the participant's case manager, critical incident reporting, the complaint process, and oversight of participant-directed services. DHCF works with the participant's case manager to provide additional training, education, and support to help the participant understand the need for the IPC and for services to meet their health and welfare needs. However, if significant concerns with the participant's health and welfare continues, DHCF may involuntarily terminate the participant from participant-direction.

3) Situations involving the commission of fraudulent or criminal activity associated with self-direction of services are identified.
When these situations occur, DHCF will work with Program Integrity, and in some cases the SMA, the Medicaid Fraud Control, Unit and the Attorney General's office to identify the appropriate steps to identify appropriate steps to take pending substantiation of allegations and outcome of related investigation.

The transition process includes a transition team meeting to assure the team, including all providers, has current information on the changes being made to the IPC. During the transition team meeting the case manager revises the IPC to reflect the changes in services and service providers. The IPC is submitted to DHCF for review before the transitions occur. DHCF has seven (7) calendar days to review the revised IPC.

The case manager works with the participant or their legally authorized representative to notify the FMS of the termination of self-directed services, and assists the participant in completing any required paperwork.

DHCF has an emergency transition process in place if there are significant health and welfare concerns that may require a quicker transition out of self-directed services. This transition process requires DHCF staff to be involved in the transition process so DHCF can assure the new services and service providers meet the needs of the participant, and to assure the participant's health and welfare needs are met during the transition from participant-direction. The case manager submits the revised IPC to DHCF, which can review the revised plan within one (1) business day if an emergency situation exists. Once a participant is involuntarily terminated from participant-direction, they cannot choose the participant-directed service model until their semi-annual or annual plan of care meeting, which will assure that the participant and team have an opportunity to carefully plan the transition back to participant-directed services. In addition, DHCF works with the team to assure that safeguards have been put in place as necessary to assure the previous concerns or difficulties the participant had with the participant-direction service model have been adequately addressed.

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

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1		339
Year 2		356
Year 3		373
Year 4		378
Year 5		383

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☐ **Refer staff to agency for hiring (co-employer)**

☐ **Select staff from worker registry**

☒ **Hire staff common law employer**

☒ **Verify staff qualifications**

☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

The cost of criminal history background screenings is an administrative cost absorbed by DHCF.

☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

Does not vary

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☒ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☐ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

☒ **Reallocate funds among services included in the budget**

☒ **Determine the amount paid for services within the state's established limits**

☒ **Substitute service providers**

☒ **Schedule the provision of services**

☒ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**

☒ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

☒ **Identify service providers and refer for provider enrollment**

☒ **Authorize payment for waiver goods and services**

☒ **Review and approve provider invoices for services rendered**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

DHCF assigns a budget amount for each participant as described in Appendix C-4 of this application. The budget amount does not change if a person chooses to use the participant-directed service delivery model. The participant or the legally authorized representative may choose to use the participant-directed model in the delivery of some or all of their services, except for case management, and may determine what portion of the DHCF assigned budget will be utilized for those services.

A request for a budget increase must be submitted and approved by the ECC. The ECC policy, procedure and forms for requesting additional funds are available on the DHCF website.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

A participant is notified of their IBA at the time a funding opportunity is offered, and before the IPC is developed. Participants receive the same IBA if they choose to self-direct services. A participant can submit a request through their case manager for an increase in the IBA if the participant's team identifies that the budget allotted to a participant does not meet the services and supports needed.

A request for a budget increase must be submitted and approved by the ECC. The ECC policy, procedure, and forms for requesting additional funds are available on the DHCF website.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ◉ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

During the plan year, the participant may choose to modify services included in their participant-directed budget without prior DHCF approval as long as service costs stay within the IBA. The participant shall coordinate modifications to the participant-directed service budget with their case manager, who will submit the change to the FMS. The case manager shall assure the assessed needs of the participant can continue to be met, then update the IPC to reflect the change in services and budget. DHCF monitors the modification process to the IPC and budget.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

DHCF and the FMS have established safeguards to prevent the premature depletion of the participant's IBA and address potential service delivery problems that may be associated with budget over- or underutilization. DHCF is responsible for ensuring the implementation of safeguards developed for participants who are participant-directing services. The FMS tracks budget utilization and provides monthly reporting to participants, case managers, and DHCF.

DHCF and the FMS have developed business rules that will flag participants for possible over-utilization. For example, if the participant's claims exceed more than 20% of the expected monthly utilization, DHCF, and the participant's case manager will automatically be notified through an electronic message. Likewise, the rules flag participants if two consecutive pay periods bear no claims or claims total 20% less than expected utilization. If premature depletion of the budget or the lack of claims are noted by the FMS, DHCF, and the participant's case manager are automatically notified.

DHCF follows up with the case manager to assure that the concern is addressed and resolved according to DHCFs monitoring requirements as outline in Appendix C1/C3 of the case management service definition.

All issues reported to DHCF are documented and reviewed quarterly for trends, and to determine if participant education, provider re-education, or further actions are needed from DHCF or the FMS to prevent future occurrences of the same problem.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR ?431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Information regarding the fair hearing process is included in the Application Packet all applicants and legally authorized representatives receive when applying for waiver services, and is explained during the review of the application process. If a participant is receiving waiver services at the time of an adverse action, they are notified that services will not be terminated or reduced pending the results of the reconsideration and/or fair hearing, unless otherwise authorized as specified in 42 CFR §431.230. More information can be found in the HCBS Process Manual.

In accordance with Chapter 4 of Wyoming Medicaid Rules, individuals are notified and afforded the opportunity to request a fair hearing when the following occurs:
- An applicant does not meet the eligibility requirements for the waiver;
- An applicant is not provided the choice of home and community-based services as an alternative to institutional care;
- A participant is denied the service(s) of their choice or the provider(s) of their choice; or
- A participant's services are denied, suspended, reduced, or terminated.

If one of these situations occurs, the applicant or participant is notified in writing. The notification outlines instructions on how to request a fair hearing in accordance with Chapter 4 of Wyoming Medicaid Rules, including time frames and procedures. The applicant or participant is also informed they may choose to have an attorney, relative, friend, or other spokesperson represent them at the hearing.

A request for a fair hearing must be submitted to the HCBS Section Administrator or designee in accordance with Chapter 4 of Wyoming Medicaid Rules.

If a request for a fair hearing concerning this action is submitted in a timely manner, DHCF will advance the request to the Office of Administrative Hearings (OAH). OAH will notify the participant or applicant of the date, time, and place of the hearing, and provide other relevant information.

Notices of adverse actions and the opportunity to request a fair hearing are kept on file for 6 years. Notices of an adverse action, which include specific information on a participant's right to request a fair hearing, are stored in the EMWS case file.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

In addition to the fair hearing process, DHCF offers applicants and participants an opportunity to request a reconsideration. The reconsideration process does not prohibit a participant or legally authorized representative from requesting a fair hearing, and can be waived if the participant chooses to proceed straight to a fair hearing.

In accordance with Chapter 46 of Wyoming Medicaid Rules, a request for reconsideration for a specific decision may be submitted, in writing, to the HCBS Section Administrator if one of the following conditions is documented and supported in the request:
1) Information presented in the case was misrepresented;
2) Information was not represented to the fullest extent needed;
3) There was a misapplication of DHCF standards or policy in the case; or
4) The criteria for the case was misunderstood.

DHCF has thirty (30) calendar days to notify the applicant or participant, in writing of the determination. An individual who is adversely affected by the reconsideration decision may also request an administrative hearing in accordance with Chapter 4 of Wyoming Medicaid Rules.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

Wyoming Department of Health, Division of Healthcare Financing

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Participants, legally authorized representatives, providers, and other interested parties may file anonymous complaints with DHCF by using the web-based complaint system available on the DHCF website. Complaints regarding an imminent threat to a participant's health or welfare can also be submitted via phone, letter, or email. DHCF staff are responsible for reviewing complaints in the electronic provider management system. Complainants who identify themselves are sent a letter verifying that the complaint has been received, next steps that will be taken, and the process of notifying them once a review of the complaint is complete. The complaint process does not prohibit a participant or legally authorized representative from requesting a fair hearing.

DHCF staff review the information in the complaint to determine if there is suspicion of abuse, neglect, exploitation, intimidation, or self-neglect, which by state law must be reported to the Protective Services unit of the Department of Family Services (DFS). In these cases, DHCF will report the complaint to, and collaborate with, DFS to determine the appropriate follow-up as described in Appendix G -1 of this application. If staff believe there are significant participant health and welfare concerns, but the complaint does not identify suspected abuse, neglect, exploitation, intimidation, or self-neglect, then staff are required to contact the appropriate DHCF manager immediately to determine appropriate follow-up actions. The manager coordinates the follow-up on these complaints to assure the immediate health and welfare issues are addressed, and to oversee completion of the complaint investigation.

Complaints that involve waiver policies and procedures, waiver staff, or other specific waiver issues are referred to the appropriate DHCF manager for review and/or follow-up. Complaints that involve provider noncompliance are referred to the appropriate DHCF staff for review. Complaints that identify concerns with the overall service system are reviewed by the DHCFs management team and, when appropriate, the DD Advisory Council to determine if changes to rules, regulations, policies, or procedures need to be made.

Chapter 45, Section 21 of the Department of Health’s Medicaid rules addresses the complaint process in detail, as does the Developmental Disabilities Section Complaint Response process.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Abuse with respect to a child means inflicting or causing physical or mental injury, harm or imminent danger to the physical or mental health or welfare of a child other than by accidental means, including abandonment, excessive or unreasonable corporal punishment, malnutrition or substantial risk thereof by reason of intentional or unintentional neglect, and the commission or allowing the commission of a sexual offense against a child as defined by law (W.S. § 14-3-202.)

In accordance with the Wyoming Adult Protective Services Act (WS 35-20-103): "Any person or agency who knows or has reasonable cause to believe that a vulnerable adult is being or has been abused, sexually abused, neglected, exploited, intimidated, abandoned or is committing self-neglect, shall report the information immediately…"

In accordance with Chapter 45 of the Wyoming Medicaid Rules, all waiver providers and provider staff are required to report critical and identified non-critical incidents to DHCF, the case manager, the legally authorized representative, and, depending on the nature of the incident, DFS, Protection & Advocacy System Inc., and law enforcement. Critical incidents must be filed immediately after assuring the health and safety of the participant and other individuals, and include the following categories:
• Suspected abuse as defined by Wyo. Stat. Ann. § 35-20-102 or Wyo. Stat. Ann. § 4-3-202;
• Suspected neglect and self-neglect as defined in Wyo. Stat. Ann. § 35-20-102 or Wyo. Stat. Ann. § 4-3-202;
• Suspected abandonment as defined in Wyo. Stat. Ann. § 35-20-102;
• Suspected exploitation as defined in Wyo. Stat. Ann. § 35-20-102;
• Suspected intimidation as defined by Wyo. Stat. Ann. § 35-20-102;
• Sexual abuse as defined in Wyo. Stat. Ann. § 35-20-102; and
• Unexpected or unexplained death.

Non-critical incidents must be filed within one (1) business day and include the following categories:
• Police involvement, such as arrests of participants or the participant's direct care provider, while they are providing services, or questioning of participants by law enforcement;
• Any use of restraint;
• Any use of seclusion;
• Injuries caused by restraints;
• Serious injury to the participant;
• Elopement;
• Medical or behavioral admission and Emergency Room visits that are not scheduled medical visits; and
• Other incidents of death that are not defined as unexpected or unexplained.

Both the critical and non-critical incidents outlined in this section are reported for both children and adults.

Medication errors shall be filed within three (3) business days after the error is discovered, and include provider action or inaction that result in:
• A participant receiving the wrong medication;
• A participant receiving the wrong dosage;
• A participant missing a medication;
• Medication being administered to the wrong participant;
• A participant taking a medication through the wrong route; and
• A participant receiving the medication at the wrong time, which is any deviation from the accepted standard time frame for the medication assistance.

Providers must report incidents through DHCFs web-based system. Participants and legally authorized representatives may use the web-based complaint portal or contact DHCF to report an incident. If appropriate, they are also encouraged to report directly to DFS or law enforcement so pertinent information can be gathered for the investigation. If the participant or legally authorized representative does not want to contact other agencies, DHCF will file the report on their behalf.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Information regarding a participant's right to be free from abuse, neglect, and exploitation, including the steps to take to notify appropriate authorities, is discussed during the initial IPC planning process and annually thereafter. The case manager is responsible for reviewing this information with the participant and, as required, the legally authorized representative, either verbally or utilizing the information available on the DHCF website. Case managers also ask open ended questions during regular home and service observations, and review behavior and medical trends to detect potential abuse.

In accordance with Chapter 45 of Wyoming Medicaid Rules, providers are required to implement policies and procedures to ensure participants are free from abuse, neglect, and exploitation. These policies and procedures must be shared with participants and legally authorized representatives.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

As outlined in Chapter 45 of Wyoming Medicaid Rule, providers must report critical incidents involving waiver participants to DHCF, DFS, P&A, the case manager, the legally authorized representative, and law enforcement immediately after assuring the health and safety of the participant and other individuals. The Provider Support Unit reviews incidents to assure all required reporting timelines are met.

Critical incidents are reported using DHCFs web-based system. The Provider Support Unit reviews and evaluates all critical incident reports within one business day of the submission. Based on the type of incident, which is outlined in the Incident Management Process, the Provider Support Unit refers the incident to the appropriate authority (DFS, Medicaid Fraud Control Unit, law enforcement) for investigation. Referrals to investigating authorities occur if suspected abuse, suspected neglect, suspected exploitation, or unexplained death is identified. Upon review and gathering findings, a referral to investigating authorities is made within thirty (30) calendar days of the incident submission. The methods and timelines of the investigation are determined by the investigative authority. As the reporting agency, DHCF cooperates with the investigative authority to provide follow-up documentation and evidence, as requested.

For clinical reviews needed in specific critical incidents and mortality review cases, DHCF utilizes the expertise of the Utilization Management contractor and the Medicaid Medical Director. DHCF and the contractor have monthly meetings to review findings and aggregated data, and track case specific remediation steps. Referrals to the Utilization Management Contractor fall into four (4) categories:

1. Death;
2. Quality of care issues beyond DHCFs scope to research (i.e. suspected medical neglect);
3. Systemic issues (i.e., repeated injury or accident with the same provider); and
4. Crisis cases (i.e., repeated restraints, behavioral health admissions).

In accordance with Chapter 45 of Wyoming Medicaid Rules, P&A must be informed of specific critical and non-critical incidents. Critical incidents of which P&A must be notified immediately after assuring the health and safety of the participant and other individuals include:

- Suspected abuse as defined by Wyo. Stat. Ann. § 35-20-102 or Wyo. Stat. Ann. § 14-3-202;
- Suspected neglect and self neglect as defined in Wyo. Stat. Ann. § 35-20-102 or Wyo. Stat. Ann. § 14-3-202;
- Suspected abandonment as defined in Wyo. Stat. Ann. § 35-20-102;
- Suspected exploitation as defined in Wyo. Stat. Ann. § 35-20-102;
- Suspected intimidation as defined by Wyo. Stat. Ann. § 35-20-102;
- Sexual abuse as defined in Wyo. Stat. Ann. § 35-20-102; and
- Death.

Non-critical incidents of which P&A must be notified within one (1) business day include:

- Police involvement, such as arrests of participants, arrests of the participant’s direct care provider while they are providing services, or questioning of participants by law enforcement;
- Any use of restraint;
- Any use of seclusion;
- Injuries caused by restraints;
- Serious injury to the participant;
- Elopement; and
- Medical or behavioral admission and Emergency Room visits that are not scheduled medical visits.

Appropriate Division staff review all submitted incidents within three business days. The Division staff member reviews the incident, the participant’s IPC and other documentation, such as protocols and positive behavior support plans, in order to determine if the incident should be closed or investigated. If the information in the incident is not sufficient to demonstrate compliance with Chapter 45 of Wyoming Medicaid rules, an investigation is initiated. Division staff follow the Process for Investigations of Provider Incidents and Complaints when conducting an investigation of an incident. The Division staff member works with other agencies as necessary, and closes the investigation as quickly as possible; generally within 90 calendar days.

Upon completion of an investigation, if the provider is found to have violated Wyoming Medicaid Rules, have violated their own policies and procedures, or have cause harm due to egregious action or inaction, the Provider Support Unit may impose a corrective or adverse actions, as outlined in Chapters 16 and 45 of Wyoming Medicaid Rules Possible adverse actions include additional education, medical clearance from a medical specialist, restricting a provider’s provision of services, denying new admissions, imposing a monitor, civil monetary penalties, suspension of payments,

and provider suspension. Ultimately, DHCF has the authority to decertify providers.

Final detailed results of the investigation are provided to the participant by the investigative authority. Once DHCF completes the investigation of rule violation, staff send a resolution letter to the participant, and legally authorized representative if necessary, within fifteen (15) business days.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

DHCF may share the responsibility for overseeing the response to critical incidents or events with other agencies (e.g., Adult Protective Services, law enforcement) depending on the type and circumstances of the incident or event. However, DHCF is ultimately responsible for the oversight of critical incidents or events that affect waiver participants. DHCF monitors progress of any open incident every ten (10) business days and updates the status in IMPROV at least every thirty (30) days. At the conclusion of any external investigation, oversight and follow-up efforts of resulting provider corrective or adverse actions are ongoing until all action items are complete, or identified issues are resolved.

DHCF analyzes all critical incident information and conducts a root cause analysis on a quarterly basis to identify provider and systemic trends. Identified trends are used to develop targeted provider and more global systemic technical assistance to address challenges and decrease the number of critical incidents over time.

The Division has appointed a Root Cause Analysis Team to review the findings of closed investigations, as well as the participant's IPC, positive behavior support plan, protocols, and other incidents that have occurred within the past 6 months. Based on this review, the team identifies the root cause of the incident. Quarterly, the HCBS Leadership Team reviews identified root causes to determine individual (specific participant or provider) and systemic (overall programmatic) trends and recommend strategies to address any trends identified. This process is outlined in more detail in the Root Cause Analysis process.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Although the state is exploring ways to reduce or even eliminate all restraints in the future, restraints are allowed in some instances. Safeguards are in place and must be practiced by providers.

Safeguards for restraint usage are written into Wyoming State Statute 35-1-625 and 626, which mandate participants must be free from physical restraints and isolation except for emergency situations or when isolation or restraint is a part of a treatment program. Isolation or restraint of a participant may be used only when less restrictive measures are ineffective or not feasible for the welfare of the participant and must be used for the shortest time possible.

Specific DHCF safeguards concerning the use of restraints are found in Chapter 45 of Wyoming Medicaid Rules.

DHCF has robust incident reporting and complaint processes, by which case managers, provider staff members, legally authorized representatives, community members, and other stakeholders report the use of restraints, as well as other identified incidents. Additionally, the case manager, as a conflict-free, second line monitor, is responsible for reviewing provider internal incidents, and discusses participant satisfaction and concerns, behavioral changes, service delivery, and self-determination during regular service observations and home visits. This relationship and regular interaction is a critical step in identifying situations in which the unauthorized use of restraint may occur.

Restraints may only be used in emergency circumstances and may only be performed by individuals trained and certified in restraint usage. A positive behavior support plan must be in place and implemented prior to the use of restraints.

Chapter 45 of Wyoming Medicaid Rules lists specific documentation required if a provider performs restraints. This documentation includes the tracking and analysis of each restraint, its antecedents, reason(s) for the restraint, the participant's reaction to the restraint, and actions that may make future restraints unnecessary. All available data must be regularly reviewed to work toward reducing the duration and frequency of restraint occurrences. Information must be submitted to the case manager within five (5) business days of a restraint event.

If a restraint protocol is included in the participant's IPC, the protocol must include the authority that has authorized the restraint, and demonstration that the following standards have been met:
• Identification of the specific and individualized assessed need;
• Documentation of the positive interventions and supports that have been used prior to any modifications to the IPC;
• Documentation of less intrusive methods of meeting the need that have been tried but did not work; • A clear description of the condition that is directly proportionate to the specific assessed need;
• Regular collection and review of data to measure the ongoing effectiveness of the modification or restraint;

• Established time limits for periodic reviews to determine if the modification or restraint is still necessary or can be terminated;
• Informed consent of the individual; and
• Assurance that interventions and supports will cause no harm to the individual.

Additionally, the IPC must address how the team will work to restore any right that has been limited or denied, including those associated with restraints.

The provider and provider staff shall maintain certification and receive ongoing training in de-escalation techniques, crisis prevention and intervention, and proper restraint usage from entities certified to conduct the training, such as Crisis Prevention Intervention (CPI), MANDT, or other entity approved by DHCF.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

DHCF is responsible for overseeing the use of restraints and ensuring that safeguards concerning their use are followed. This oversight includes a semi-annual IPC review, which incorporates a review of authorized restraints written into the IPC.

The provider certification renewal process occurs at least once every three (3) years and includes a review of required policies, procedures, and staff training related to restraints.

A review of complaints and critical incidents, which includes all restraints, is conducted on an ongoing basis to identify trends and the inappropriate use of restraint.

Case managers are required to report aggregate information on restraint usage, by participant, on a quarterly basis. Quarterly, DHCF reviews aggregate data, by participant and provider, to identify systemic trends in this area, as outlined in Appendix H – Quality Improvement Strategy.

In accordance with Chapter 45 of Wyoming Medicaid Rules, providers found to be out of compliance with rules, regulations, or policies, including the unauthorized use of restraints, are subject to corrective or adverse action.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Specific DHCF safeguards concerning a restriction to a person's rights are outlined in Chapter 45 of Wyoming Medicaid Rules.

DHCF has a robust incident reporting process, by which case managers, provider staff members, legally authorized representatives, community members, and other stakeholders report the use of restraints, as well as other identified incidents. Additionally, the case manager, as a conflict-free, second line monitor, is responsible for reviewing provider internal incidents, and discusses participant satisfaction and concerns, behavioral changes, service delivery, and self-determination during regular service observations and home visits. This relationship and regular interaction is a critical step in identifying situations in which the unauthorized use of restraint may occur.

Before a restrictive intervention may be employed, the plan of care team must address the reason for the rights restriction, including the legal document, court order, guardianship papers, or medical order that allows a person other than the participant to authorize a restriction to be imposed. The IPC must:
• Identify the specific and individualized assessed need;
• Document the positive interventions and supports used prior to any modifications to the individualized plan of care;
• Document less intrusive methods of meeting the need that have been tried but did not work;
• Include a clear description of the condition that is directly proportionate to the specific assessed need;
• Include regular collection and review of data to measure the ongoing effectiveness of the modification;
• Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;
• Include the informed consent of the individual; and
• Include an assurance that interventions and supports will cause no harm to the individual.

In addition to the items mentioned above, the IPC must address how the team will work to restore any right that has been limited or denied.

Personnel involved in authorization and administration of restrictive interventions must meet the training standards set forth in Chapter 45 of Wyoming Medicaid Rules.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

DHCF is responsible for monitoring and overseeing the use of restrictive interventions.

This oversight includes a semi-annual IPC review, which incorporates a review of authorized restrictive interventions written into the IPC. Each month, DHCF conducts quality improvement reviews of randomly selected IPCs to ensure restrictive interventions are being applied in accordance with Wyoming Medicaid Rules.

The provider certification renewal process occurs at least once every three (3) years and includes a review of required policies, procedures, and staff training related to restrictive interventions.

A review of complaints and critical incidents is conducted on an ongoing basis to identify trends and the inappropriate use of restrictive interventions, including a root cause analysis. The case manager also conducts regular home and service observations, during which time both approved and inappropriate restrictive interventions may be detected.

In accordance with Chapter 45 of Wyoming Medicaid Rules, providers found to be out of compliance with rules, regulations, or policies, including the unauthorized use of restrictive interventions, are subject to corrective or adverse action.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of

3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

DHCF is responsible for detecting the unauthorized use of seclusion.

This oversight includes a semi-annual IPC review process, which incorporates a review of authorized restraints and restrictive interventions that are written into the IPC.

The provider certification renewal process occurs at least once every three (3) years and includes a review of required policies, procedures, and staff training related to restrictive interventions.

A review of critical incidents and complaints, including a root cause analysis, is conducted on an ongoing basis. The case manager also conducts regular home and service observations, during which time unauthorized seclusion may be detected.

In accordance with Chapter 45 of Wyoming Medicaid Rules, providers found to be out of compliance with rules, regulations, or policies, including any use of seclusion, are subject to corrective or adverse action.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

○ **No. This Appendix is not applicable** *(do not complete the remaining items)*

◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

First line monitoring:
The participant's physician, psychiatrist, or other licensed medical professional who prescribes medications to the participant is the first line monitor of the participant's medication regimen.

Second line monitoring:
Case managers are responsible for conducting second line medication monitoring to help ensure a participant's medical needs are addressed and medication regimens are delivered in a manner that promotes the health, safety, and well-being of the participant. The case manager monitors, and reviews trends regarding, the usage of all over-the-counter and prescription medications, including vitamins, herbal remedies and psychotropic medications, through a monthly review of medication assistance records and PRN medication usage records, including behavior modifying medications. Over-the-counter medications must be reviewed by the licensed medical professional to mitigate the potential for medical concerns or side effects.

Use of psychotropic PRN medication requires secondary documentation, including the time the medication was taken, the purpose for the medication, and a one-hour follow up to determine the result of the medication usage. If the intent of the medication is not met, the information is sent to the prescribing authority for further evaluation.

DHCFs monitoring system is multi-faceted. The case manager reviews all Medication Assistance Records and supplemental PRN documentation. Concerns or exceptions are reported to the physician, guardian, or DHCF. Providers are required to report all medication errors through the DHCF Notification of Incident reporting system. DHCF then reviews exceptions in order to identify trends. This robust system of review offers the highest probability of detection of harmful practices, and allows opportunity on the part of the case manager and DHCF to provide timely and necessary follow-up.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

In accordance with Chapter 45 of Wyoming Medicaid Rules, providers must report all instances of medication errors using DHCFs web-based system. DHCF reviews all critical incident reports as outlined in Appendix G-1-a.

DHCF is responsible for overseeing and monitoring provider compliance with medication assistance standards, potentially harmful practices, and the provider's own policies and procedures. DHCF reviews all incident reports related to medication errors to gather information on potentially harmful practices. If a concern is identified, the provider is contacted to review the incident. Based on the result of the provider contact, 1) further clarification is added to the incident report; 2) the provider is offered technical assistance; or 3) corrective action is issued.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

○ **Not applicable.** *(do not complete the remaining items)*

◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of**

medications. *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

In accordance with Chapter 45 of Wyoming Medicaid Rules, providers, subcontractors, and provider employees must maintain a current certificate in medication assistance training offered through DHCF if a provider is assisting with medications. Providers offering medication assistance must develop and implement internal medication assistance policies and procedures that meet DHCF standards.

iii. Medication Error Reporting. *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

DHCF is responsible for overseeing and monitoring medication errors.

DHCF will involve DFS, Protection & Advocacy, and law enforcement if an error is reported that falls into one of the other reportable incident categories, which requires notification to other parties included in the DHCF Notification of Incident process.

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

Providers shall record the following medication errors that are the result of provider action or inaction:
• A participant receiving the wrong medication;
• A participant receiving the wrong dosage;
• A participant missing a Missed medication;
• Medication being administered to the wrong participant;
• A participant taking a medication through the wrong route; and
• A participant receiving the medication at the wrong time, which is any deviation from the accepted standard time frame for the medication assistance.

Providers have additional medication errors or incidents that are recorded within their organization, but not reportable to DHCF. These categories include:
• Refusals,
• Dropped medication,
• Expired or damaged medication,
• Other medication events determined to need action

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

In accordance with Chapter 45 of Wyoming Medicaid Rules, providers must report the following medication errors that are a result of provider action or inaction, within three (3) business days after the error is discovered:
• A participant receiving the wrong medication;
• A participant receiving the wrong dosage;
• A participant missing a missed medication;
• Medication being administered to the wrong participant;
• A participant taking a medication through the wrong route; and
• A participant receiving the medication at the wrong time, which is any deviation from the accepted standard time frame for the medication assistance.

Providers are required to report exploitation of participants, including medication diversion, through the DHCF Notification of Incident process. Providers receive training on the discouragement and prevention of, as well as risk mitigation associated with, medication diversion during Medication Assistance Training, which is required for any provider assisting with medication.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

DHCF is responsible for monitoring the performance of providers in the administration of medications to waiver participants.

During provider certification renewal, a review of provider policies, procedures, and documentation is conducted to determine the adequacy of and compliance with DHCF standards. Additionally, a sample of provider staff are interviewed, and must demonstrate knowledge of procedures, incident reporting requirements, and individual medication assistance needs.

DHCF reviews all critical incident reports and complaints as outlined in Appendix G-1-a. Data is reviewed on a quarterly and as needed basis to identify trends related to:
• Provider
• Staff member
• Participant
• Time of day
• Scheduled vs. PRN medication
• New vs. existing prescriptions

If trends related to the provider, staff member, or participant are identified, targeted technical assistance is conducted for the relevant provider. Other identified trends are addressed during regularly scheduled provider support calls and other provider training, as well as DHCF Medication Assistance Training.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's 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.

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.***

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 - The number and percent of substantiated abuse, neglect, exploitation, and unexplained deaths (ANEUD) reported and referred to the appropriate authority in accordance with DHCF policy and timelines. Numerator: # of substantiated ANEUD's reported and referred to the appropriate authority in accordance with DHCF policy and timelines Denominator: # of substantiated ANEUD's

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
IMPROV

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

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

Data Aggregation and Analysis:

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

Performance Measure:
G.a2 - Number of participants informed of how to identify and report incidents of abuse, neglect, and exploitation (ANE). Numerator: # of individual plan of cares containing verification of education on identifying and reporting ANE's Denominator: total # of participants

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
IMPROV

Responsible Party for data	**Frequency of data collection/generation**	**Sampling Approach** *(check each that applies):*

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

Data Aggregation and Analysis:

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

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

Performance Measure:
G.a3 Number and percent of substantiated abused, neglect, exploitation, unexplained death (ANEUD) incidents where a required corrective action plan (CAP) was completed or is in compliance with DHCF policy and timeframes. Numerator: # of substantiated ANEUD's where a required CAP was completed or is in compliance with DHCF policy and timeframes Denominator: # of substantiated ANEUD's with a CAP

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
IMPROV

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
G.a4 - Number and percent of substantiated abuse, neglect, exploitation, and unexplained death (ANEUD) incidents reviewed in accordance with DHCF policy and required timeframes. Numerator: # of substantiated ANEUD incidents reviewed in accordance with DHCF policy and timeframes Denominator: # of incidents of substantiated ANEUD incidents received.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
IMPROV

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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 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 - # of substantiated critical incidents where intervention was implemented. Numerator: # of substantiated critical incidents trends that were identified and intervention was implemented Denominator: # of substantiated critical incident trends that were identified

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**	☐ **Annually**	☐ **Stratified**

Specify:		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.b2 - Number and percent of incidents of abuse, neglect, exploitation and death (ANEUD) in which root cause was identified. Numerator: # of incidents of ANEUD with with root cause identified Denominator: # of closed ANEUD's reviewed for root cause

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
G.c1 - Number and percent of restraints reported to DHCF that received appropriate follow-up action in accordance with state rules and procedures. Numerator: Number of restraints report to DHCF that received appropriate follow-up action in accordance with state rules and procedures. Denominator: Number of restraints reported

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

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

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

Data Aggregation and Analysis:

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
G.d1 - Number and percent of participants who received medical care according to the state standard. Numerator: Number of participants who received medical care according to the state standard Denominator: Number of participants who require medical care as listed on the plan of care

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The anticipated outcome for this data collection is ensuring that the state has designed and implemented an adequate system for assuring that participants are safe and healthy. The state will review the performance measure data for this assurance on a quarterly basis. If, during a quarterly review, there are areas that do not meet anticipated outcomes, DHCF will ensure that issues caused by failure to follow process or policy are remedied through technical assistance and re-education, both at an individual level and, where possible, through statewide training. Individual remediation activity requires follow up from DHCF to determine that the provider successfully completed the required corrective action, required sanctions, or other disciplinary action Corrective action plans, sanctions, and decertification may occur if a provider fails to meet remediation efforts. Remediation strategies include training, revision of administrative processes and procedures, administrative rule revisions, and waiver amendments. These strategies will be used based on the results of the discovery and analysis of the related performance measure. If compliance with the performance measure falls below 86%, a request for a corrective

action plan, including activities and time lines for completion and follow-up will be required. Follow-up will include a discovery process using a valid random sample.

DHCF will review 100% of critical incidents related to abuse, neglect, exploitation, and unexplained death on an ongoing basis. Individual provider remediation requires follow up to determine the cause of the incident and if the provider successfully completed the required corrective action, sanctions, or other disciplinary action. Corrective action plans, sanctions, and decertification may occur if a provider fails to meet remediation efforts. Performance measures, corrective action, and other meaningful data listed above. DHCF will study processes for such review, and possibly adjusted on an annual basis.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of health and welfare that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under Section 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 (QIS) 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 QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, 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 QIS 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 QIS. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Quality Improvement Strategy (QIS) utilizes discovery, analysis, and remediation activities as the method of ensuring that services provided through the Comprehensive and Supports waivers are routinely monitored, and that necessary corrective action processes are in place. While performance measure review occurs on a quarterly basis for Comprehensive and Supports waiver services, discovery, analysis, and remediation efforts are continuous. Data informing the performance measures are reviewed and analyzed on an ongoing basis by the DD section staff in each area (outlined within each assurance). Each unit works to identify areas of deficiency, required improvement actions, and to assure completion of remediation efforts. Review and remediation activities are tracked and made accessible to appropriate DHCF and State Medicaid Agent staff for maintaining timelines, ensuring compliance, and to issue reports relating to review and remediation activities.

DHCF has a variety of processes employed to aggregate, analyze, and evaluate waiver performance, as well as to assist in the identification and remediation of problems. These processes, and the assurance categories that they encompass, are:

1. Waiver Applicant Process: Informs Level of Care. This process includes eligibility assessments and determination of eligibility. Data is collected in EMWS, or its successor.

2. Plan of Care Development: Informs Service Plan, and Health and Welfare. DHCFs Benefits and Eligibility Unit provides education to applicants and families on the waiver system, and defines participants and/or guardians, and case manager roles and responsibilities.

3. Plan of Care Review: Informs Service Plan, Qualified Providers, Health and Welfare. DHCSs Benefits and Eligibility Unit reviews certain IPCs to ensure accurate service plans, services are delivered by certified providers, and the health and welfare of participants. Data is collected in EMWS and IMPROV, or their successors.

4. Extraordinary Care Review: Informs Service Plan, Qualified Providers, Health and Welfare, Financial Accountability. This process allows participants, through their case managers, to request additional funding and services beyond their initial individual budget amount. The Benefits and Eligibility Unit prepares documentation for a committee comprised of medical professionals, staff from Medicaid finance, and DHCF staff. The committee meets routinely to review the requesting participant’s IPC for services, qualified providers, health and welfare, and financial accountability. Data is collected in the Extraordinary Care Committee Google Drive.

5. Provider Certification Renewal: Informs Service Plan, Qualified Providers, Health and Welfare, Administrative Authority, Financial Accountability. DHCFs Provider Support Unit certifies qualified providers in accordance with rules, regulations, and policy. Policies and procedures are in place to identify noncompliance and remediation efforts. Data is collected in IMPROV, or its successor.

6. Complaint Process: Informs Service Plan, Qualified Providers, Health and Welfare, Financial Accountability. Complaints are reviewed and addressed in accordance with DHCF rules, regulations, and policy. Data is collected in IMPROV, or its successor.

7. Incident Reporting: Informs Service Plan, Qualified Providers, Health and Welfare, Financial Accountability. Each incident is reviewed, and addressed in accordance with Division rule, regulation, and policy. A root cause analysis is conducted on all closed critical incidents to identify trends and inform systemic change. Data is collected in IMPROV, or its successor.

8. Mortality Review: Informs Service Plan, Qualified Providers, Health and Welfare, Administrative Authority, Financial Accountability. The 1915(c) Mortality Review Committee is comprised of individuals from the Wyoming Department of Health and the contractor for utilization review. The committee reviews participant cases associated with critical incidents and complaints related to participant deaths reported to DHCF. If there is a recommendation for further action determined by the Mortality Review Committee, DHCF ensures that there is proper follow-up and assists providers in implementing necessary changes to internal processes to ensure participant safety. Data is collected in the Mortality Review Database.

9. Plan of Care Quality Review: Informs Service Plan, Qualified Providers, Health and Welfare, Financial Accountability. This process randomly selects and reviews IPCs approved through the EMWS system, or its successor. Data is used to target case management training and improve practices.

10. Utilization Review Process: Informs Service Plan, Financial Accountability, Qualified Providers, and Administrative Authority. This process reviews IPCs to ensure that participants are receiving services in accordance with the type, scope, amount, duration, and frequency specified. Responses to the Case Management quarterly reports are reviewed, and identified deficiencies, separated by category, are noted. If needed, DHCF staff work with case managers to ensure that IPCs are accurate and participants are receiving the services outlined in their IPCs.

11. Assurance of Proper Provider Payments: All services must be prior authorized. In order to be prior authorized, services must be included on the participant's individualized plan of care (IPC), which is created in the Electronic Waiver Management System (EMWS). Services are included in the participant's IPC in accordance with the participant's assessed needs and within the limits established by the HCBS waiver application. BMS audits IPCs to ensure services are authorized within those established limits, and submits a prior authorization request to BMS. BMS validates the participant's Medicaid eligibility and verifies enrollment in the particular waiver program for which the prior authorization request is submitted. All agency claims for reimbursement for services are submitted to BMS. BMS edits claims for participant eligibility and for prior authorization. Claims for eligible participants are posted against the prior authorization, and BMS allows payment only if the services included on the claim are delivered within the authorized dates and amounts. Case managers are required to conduct monthly monitoring of service plans and documentation, and conduct regular service observations to assure services are provided in accordance with the IPC, including the type, scope, amount, duration, and frequency of each service. The case manager is required to report variances on the Case Management Monthly Review Form.

12. Performance Metric Review Committee: This committee meets quarterly to review performance metric data from the previous quarter and all quarters in the current 5 year waiver period. This review is to ensure that data is being collected how it needs to be, identify any potential trends, and brainstorm ideas on how to address performance deficits.

While these processes are continuous, performance measures are collected and reviewed quarterly. In addition, DHCF reviews a summary of its performance measures, remediation efforts, recommendations for system improvements, and the 372(S) report annually. The results of the review are noted on the QIS portion of the 372(S) report. Changes in indicators, new data measurement, or discontinuance of indicators due to demonstrated ongoing goal compliance is noted.

The Wyoming Supports and Comprehensive waivers are very similar, with the only notable difference to design being the cost limit set for participants receiving services. In accordance with the guidance issued by CMS on March 12, 2014, the two waivers are almost identical with regard to participant services, participant safeguards, and quality management, with the only notable difference to participant services being the level of community living services that are available. The quality management approach is identical across waivers, including methodology for discovering information, the manner in which individual issues are remedied, the process for identifying and analyzing patterns and trends, and performance indicators. Provider networks and oversight are the same.

The State does not intend to consolidate evidence reports given that the State collects and analyzes all data, outside of Appendix A, separately.

ii. System Improvement Activities

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

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **Other** Specify: Developmental Disability Advisory Council	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

Quality review of the performance measures undertaken by DHCF may indicate the need for recommendations for system design changes. DHCF presents recommendations for such changes to the Developmental Disabilities Advisory Council (DDAC) for discussion.

Review for system-wide change occurs every two years, or as needed, based on continuous discovery and analysis efforts. Once all parties agree on recommended system design changes, DHCF and the State Medicaid Agent identify the following:
• Individuals responsible for oversight of the systems change, which depends on the assurances impacted by the change.
• The State Medicaid Agent or designee leads the efforts on the changes impacting Administrative Authority and/or Financial Accountability
• DHCF leads the efforts on changes impacting Level of Care, Service Plan, Qualified Providers, and Health and Welfare
• Other agencies or stakeholders who should be involved in system design changes.
• Major action steps needed to implement the change.
• The timeline for the change, including time lines for each major action step.
• Performance measures and appropriate data collection to track the results of the systems change.
• The timeline for assessing the impact of changes made.

Once a change has been implemented, DHCF, the Medicaid Waiver Liaison, and the Medicaid Program Integrity Manager review the implementation of systems changes quarterly to identify potential barriers and to make changes as needed to the action plan created during implementation of the system changes. The DDAC is updated annually, or as needed, on the implementation of the system improvements.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

DHCF presents information on the effectiveness of the quality improvement strategy annually to the DDAC. Topics include:
- Effectiveness of the performance measures;
- Processes used by DHCF to gather data;
- Changes to databases or data analysis; and
- Issues with data reliability.

The DDAC may make recommendations on changes to the quality improvement strategy related to policy changes, data collection efforts, and changes to service definitions. DHCF works with the State Medicaid Agent to identify appropriate changes based on these recommendations.

On an annual basis, the Outcomes and Evaluation Unit reviews its processes for collecting and utilizing performance measure data related to remediation efforts, trend analysis, systemic issues, and the prioritization and implementation of system improvements. This review is summarized and presented to the DDAC and PIT.

Upon completion of DHCFs analysis and review of quality assurance activity data and reports, and DHCFs own review of its operations, all relevant information is compiled into a Quality Assurance overview report and is submitted to the Medicaid State Agent. The Medicaid State Agent may offer feedback on trends and implementation of systemic quality improvement activities. A timeline is developed to implement changes that include responsible parties, action steps, and deadlines for each major step. The DDAC is updated on the progress of the changes, and the changes are reported to CMS in an annual report.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- (●) **No**
- ( ) **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ( ) **HCBS CAHPS Survey :**
- ( ) **NCI Survey :**
- ( ) **NCI AD Survey :**
- ( ) **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

(a) In accordance with 2 CFR §200.502(i), provider agencies are not subject to an independent audit as payments for services rendered are not made on a cost-reimbursement basis. Provider certification renewal occurs at least once every three (3) years.

Providers that do not provide services in a setting that is owned, leased, or controlled by the provider are not subject to an on-site visit. Other providers will be subject to an on-site visit at least once every three (3) years. DHCF utilizes a survey tool which incorporates a review of specific HCB setting components and other standards outlined in Chapter 45 of the Department of Health's Medicaid Rules, and 42 CFR 441.301(c)(4)-(5). Provider compliance with each standard is rated, and the final score determines a one (1), two (2) or three (3) year certification period.

- *A sample of participant files is reviewed during the certification renewal process. This review includes a review of service and billing documentation.*
  Additionally, the case manager is responsible for reviewing service and billing documentation of each participant each month.
- *A statistically significant number of claims is not reviewed. State resources do not accommodate the workload that is necessary to review that number of*
  claims.
- *Post payment review is conducted by Wyoming Medicaid Program Integrity through data mining and analytics, receipt of referrals from Medicaid programs,*
  referrals from third contracted vendors, and coordination of efforts the contracted Financial Management Service agency. Analytics are conducted at the
  provider agency level. When anomalies are identified and the need for clinical expertise (i.e. medical necessity determinations) the PI unit will coordinate
  additional reviews with a third party vendor Optum to conduct these medical necessity reviews. A monthly meeting is held with Optum to review ongoing medical
  record reviews that have been assigned and receive results of completed reviews. These reviews are conducted randomly. The State has implemented the mandatory
  risk based screening requirements outlined in 42 CFR 455.434. This requirement is specifically related to ownership interest in entities designated as "high"
  risk provider types (i.e. Newly Enrolling: Home Health Agencies, DMEPOS). All waiver providers are reviewed and receive an onsite visit from DHCF provider
  certification staff prior to enrollment. Recurring onsite visits take place upon provider recertification.
- *DHCF does not complete an audit of claims processed by the FMS. All Medicaid claims are processed through MMIS. Oversight activities of the FMS are outlined*
  in Appendix E-1(iv).
- *In addition, the State agency coordinates and collaboratively executes the beneficiary verifications (EOMBs) process. The data analytics personnel within*
  Program Integrity creates an annual schedule for the mailing of EOMBs. This is done through the evaluation of category of service and expenditure. Each month
  a total of 400 EOMBs are submitted to beneficiaries. 300 are sent at a consistent amount every month (i.e. 90/every month to Home health, 50/every month to DD
  etc.). Then a targeted group is selected to receive 100 each month per month of the year. The results of the EOMBs are received by the contracted fiscal agent
  and if issues are identified the fiscal agent initiates contact with the State agency to take action on and investigate the identified issue. The State agency
  tracks the number of EOMBs that receive responses from beneficiaries and the average return rate is approx. 50 % year. There have been no issues noted or
  cases generated related to PCS service expenditures.
- *Prior authorizations are managed through EMWS and MMIS. These systems are both overseen by the State Medicaid Agency. Dedicated contract managers provide*
  direct oversight of these contracts, as specified in Appendix A. Any changes to waiver billing procedures and criteria must receive the approval of the Change
  Control Board (CCB) designated for MMIS.
- *The Medicaid Program Integrity Unit has an electronic referral process in place to receive potential fraud, waste, and abuse referrals from: Medicaid*
  Programs, third party vendors that are contracted with the State agency, and the general public. The Program Integrity Unit also manages the fraud hotline. A
  designated individual is tasked with receiving and conducting an initial interview to ascertain the pertinent information.

If an error is identified, it is
reported directly to the Medicaid Program Integrity through the above identified channels. Program Integrity then coordinates with MFCU and other fraud,
waste, and abuse agencies as necessary. Programmatic errors are discussed within the State Medicaid Agency via regularly occurring coordination meetings
between the units tasked with oversight (DHCF specifically).

(b) & (c)

The waiver, through the SMA, is part of the annual State Financial Audit which is conducted every year by an external accounting group, McGee, Hearne & Paiz. The audit always includes a sample of waiver claims. The audit includes the entire process of Medicaid from eligibility to final payment. The sample is determined by Program Integrity's contractor for the audit. It is a random statistically valid sample with a 95% confidence interval and a +/-5% margin of error.

Title XIX of the Social Security Act, federal regulations, the Wyoming Medicaid State Plan, state regulations, and contracts establish record maintenance and retention requirements for Medicaid services. Providers must maintain files for each waiver participant, and are required to retain records that document the services provided and support the claims submitted for a period of six years. Records must be maintained for a minimum of six years, and records must be maintained longer than six years as required to resolve any pending matters such as an ongoing audit or litigation.

DHCF maintains documentation of provider qualifications, which includes copies of the Medicaid Provider Agreement, required training, and any other documentation necessary to demonstrate compliance with the established provider qualification standards.

Claims are submitted, and claims data is maintained through MMIS. The MMIS is designed to meet federal certification requirements for claims processing, and submitted claims are adjudicated against MMIS edits prior to payment.

In accordance with Chapter 45 of the Department of Health's Medicaid rule, the case manager is responsible for ongoing monitoring of IPC implementation. This includes a monthly review of provider billing and documentation, monthly review of service utilization, and at least quarterly service observations. The case manager is responsible for reviewing service and billing documentation of every participant each month. This review includes a verification of the units that were provided, service documentation meets the service definition and participant preferences as outlined in IPC, service documentation aligns with the services that were billed, and identification of any over or underutilization of services. Service documentation is reviewed the month after the service is provided. Billing documentation is reviewed the month after billing is submitted. If concerns are found, the case manager must include the concerns in their monthly documentation, and submit a complaint to the Division using the complaint process. The Division conducts follow up on complaints and refers to Program Integrity or the Medicaid Fraud Control Unit if issues are verified. The Division samples Case Manager Monthly Review forms during the provider certification renewal process to ensure that case managers are conducting their review of documentation as required by rule.

DHCF conducts a documentation review for each provider during the certification renewal process, including complaints or referrals submitted relating to documentation or claims concerns. Results of the documentation reviews are recorded if concerns are found, and referrals to Program Integrity and MFCU are recorded as needed. Reviews and on-site visits may include, but are not limited to:

Examination of records
- Interviews of providers, associates, and employees
- Interviews of program participants
- Verification of the professional credentials of providers, their associates, and their employees
- Examination of any equipment, stock, materials, and other items used in or for the treatment of participants in the program
- Audit of facility financial records for reimbursement
- Random sampling of claims submitted by and payments made to providers

DHCF, in conjunction with the Medicaid Program Integrity Unit, utilizes a process for monitoring the Financial Management Service Fiscal/Employer Agent, including a process to audit claims submitted by the agent, as outlined in Appendix E.

Rules outlining Wyoming's required oversight are found in Chapters 3, 4, 16, 44, 45, and 46 of the Department of Health's Medicaid Rules.

To review Medicaid Chapters, visit https://rules.wyo.gov/.
Select Current Rules
Select Health, Department of (048)
Select Medicaid (0037)
Select the Chapter you wish to review

If data analysis or a review conducted by the Program Integrity Unit results in a determination that there is a credible allegation of fraud, the Program Integrity will refer to the Medicaid Fraud Control Unit (MFCU) or other law enforcement agency for investigation. MFCU may institute criminal or civil cases against a provider. In accordance with 42 CFR §455.23, Medicaid payments may be suspended while credible allegations of fraud are investigated, except when it is determined that there is good cause not to suspend payments, or a law enforcement hold is requested. In such cases where the decision not to suspend is invoked, written documentation shall be retained to support that decision.

Program Integrity conducts: data mining, data analysis, and record reviews, to support identified over payments for recovery action and other authorized provider sanctions listed in Medicaid Rules Chapter 16. Selection of issues or providers for review can be based upon surveillance and utilization review subsystem (SURS) reports, complaints, issues identified internally or externally, referrals, or management. Claim types or providers identified as posing a risk for potential over payments are reviewed to determine if claims were correctly coded and paid in accordance with DHCFs reimbursement methodology. In addition, claims are monitored by Payment Error Reporting Measurement (PERM) audits.

EVV
An approved EVV system was implemented for participant-directed services that were subject to EVV on January 1, 2021. The State of Wyoming fully implemented the EVV system for traditional services, which are those services that are not provided through the participant-directed service delivery model, on April 1, 2022.

The following services will be subject to EVV:
** Respite (participant-directed and traditional service delivery models);*
** Personal care(participant-directed and traditional service delivery models);*
** Companion (participant-directed and traditional service delivery models);*
** Child habilitation (participant-directed and traditional service delivery models); and*
** Skilled nursing (traditional service delivery model only).*

Additional EVV information can be found in the Main Section B - Optional page.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's 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.

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

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 - Number and percent of claim lines reimbursed using the correct code as specified in the Service Index Numerator: # of claims lines reimbursed using the correct code as specified in the Service Index Denominator: # of claim lines

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:
MMIS report, exceptions and recoup databases

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

Data Aggregation and Analysis:

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

Performance Measure:
I.a2 - Number and percent of claims that were paid for services rendered only when services were provided by a qualified provider. Numerator: # of claims paid for services rendered only when services were provided by a qualified provider Denominator: # of claims paid

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:
MMIS report, exceptions and recoup databases

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

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

Data Aggregation and Analysis:

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

Performance Measure:
I.a3 - Number and percent of claims that were paid for services rendered only when participants were enrolled in the waiver and eligible for such services. Numerator: # of claims paid for services rendered only when participants were enrolled in the waiver and eligible for such services Denominator: # of claims paid

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:
MMIS report, exceptions and recoup databases

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

Data Aggregation and Analysis:

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

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

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 - Number and percent of provider payment rates that were consistent with rate methodology in the approved waiver application. Numerator: # of claims paid that were consistent with approved waiver rate methodology Denominator: total # of rates

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:
MMIS report

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

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

Data Aggregation and Analysis:

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

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

DHCFs certification renewal process and complaint process identifies billing errors or potential fraud, as can routine investigative techniques used by the Medicaid Program Integrity Unit. DHCF makes referrals to the Medicaid Program Integrity (PI) Unit or Medicaid Fraud Control Unit (MFCU) for investigation. The status of recoveries and investigations is discussed at monthly CURT (Core Utilization Review Team) meetings held by the Medicaid Program Integrity Unit.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing*

information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Billing and claim errors shall be investigated in order to 1) determine why the error occurred, and 2) implement remediation strategies. DHCF shall determine if an error is an isolated incident, or a system issues, which may indicated the need for a systems change. Claims errors will be recovered. DHCF may offer provider reeducation , or refer the case to PI for investigation of fraud. If the preliminary PI investigation indicates the error was unintentional, DHCF will conduct continuing provider reeducation. If fraud is indicated, the case shall be referred to MFCU for further investigation.

Recoveries and investigations are tracked through E-FADS, an enhancement to the Program Integrity Unit's tracking system.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

In 2008, the Department of Health was required by state statute (W.S. 42-4-120 (g)) to establish a cost-informed reimbursement system to pay providers of services and supplies under home and community based waiver programs for persons with developmental disabilities or acquired brain injury. This state statute also required that rates be rebased at least once every four (4) years, but not more than once in any two (2) year period. As Wyoming's state statute requires a cost-informed rate methodology, provider cost surveys are collected to inform the rate model. The State Medicaid Agency may adjust rates as directed by the state legislature or Governor in order to balance the State's budget. The Home and Community Based Services Section in the Department of Health's Division of Healthcare Financing is responsible for rate determination and oversight of the rate determination process, and directs the issuance and analysis of provider cost surveys, analysis of publicly available data, development or updating of rate models, and other activities as part of the rate determination process with contractor input within the statutorily required timeframe.

The Department of Health contracted a rate study for Wyoming's (HCBS) waivers in 2020-2021.
The Department and its contractor worked with key stakeholders from April 2020 to December 2021 to conduct the rate study and develop proposed waiver program rates. Stakeholder involvement included the following workgroups:

Provider Team – Composed of small and large providers and case management agencies who reviewed the survey design and materials, gave input on rate component assumptions, and developed related recommendations for consideration by the Steering Committee.

Steering Committee – Composed of key state agency staff, legislators, and consumer and provider representatives who reviewed and selected key rate assumptions based on contractor-developed materials and recommendations from the Provider Team.

Rate Components:
An independent rate build-up methodology based on cost and wage data from providers and other state and national data sources was used. The independent rate build-up methodology comprises direct care and indirect care components and uses assumptions about types of employees; wage rates; benefits; program support and administration costs; supervisor span of control; staffing patterns; and direct care work productivity factors. Some components vary between services while others are the same across the services. This rate determination methodology was used to calculate rates for the following services:

** Adult Day - all levels*
** Behavioral Support - all levels*
** Case Management*
** Child Habilitation*
** Cognitive Retraining*
** Community Living - all levels*
** Community Support - all levels*
** Companion*
** Crisis Intervention*
** Individual Habilitation Training*
** Personal Care*
** Respite*
** Special Family Habilitation Home*
** Supported Employment*
** Transportation*

The Department of Health distinguishes between "agency providers" and "independent providers" for some services, with varying rates based on differences in indirect costs incurred by the two provider types. Independent providers are defined as providers that do not designate wage rates and do not employ staff members other than themselves. Analysis during the rate study determined that administrative costs are significantly lower for independent providers than agency providers. Reimbursement rates for independent providers reflect reduced administrative cost assumptions for these providers.

Direct Care Cost Rate Components:
Staff Wages: For the direct care worker wage, the BLS occupational category of Home Health and Personal Care Aides (BLS category: 31-1120) was used as the wage benchmark. This benchmark was also used for job coaches and

vocational trainers. Effective September 1, 2022 DHCF used CMS Market Basket data, which were inflated to the midpoint of SFY 2023, to a limit established by projections of available funding in order to support retention of experienced, skilled staff for services tiered to deliver care to individuals with high resource needs. BLS wages for Maids and Housekeeping Cleaners (37-2012) were used for homemaker services, and Rehabilitation Counselor (BLS occupational category 21-1015) was used to identify the wage for rehabilitation counselors. Shift and unit supervisors were benchmarked to First Line Supervisors of Personal Service Workers (39-1022); registered behavioral technicians to Psychiatric Technicians (29-2053); behavior analysts to Clinical, Counseling and School Psychologists (19-3031); and assistant behavior analysts to Counselors, All Other (21-1019). Case managers were benchmarked to a blended wage based on 50% Healthcare Social Workers (21-1022) and 50% Child, Family, and School Social Workers (21-1021). All wage data were inflated to the midpoint of SFY 2023 using CMS Market Basket data .

Employee Related Expense (ERE) Factor:
The ERE factor reflects the cost of program employee benefits, specifically: federally required benefits such as FICA, FUTA, SUTA, and workers compensation; health and dental insurance; retirement benefits; and long- and short-term disability benefits.

Health insurance costs were identified using the Medical Expenditure Panel Survey (MEPS) average employer portion (Wyoming 2019 MEPS Table) with an inflation factor added to update insurance costs to the midpoint of SFY 2023 based on CMS Market Basket data. Retirement benefit costs were calculated using BLS data reported on retirement costs as a percent of salary and wages for private industry health care and social assistance "service" workers. Federally required benefits were calculated using national and state percentages, and additional benefits were based on provider cost report data.

Full Time Equivalent (FTE) Factor:
The FTE factor represents costs associated with payroll hours required to cover for staff when they are not available to provide direct services (i.e., vacation days, sick time, training). Approximately 22 days per year were included for the FTE factor based on the average number of paid time off and paid training hours per employee reported in the provider cost and wage surveys.

Productivity Adjustment: The rate model includes service-specific productivity factors to account for non-face-to-face time necessary to deliver services (planning, meetings, recordkeeping, etc.). The Provider Team provided productivity factor recommendations to the Steering Committee based on provider experience, service requirements and a review of the productivity factors used in the SFY 2019 study. The proposed factors were reviewed and any changes that were needed were made based on service requirements.

Indirect Care Cost Rate Components
Administration Factor: The administration factor reflects costs associated with operating a provider agency. These costs include: administrative employees' salaries, office supplies and services, information technology expenses, central corporate office other administration expenses allocated to the local level, licenses/taxes, liability and other insurance, background checks, and non-service related transportation. Provider cost data specific to non-case management service providers was used to calculate an administrative factor representing approximately 6 to 22 percent of the rate (varies by service).

Program Support Factor: The program support factor reflects the costs that support direct care services, such as non-payroll program support costs, non-payroll facility, vehicle and equipment expenses, maintenance costs, and program supplies. The Program Support Factor was tailored by service to reflect whether service provision required facility and/or vehicle costs. Costs related to room and board for participants including facility maintenance, upkeep, and improvement related to community living (residential) program services were excluded from the total costs collected for the rate determination. Additionally, cost outliers from provider costs and wage surveys were excluded and the program support portion of the rate for community living services was capped at the level 4 amount. Program support factors vary by service and range from 6 to 18 percent of the rate. Transportation services are calculated without a program support factor as the program support portion of the rate is provided through the mileage payment adjustment.

Skilled Nursing and assessment; Dietician; Occupational Therapy; Physical Therapy; Speech, Hearing and Language services were not included in the updated rate methodology. These rates shall be based on the rates paid through the Medicaid State Plan.

Due to the variable nature of some services, services consisting of equipment purchase and installation are reimbursed at the cost to the provider rather than a standardized reimbursement rate. Case managers must obtain at least two competitive bids for environmental modification and specialized equipment services. Payment is authorized to the provider with the most cost-effective bid which meets the needs of the participant. The Service Index and Fee Schedule for all services can be found on the Department's website .

For self-directed services, the participant does not utilize the provider-managed rate methodology. Instead, s/he pays staff a wage that covers the needed services and can be paid within his/her IBA. The cost to the participant's IBA is the wage, which includes employer payroll taxes, state and federal unemployment taxes. The participant may increase the wage to assist with employee medical benefits. The wage minimum is based upon the federal minimum wage and the wage maximum is based upon what the IBA will support.

Participants using self-directed services are assigned an IBA using the same methodology as participants who don't self-direct. When services receive rate increases, the budget methodology is updated so participants maintain the same purchasing power to include the IBA given to participants using self-directed services.

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.

Participants are notified of the rates through email. Case managers are notified about the specific details of all rate changes and are required to notify the participant of the changes, discuss how the changes may impact the participant, and address any questions or concerns the participant may have. For information on how the state solicits public comment on rate determination methods refer to Main Section 6-I.

The Service Index and Fee Schedule for all services can be found at https://health.wyo.gov/healthcarefin/hcbs/services-regulations/.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

The Wyoming Benefits Management System (BMS) is the system used to accept and process claims for services rendered by waiver providers. Providers will directly submit electronic claims using an electronic software system or via web online entry, which are both direct input tools to BMS. Once a provider submits a claim, the claim enters BMS and is processed through the processing cycle, which includes all edits and audits.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- ◉ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

All service requests through traditional service delivery are reviewed and subject to prior authorization by DHCF. IPCs are reviewed to ensure the service descriptions, units, rates, and quantity of services requested is within the IBA, that services align with assessed need, and that the units requested do not exceed the specified methodology. Traditional services must receive a prior authorization number that is assigned through MMIS. Billing for waiver services is submitted electronically through MMIS and providers are paid through that system. There are many edits built into MMIS that do not allow payment for more units or dollar requests above the amount approved. System edits include service codes with set rates, limits on number of days that can be billed in a month, number of hours that can be billed in a day, and other time specific rules which limit the amount of services that can be billed. Since all claims are submitted electronically using a prior authorization number, MMIS utilizes edits to assure that payments never exceed authorization. No traditional waiver services are authorized without a prior authorization number.

Self-Directed Services are reviewed by DHCF and authorized in the FMS web-based system. Claims to the FMS are paid through MMIS.

An individual must be an active Medicaid recipient enrolled in the appropriate waiver program in order for services to be processed and paid. This assurance is an integral component managed by MMIS. Additional checks regarding services rendered, including appropriate provider type, no duplicate claims submitted, etc. are also performed.

The Wyoming Claims Processing Subsystem uses a Recipient Master File to verify recipient eligibility for services billed by a provider. Once an individual becomes eligible for services, the participant's eligibility information is updated in MMIS. Only services in the client's plan will be covered based on limits established by the prior authorization number assigned to the service. MMIS posts exceptions if a recipient is not eligible on the service date or is restricted from the service, as indicated in the service restrictions on the Recipient Master File. Service restrictions may include restricting the recipient to a particular provider for treatment or placing the recipient on review.

MMIS checks other service limitations by referencing recipient Medicaid eligibility, TPL, and by various benefit plan specific limits established by the Utilization Review Criteria File. Each claim processed by the Wyoming Claims Processing cycle, regardless of the entry method, has to pass the provider eligibility edit module. The Provider Master File verifies that the provider is actively enrolled and licensed according to the benefit plan for the category of service and dates of service. It also verifies any special restrictions for the provider for the service date on the claim. For each test that fails, MMIS posts an exception code. The claim is adjudicated according to the exception disposition codes maintained on the Exception Control File.

All waiver services must be prior authorized. In order to be prior authorized, a service must be included on the participant's service plan created in the Electronic Waiver Management System (EMWS). Services are included in the participant's service plan in accordance with the participant's assessed needs and within the limits established by the HCBS waiver application. EMWS edits service plans to ensure services are authorized within those established limits and submits a prior authorization request to the Medicaid Management Information System (MMIS). MMIS validates the participant's Medicaid eligibility and verifies enrollment in the particular waiver program for which the prior authorization request is submitted. All agency claims for reimbursement for PCS are submitted to MMIS. MMIS edits PCS claims for participant eligibility and for prior authorization. Claims for eligible participants are posted against the prior authorization and MMIS allows payment only if the services included on the claim are delivered within the authorized dates and amounts.

In accordance with Chapter 46 Wyoming Medicaid Rule, all providers are required to provide detailed documentation to substantiate claims and to verify services were delivered in accordance with Division Requirements. This documentation is submitted to case managers the following month after the delivery of services. Case Managers are responsible for reviewing documentation verifying services were delivered as outlined by Division requirements and in accordance with the participants IPC.

Recovery for overpayments is described in the optional tab.

The Claims Processing Subsystem also uses several edits to verify the reasonableness of provider charges. First the system performs internal balancing of claim charges. Second, the system edits and checks each service charge against pricing information on the reference files. Medicaid determines the disposition of the exception codes posting to claims and the system maintains this information on line in the Exception Code File. The Claims Processing Subsystem has the capability of allowing the force payment of services on an exceptional basis, as directed in writing by Medicaid. Through

the life of a claim, the system retains in the claim record all exception codes posting to the claim, the adjudication ID of the person who forced or denied any exceptions to the claim, and the date and adjudication ID of the last person who worked on the claim. These features provide an audit trail to support the claim's payment process.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

◉ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***

○ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

◉ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*

○ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

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

- ○ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.***
- ○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- ◉ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 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 section 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 section 1915(b)/section 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 section 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 section 1115/section 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 section 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 text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 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 section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid Agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***

◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Costs related to room and board for participants, as well as facility maintenance, upkeep and improvement related to residential program services are not covered by home and community based waivers. These costs were excluded from the total costs collected for the rate determination and are therefore excluded from the payment rates. The payment rates are based solely on service costs.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- ◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor*

D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility, ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	66687.56	6482.63	73170.19	376124.85	8541.32	384666.17	311495.98
2	49527.20	6798.98	56326.18	405490.54	8888.10	414378.64	358052.46
3	63141.31	7130.77	70272.08	437161.27	9248.96	446410.23	376138.15
4	62914.64	7478.75	70393.39	471316.31	9624.47	480940.78	410547.39
5	62914.64	7843.71	70758.35	508150.85	10015.22	518166.07	447407.72

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
		Nursing Facility	ICF/IID
Year 1	1850	113	1737
Year 2	1850	113	1737
Year 3	1850	113	1737
Year 4	1850	113	1737
Year 5	1850	113	1737

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The Department analyzed historical growth rates of total waiver enrollment days and average length of stay (ALOS) using CMS 372 Report data for the waiver years 19 - 23 ending March 31st. The Department selected a standard linear regression model, applied the average growth rate to the previous years' total waiver enrollment days, and divided by the forecasted unduplicated participant count to derive the ALOS estimates.

Data source: The Division has developed a custom CMS 372(s) report template using IBM Cognos Analytics software. The report template extracts Benefits and Management System (BMS) 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 five waiver years ending March 31st, 2023 as the basis for these estimates.

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 determine costs for each service covered under the waiver (Factor D), DHCF started by analyzing calendar year 2022 (January 1, 2022 - December 31st, 2022) claim data from the Electronic Medicaid Waiver System (EMWS) for services utilized by users covered under the waiver at the time of service. The number of unique participants utilizing each service were derived from calendar year 2022 claim data. Then an overall trend was calculated by taking the forecasted number of 2024 participants minus the average number of enrolled participants in calendar year 2022 and then dividing by the 2022 participants. This trend was applied to the number of 2022 participants for each service and rounded to the nearest whole number.

DHCF does not anticipate significant changes in total participants or service utilization in the waiver. Therefore, average utilization per user and the proportion of distinct users of a service to overall participants are projected to remain consistent for Waiver Year 1 through Waiver Year 5.

Since there are no changes anticipated, the values from 2022 were used as the estimate for individual service participants for Waiver Year 1-Waiver Year 5 and the average units per service were carried forward from 2022 with no change.

For average cost, per unit payment rates were used. Payment rates are subject to legislative appropriation and DHCF has not applied administrative rate increases from Waiver Year 1 to Waiver Year 5.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The Department analyzed historical Factor D' growth rates using CMS 372 Report data for the five waiver years ending March 31, 2023 which had an annual growth trend of 18.83%. The Department selected a standard linear regression model and the state annually trended WYs 2-5 by the five year average Consumer Price Index (CPI): healthcare of 4.88% to the previous five year non-waiver Medicaid costs ending March 31, 2023 and divided by the forecasted unduplicated participant count to derive the Factor D' estimates. This accounts for Covid as being an outlier in cost increase and for Wyoming's small ICF/IID population.

The census at Wyoming's ICF/IID is very low, so one or two outliers can significantly impact the overall average acute care cost per person. This population, in addition to being small, is very medically fragile. Additionally, the rural town in which the ICF/IID is located offers limited hospital services, so individuals requiring care above which the ICF/IID can provide are generally transported via Life Flight to hospitals in surrounding states (Billings, MT; Denver, CO; Salt Lake City, UT). These costs again inflate the overall acute care cost for the ICF/IID population. These expenditures are causing Factor G' to be significantly higher than Factor D'

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 estimates for Factor G, DHCF used data collected from the Benefits Management System (BMS) for WY 19 - WY 23 end March 31 for institutional costs of nursing facilities which had an annual growth trend of 7.8%. DHCF used a standard linear regression model and applied the average annual growth trend of 7.8% to the previous WY 19-23 ending March 31 institutional costs to estimate institutional costs for WYs 2-5 and divided by the forecasted nursing facility resident count to derive the Factor G estimates. DHCF then used the weighted average of both populations based on the percentage of comparable populations within the waiver program.

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:*

DHCF used data collected from the Benefits Management System(BMS) of non-institutional costs of nursing facility participants for WY 19 - WY 23 end March 31 which had an annual growth trend of 4.06%. The Department selected a standard linear regression model and applied the five year average Consumer Price Index (CPI): healthcare of 4.88% to the previous WYs 19-23 ending March 31. To calculate these estimates, the Division's growth trends were applied the growth trends to the data from the previous years 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 for WYs 2-5. Factor G' estimates do not include costs for prescribed drugs furnished to those waiver participants dually eligible for Medicare and Medicaid.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Adult Day Services	
Case Management	
Community Living Services	
Community Support Services	
Homemaker	
Personal Care	
Respite	
Supported Employment	
Dietician Services	
Occupational Therapy	
Physical Therapy	
Skilled Nursing	
Speech, Hearing and Language Services	
Behavioral Support Services	
Child Habilitation Services	
Cognitive Retraining	
Companion Services	
Crisis Intervention Support	
Environmental Modification	
Individual Habilitation Training	
Special Family Habilitation Home	
Specialized Equipment	
Transportation	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						**17729657.40**
Adult Day Services Basic (15 Minute)	15 Minute	250	2811.24	2.78	**1953811.80**	
Adult Day Services Intermediate (15 Minute)	15 Minute	586	3784.96	3.90	**8650147.58**	
Adult Day Services High (15 Minute)	15 Minute	254	4199.69	6.68	**7125698.02**	
Case Management Total:						**7016147.46**
Case Management (15 Minute Unit)	15 Minute	101	37.13	21.36	**80102.78**	
Case Management - Certificate (15 Minute Unit)	15 minute	106	37.13	22.43	**88279.55**	
Case Management - Certificate (Monthly)	Monthly	937	10.69	358.75	**3593430.14**	
Case Management (Monthly)	Monthly	891	10.69	341.67	**3254335.00**	
Community Living Services Total:						**75918011.63**
Community Living Services Basic Individual (15 Minute)	15 Minute	352	1460.56	9.34	**4801853.90**	
Community Living Services Basic Group of 2 (15 Minute)	15 Minute	20	1125.88	5.21	**117316.70**	
Community Living Services Basic Group of 3 or more (15 Minute)	15 Minute	22	477.32	3.86	**40534.01**	
Community Living Services Basic Group (Daily)	Daily	114	219.58	152.13	**3808136.42**	
Community Living Services Level 3	Daily	239	317.97	160.93	**12229847.99**	
Community Living Services Level 4	Daily	304	292.00	196.00	**17398528.00**	
Community Living Services Level 5	Daily	283	306.14	285.01	**24692588.08**	
Community Living Services Level 6	Daily	75	309.99	478.25	**11118953.81**	
Community Living Host Home	Daily	20	322.30	265.32	**1710252.72**	
Community Support Services Total:						**5007459.94**
Community Support Services Basic (15 Minute)	15 Minute	79	1659.75	3.06	**401227.96**	
Community Support Services Intermediate	15 Minute	238	2415.70	4.59	**2638958.99**	

GRAND TOTAL:	**123371979.48**
Total Estimated Unduplicated Participants:	**1850**
Factor D (Divide total by number of participants):	**66687.56**
Average Length of Stay on the Waiver:	360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
(15 Minute)						
Community Support Services High (15 Minute)	15 Minute	138	1564.83	9.11	1967272.98	
Homemaker Total:						127131.01
Homemaker	15 Minute	98	195.96	6.62	127131.01	
Personal Care Total:						1838494.80
Personal Care	15 Minute	135	1702.31	8.00	1838494.80	
Respite Total:						3103154.09
Respite Individual (15 Minute Unit)	15 Minute	300	1000.73	8.31	2494819.89	
Respite Individual (Daily)	Daily	81	18.14	297.68	437393.13	
Respite Group (Daily)	Daily	6	44.86	157.50	42392.70	
Respite Group (15 Minute Unit)	15 Minute	40	686.69	4.68	128548.37	
Supported Employment Total:						1352637.23
Supported Employment Individual	15 Minute	8	31.30	9.13	2286.15	
Supported Employment SEFA	15 Minute	58	1713.18	3.09	307036.12	
Supported Employment Group	15 Minute	115	986.12	9.20	1043314.96	
Dietician Services Total:						0.00
Dietician Services	Session	0	0.00	31.47	0.00	
Occupational Therapy Total:						200755.75
Occupational/Physical Therapy Group	Session	3	2.00	18.43	110.58	
Occupational Therapy Individual	15 Minute	35	227.76	25.17	200645.17	
Physical Therapy Total:						58703.07
Physical Therapy Individual	15 Minute	20	98.86	29.69	58703.07	
Skilled Nursing Total:						135183.37
Skilled Nursing Assessment	Session	3	1.00	77.52	232.56	
Skilled Nursing					134950.81	

GRAND TOTAL:	123371979.48
Total Estimated Unduplicated Participants:	1850
Factor D (Divide total by number of participants):	66687.56
Average Length of Stay on the Waiver:	360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	15 minute	13	525.08	19.77		
Speech, Hearing and Language Services Total:						**80275.07**
Speech, Hearing, and Language Group	Session	0	0.00	16.04	**0.00**	
Speech, Hearing, and Language Individual	Session	32	58.53	42.86	**80275.07**	
Behavioral Support Services Total:						**3388.35**
Behavioral Support - BCaBA Level	15 Minute	0	0.00	20.52	**0.00**	
Behavioral Support - RBT Level	15 Minute	0	1.00	19.23	**0.00**	
Behavioral Support - BCBA Level	15 Minute	2	52.50	32.27	**3388.35**	
Child Habilitation Services Total:						**406949.66**
Child Habilitation (Ages 13 - 17)	15 Minute	69	1431.51	4.12	**406949.66**	
Child Habilitation (Ages 0 - 12)	15 Minute	0	0.00	4.15	**0.00**	
Cognitive Retraining Total:						**0.00**
Cognitive Retraining	15 Minute	0	0.00	13.57	**0.00**	
Companion Services Total:						**10002310.82**
Companion Individual	15 Minute	772	1465.67	8.38	**9481946.87**	
Companion Group	15 Minute	123	1215.69	3.48	**520363.95**	
Crisis Intervention Support Total:						**115539.48**
Crisis Intervention Support	15 Minute	1	12852.00	8.99	**115539.48**	
Environmental Modification Total:						**12072.00**
Environmental Modification (New)	Event	1	1.00	6036.00	**6036.00**	
Environmental Modification (Repair)	Event	1	1.00	6036.00	**6036.00**	
Individual Habilitation Training Total:						**252355.04**
Individual Habilitation Training	15 Minute	43	721.86	8.13	**252355.04**	
Special Family Habilitation Home Total:						**0.00**

GRAND TOTAL:	**123371979.48**
Total Estimated Unduplicated Participants:	**1850**
Factor D (Divide total by number of participants):	**66687.56**
Average Length of Stay on the Waiver:	360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Special Family Habilitation Home	Daily	0	0.00	255.01	0.00	
Specialized Equipment Total:						3507.52
Specialized Equipment (New)	Event	3	1.00	876.88	2630.64	
Specialized Equipment (Repair)	Event	1	1.00	876.88	876.88	
Transportation Total:						8245.80
Transportation (5 Miles)	Trip	4	135.00	14.77	7975.80	
Transportation (10 Miles)	Trip	0	0.00	18.25	0.00	
Multipass	Per Purchase	1	6.00	45.00	270.00	
				GRAND TOTAL:		123371979.48
				Total Estimated Unduplicated Participants:		1850
				Factor D (Divide total by number of participants):		66687.56
				Average Length of Stay on the Waiver:		360

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						17715601.20
Adult Day Services Basic (15 Minute)	15 Minute	250	2811.24	2.76	1939755.60	
Adult Day Services Intermediate (15 Minute)	15 Minute	586	3784.96	3.90	8650147.58	
Adult Day Services High (15 Minute)	15 minute	254	4199.69	6.68	7125698.02	
Case Management Total:						6840853.84
Case Management (15 Minute Unit)	15 Minute	207	37.13	21.36	164171.04	
Case Management -					0.00	
				GRAND TOTAL:		91625311.68
				Total Estimated Unduplicated Participants:		1850
				Factor D (Divide total by number of participants):		49527.20
				Average Length of Stay on the Waiver:		360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Certificate (15 Minute Unit)	15 minute	0	0.00	22.43		
Case Management - Certificate (Monthly)	Monthly	0	0.00	358.75	0.00	
Case Management (Monthly)	Monthly	1828	10.69	341.67	6676682.80	
Community Living Services Total:						45656199.24
Community Living Services Basic Individual (15 Minute)	Daily	352	1460.56	9.34	4801853.90	
Community Living Services Basic Group of 2 (15 Minute)	15 Minute	20	1125.88	5.21	117316.70	
Community Living Services Basic Group of 3 or more (15 Minute)	Daily	22	477.32	3.86	40534.01	
Community Living Services Basic Group (Daily)	Daily	114	219.58	152.16	3808887.38	
Community Living Services Level 3	Daily	239	317.97	83.80	6368366.75	
Community Living Services Level 4	15 Minute	304	292.00	109.30	9702342.40	
Community Living Services Level 5	Daily	283	306.14	158.35	13719067.13	
Community Living Services Level 6	Daily	75	309.99	264.60	6151751.55	
Community Living Host Home	Daily	20	322.30	146.77	946079.42	
Community Support Services Total:						5006148.74
Community Support Services Basic (15 Minute)	15 Minute	79	1659.75	3.05	399916.76	
Community Support Services Intermediate (15 Minute)	15 Minute	238	2415.70	4.59	2638958.99	
Community Support Services High (15 Minute)	15 Minute	138	1564.83	9.11	1967272.98	
Homemaker Total:						124826.52
Homemaker	15 Minute	98	195.96	6.50	124826.52	
Personal Care Total:						1698309.57
Personal Care	15 Minute	135	1702.31	7.39	1698309.57	
Respite Total:						2852037.83
Respite Individual (15					2311686.30	

GRAND TOTAL:	91625311.68
Total Estimated Unduplicated Participants:	1850
Factor D (Divide total by number of participants):	49527.20
Average Length of Stay on the Waiver:	360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Minute Unit)	15 Minute	300	1000.73	7.70		
Respite Individual (Daily)	Daily	81	18.14	265.36	389904.06	
Respite Group (Daily)	Daily	6	44.86	141.57	38104.98	
Respite Group (15 Minute Unit)	15 Minute	40	686.69	4.09	112342.48	
Supported Employment Total:						1239613.04
Supported Employment Individual	15 Minute	8	31.30	9.11	2281.14	
Supported Employment SEFA	15 Minute	58	1713.18	9.04	898254.54	
Supported Employment Group	15 Minute	115	986.12	2.99	339077.36	
Dietician Services Total:						0.00
Dietician Services	Session	0	0.00	31.47	0.00	
Occupational Therapy Total:						200645.17
Occupational/Physical Therapy Group	Session	0	0.00	18.80	0.00	
Occupational Therapy Individual	15 Minute	35	227.76	25.17	200645.17	
Physical Therapy Total:						58703.07
Physical Therapy Individual	15 Minute	20	98.86	29.69	58703.07	
Skilled Nursing Total:						135183.37
Skilled Nursing Assessment	Session	3	1.00	77.52	232.56	
Skilled Nursing	15 Minute	13	525.08	19.77	134950.81	
Speech, Hearing and Language Services Total:						80275.07
Speech, Hearing, and Language Group	Session	0	0.00	16.04	0.00	
Speech, Hearing, and Language Individual	Session	32	58.53	42.86	80275.07	
Behavioral Support Services Total:						2917.95
Behavioral Support - BCaBA Level	15 Minute	0	0.00	9.36	0.00	
Behavioral Support - RBT Level	15 Minute	0	0.00	7.00	0.00	

GRAND TOTAL:	91625311.68
Total Estimated Unduplicated Participants:	1850
Factor D (Divide total by number of participants):	49527.20
Average Length of Stay on the Waiver:	360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Behavioral Support - BCBA Level	15 Minute	2	52.50	27.79	2917.95	
Child Habilitation Services Total:						388182.57
Child Habilitation (Ages 13 - 17)	15 Minute	69	1431.51	3.93	388182.57	
Child Habilitation (Ages 0 - 12)	15 Minute	0	0.00	3.61	0.00	
Cognitive Retraining Total:						0.00
Cognitive Retraining	15 Minute	0	0.00	9.64	0.00	
Companion Services Total:						9244207.67
Companion Individual	15 Minute	772	1465.67	7.71	8723843.72	
Companion Group	15 Minute	123	1215.69	3.48	520363.95	
Crisis Intervention Support Total:						105900.48
Crisis Intervention Support	15 Minute	1	12852.00	8.24	105900.48	
Environmental Modification Total:						12072.00
Environmental Modification (New)	Event	1	1.00	6036.00	6036.00	
Environmental Modification (Repair)	Event	1	1.00	6036.00	6036.00	
Individual Habilitation Training Total:						252355.04
Individual Habilitation Training	15 Minute	43	721.86	8.13	252355.04	
Special Family Habilitation Home Total:						0.00
Special Family Habilitation Home	Daily	0	0.00	255.01	0.00	
Specialized Equipment Total:						3507.52
Specialized Equipment (New)	Event	3	1.00	876.88	2630.64	
Specialized Equipment (Repair)	Event	1	1.00	876.88	876.88	
Transportation Total:						7771.80
Transportation (5 Miles)	Trip	4	135.00	13.77	7435.80	
Transportation (10 Miles)	Trip	0	0.00	16.33	0.00	

GRAND TOTAL:	91625311.68
Total Estimated Unduplicated Participants:	1850
Factor D (Divide total by number of participants):	49527.20
Average Length of Stay on the Waiver:	360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Multipass	Per Purchase	1	6.00	56.00	336.00	

GRAND TOTAL:	91625311.68
Total Estimated Unduplicated Participants:	1850
Factor D (Divide total by number of participants):	49527.20
Average Length of Stay on the Waiver:	360

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						17708573.10
Adult Day Services Basic (15 Minute)	15 Minute	250	2811.24	2.75	1932727.50	
Adult Day Services Intermediate (15 Minute)	15 Minute	586	3784.96	3.90	8650147.58	
Adult Day Services High (15 Minute)	15 minute	254	4199.69	6.68	7125698.02	
Case Management Total:						6034644.32
Case Management (15 Minute Unit)	15 Minute	207	37.13	16.97	130429.89	
Case Management - Certificate (15 Minute Unit)	15 minute	0	0.00	22.43	0.00	
Case Management - Certificate (Monthly)	Monthly	0	0.00	358.75	0.00	
Case Management (Monthly)	Monthly	1828	10.69	302.14	5904214.42	
Community Living Services Total:						72518557.84
Community Living Services Basic Individual (15 Minute)	15 Minute	352	1460.56	9.34	4801853.90	
Community Living Services Basic Group of 2 (15 Minute)	15 Minute	20	1125.88	5.21	117316.70	
Community Living Services Basic Group	15 Minute				40534.01	

GRAND TOTAL:	116811428.19
Total Estimated Unduplicated Participants:	1850
Factor D (Divide total by number of participants):	63141.31
Average Length of Stay on the Waiver:	360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
of 3 or more (15 Minute)		22	477.32	3.86		
Community Living Services Basic Group (Daily)	Daily	114	219.58	156.16	3909015.86	
Community Living Services Level 3	Daily	239	317.97	144.49	10980492.99	
Community Living Services Level 4	Daily	304	292.00	188.45	16728329.60	
Community Living Services Level 5	Daily	283	306.14	273.01	23652936.64	
Community Living Services Level 6	Daily	75	309.99	456.20	10606307.85	
Community Living Host Home	Daily	20	332.30	253.05	1681770.30	
Community Support Services Total:						5006148.74
Community Support Services Basic (15 Minute)	15 Minute	79	1659.75	3.05	399916.76	
Community Support Services Intermediate (15 Minute)	15 Minute	238	2415.70	4.59	2638958.99	
Community Support Services High (15 Minute)	15 Minute	138	1564.83	9.11	1967272.98	
Homemaker Total:						123098.15
Homemaker	15 Minute	98	195.96	6.41	123098.15	
Personal Care Total:						1597192.36
Personal Care	15 Minute	135	1702.31	6.95	1597192.36	
Respite Total:						2667902.22
Respite Individual (15 Minute Unit)	15 Minute	300	1000.73	7.25	2176587.75	
Respite Individual (Daily)	Daily	81	18.14	241.95	355506.81	
Respite Group (Daily)	Daily	6	44.86	130.04	35001.57	
Respite Group (15 Minute Unit)	15 Minute	40	686.69	3.67	100806.09	
Supported Employment Total:						1225697.89
Supported Employment Individual	15 Minute	8	31.30	9.05	2266.12	
Supported Employment SEFA	15 Minute	58	1713.18	8.98	892292.67	

GRAND TOTAL:	116811428.19
Total Estimated Unduplicated Participants:	1850
Factor D (Divide total by number of participants):	63141.31
Average Length of Stay on the Waiver:	360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment Group	15 Minute	115	986.12	2.92	331139.10	
Dietician Services Total:						0.00
Dietician Services	Session	0	0.00	31.47	0.00	
Occupational Therapy Total:						200645.17
Occupational/Physical Therapy Group	Session	0	0.00	18.80	0.00	
Occupational Therapy Individual	15 Minute	35	227.76	25.17	200645.17	
Physical Therapy Total:						58703.07
Physical Therapy Individual	15 Minute	20	98.86	29.69	58703.07	
Skilled Nursing Total:						135183.37
Skilled Nursing Assessment	Session	3	1.00	77.52	232.56	
Skilled Nursing	15 Minute	13	525.08	19.77	134950.81	
Speech, Hearing and Language Services Total:						80275.07
Speech, Hearing, and Language Group	Session	0	0.00	16.04	0.00	
Speech, Hearing, and Language Individual	Session	32	58.53	42.86	80275.07	
Behavioral Support Services Total:						2577.75
Behavioral Support - BCaBA Level	15 Minute	0	0.00	9.36	0.00	
Behavioral Support - RBT Level	15 Minute	0	0.00	7.00	0.00	
Behavioral Support - BCBA Level	15 Minute	2	52.50	24.55	2577.75	
Child Habilitation Services Total:						388182.57
Child Habilitation (Ages 13 - 17)	15 Minute	69	1431.51	3.93	388182.57	
Child Habilitation (Ages 0 - 12)	15 Minute	0	0.00	3.61	0.00	
Cognitive Retraining Total:						0.00
Cognitive Retraining	15 Minute	0	0.00	9.64	0.00	
Companion Services Total:						8689774.02

GRAND TOTAL:	116811428.19
Total Estimated Unduplicated Participants:	1850
Factor D (Divide total by number of participants):	63141.31
Average Length of Stay on the Waiver:	360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Companion Individual	15 Minute	772	1465.67	7.22	8169410.07	
Companion Group	15 Minute	123	1215.69	3.48	520363.95	
Crisis Intervention Support Total:						98960.40
Crisis Intervention Support	15 Minute	1	12852.00	7.70	98960.40	
Environmental Modification Total:						12072.00
Environmental Modification (New)	Event	1	1.00	6036.00	6036.00	
Environmental Modification (Repair)	Event	1	1.00	6036.00	6036.00	
Individual Habilitation Training Total:						252355.04
Individual Habilitation Training	15 Minute	43	721.86	8.13	252355.04	
Special Family Habilitation Home Total:						0.00
Special Family Habilitation Home	Daily	0	0.00	253.05	0.00	
Specialized Equipment Total:						3507.52
Specialized Equipment (New)	Event	3	1.00	876.88	2630.64	
Specialized Equipment (Repair)	Event	1	1.00	876.88	876.88	
Transportation Total:						7377.60
Transportation (5 Miles)	Trip	4	135.00	13.04	7041.60	
Transportation (10 Miles)	Trip	0	0.00	16.33	0.00	
Multipass	Per Purchase	1	6.00	56.00	336.00	

GRAND TOTAL:	116811428.19
Total Estimated Unduplicated Participants:	1850
Factor D (Divide total by number of participants):	63141.31
Average Length of Stay on the Waiver:	360

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						**17708573.10**
Adult Day Services Basic (15 Minute)	15 Minute	250	2811.24	2.75	**1932727.50**	
Adult Day Services Intermediate (15 Minute)	15 Minute	586	3784.96	3.90	**8650147.58**	
Adult Day Services High (15 Minute)	15 minute	254	4199.69	6.68	**7125698.02**	
Case Management Total:						**5765791.43**
Case Management (15 Minute Unit)	15 Minute	207	37.13	15.50	**119131.60**	
Case Management - Certificate (15 Minute Unit)	15 minute	0	0.00	22.43	**0.00**	
Case Management - Certificate (Monthly)	Monthly	0	0.00	358.75	**0.00**	
Case Management (Monthly)	Monthly	1828	10.69	288.96	**5646659.83**	
Community Living Services Total:						**72368069.68**
Community Living Services Basic Individual (15 Minute)	15 Minute	352	1460.56	9.34	**4801853.90**	
Community Living Services Basic Group of 2 (15 Minute)	15 Minute	20	1125.88	5.21	**117316.70**	
Community Living Services Basic Group of 3 or more (15 Minute)	15 Minute	22	477.32	3.86	**40534.01**	
Community Living Services Basic Group (Daily)	Daily	114	219.58	152.17	**3809137.70**	
Community Living Services Level 3	Daily	239	317.97	144.49	**10980492.99**	
Community Living Services Level 4	Daily	304	292.00	188.45	**16728329.60**	
Community Living Services Level 5	Daily	283	306.14	273.01	**23652936.64**	
Community Living Services Level 6	Daily	75	309.99	456.20	**10606307.85**	
Community Living Host Home	Daily	20	322.30	253.05	**1631160.30**	
Community Support Services Total:						**5006148.74**
Community Support Services Basic (15 Minute)	15 Minute	79	1659.75	3.05	**399916.76**	
Community Support Services Intermediate	15 Minute	238	2415.70	4.59	**2638958.99**	

GRAND TOTAL:	**116392087.14**
Total Estimated Unduplicated Participants:	**1850**
Factor D (Divide total by number of participants):	**62914.64**
Average Length of Stay on the Waiver:	360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
(15 Minute)						
Community Support Services High (15 Minute)	15 Minute	138	1564.83	9.11	1967272.98	
Homemaker Total:						123098.15
Homemaker	15 Minute	98	195.96	6.41	123098.15	
Personal Care Total:						1597192.36
Personal Care	15 Minute	135	1702.31	6.95	1597192.36	
Respite Total:						2667902.22
Respite Individual (15 Minute Unit)	15 Minute	300	1000.73	7.25	2176587.75	
Respite Individual (Daily)	Daily	81	18.14	241.95	355506.81	
Respite Group (Daily)	Daily	6	44.86	130.04	35001.57	
Respite Group (15 Minute Unit)	15 Minute	40	686.69	3.67	100806.09	
Supported Employment Total:						1225697.89
Supported Employment Individual	15 Minute	8	31.30	9.05	2266.12	
Supported Employment SEFA	15 Minute	58	1713.18	8.98	892292.67	
Supported Employment Group	15 Minute	115	986.12	2.92	331139.10	
Dietician Services Total:						0.00
Dietician Services	Session	0	0.00	31.47	0.00	
Occupational Therapy Total:						200645.17
Occupational/Physical Therapy Group	Session	0	0.00	18.80	0.00	
Occupational Therapy Individual	15 Minute	35	227.76	25.17	200645.17	
Physical Therapy Total:						58703.07
Physical Therapy Individual	15 Minute	20	98.86	29.69	58703.07	
Skilled Nursing Total:						135183.37
Skilled Nursing Assessment	Session	3	1.00	77.52	232.56	
Skilled Nursing					134950.81	

GRAND TOTAL:	116392087.14
Total Estimated Unduplicated Participants:	1850
Factor D (Divide total by number of participants):	62914.64
Average Length of Stay on the Waiver:	360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	15 Minute	13	525.08	19.77		
Speech, Hearing and Language Services Total:						**80275.07**
Speech, Hearing, and Language Group	Session	0	0.00	16.04	**0.00**	
Speech, Hearing, and Language Individual	Session	32	58.53	42.86	**80275.07**	
Behavioral Support Services Total:						**2577.75**
Behavioral Support - BCaBA Level	15 Minute	0	0.00	9.36	**0.00**	
Behavioral Support - RBT Level	15 Minute	0	0.00	7.00	**0.00**	
Behavioral Support - BCBA Level	15 Minute	2	52.50	24.55	**2577.75**	
Child Habilitation Services Total:						**388182.57**
Child Habilitation (Ages 13 - 17)	15 Minute	69	1431.51	3.93	**388182.57**	
Child Habilitation (Ages 0 - 12)	15 Minute	0	0.00	3.61	**0.00**	
Cognitive Retraining Total:						**0.00**
Cognitive Retraining	15 Minute	0	0.00	9.64	**0.00**	
Companion Services Total:						**8689774.02**
Companion Individual	15 Minute	772	1465.67	7.22	**8169410.07**	
Companion Group	15 Minute	123	1215.69	3.48	**520363.95**	
Crisis Intervention Support Total:						**98960.40**
Crisis Intervention Support	15 Minute	1	12852.00	7.70	**98960.40**	
Environmental Modification Total:						**12072.00**
Environmental Modification (New)	Event	1	1.00	6036.00	**6036.00**	
Environmental Modification (Repair)	Event	1	1.00	6036.00	**6036.00**	
Individual Habilitation Training Total:						**252355.04**
Individual Habilitation Training	15 Minute	43	721.86	8.13	**252355.04**	
Special Family Habilitation Home Total:						**0.00**

GRAND TOTAL:	**116392087.14**
Total Estimated Unduplicated Participants:	**1850**
Factor D (Divide total by number of participants):	**62914.64**
Average Length of Stay on the Waiver:	360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Special Family Habilitation Home	Daily	0	0.00	253.05	0.00	
Specialized Equipment Total:						3507.52
Specialized Equipment (New)	Event	3	1.00	876.88	2630.64	
Specialized Equipment (Repair)	Event	1	1.00	876.88	876.88	
Transportation Total:						7377.60
Transportation (5 Miles)	Trip	4	135.00	13.04	7041.60	
Transportation (10 Miles)	Trip	0	0.00	16.33	0.00	
Multipass	Per Purchase	1	6.00	56.00	336.00	
				GRAND TOTAL:		116392087.14
				Total Estimated Unduplicated Participants:		1850
				Factor D (Divide total by number of participants):		62914.64
				Average Length of Stay on the Waiver:		360

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						17708573.10
Adult Day Services Basic (15 Minute)	15 Minute	250	2811.24	2.75	1932727.50	
Adult Day Services Intermediate (15 Minute)	15 Minute	586	3784.96	3.90	8650147.58	
Adult Day Services High (15 Minute)	15 minute	254	4199.69	6.68	7125698.02	
Case Management Total:						5765791.43
Case Management (15 Minute Unit)	15 Minute	207	37.13	15.50	119131.60	
Case Management -					0.00	
				GRAND TOTAL:		116392087.14
				Total Estimated Unduplicated Participants:		1850
				Factor D (Divide total by number of participants):		62914.64
				Average Length of Stay on the Waiver:		360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Certificate (15 Minute Unit)	15 minute	0	0.00	22.43		
Case Management - Certificate (Monthly)	Monthly	0	0.00	358.75	0.00	
Case Management (Monthly)	Monthly	1828	10.69	288.96	5646659.83	
Community Living Services Total:						72368069.68
Community Living Services Basic Individual (15 Minute)	15 Minute	352	1460.56	9.34	4801853.90	
Community Living Services Basic Group of 2 (15 Minute)	15 Minute	20	1125.88	5.21	117316.70	
Community Living Services Basic Group of 3 or more (15 Minute)	15 Minute	22	477.32	3.86	40534.01	
Community Living Services Basic Group (Daily)	Daily	114	219.58	152.17	3809137.70	
Community Living Services Level 3	Daily	239	317.97	144.49	10980492.99	
Community Living Services Level 4	Daily	304	292.00	188.45	16728329.60	
Community Living Services Level 5	Daily	283	306.14	273.01	23652936.64	
Community Living Services Level 6	Daily	75	309.99	456.20	10606307.85	
Community Living Host Home	Daily	20	322.30	253.05	1631160.30	
Community Support Services Total:						5006148.74
Community Support Services Basic (15 Minute)	15 Minute	79	1659.75	3.05	399916.76	
Community Support Services Intermediate (15 Minute)	15 Minute	238	2415.70	4.59	2638958.99	
Community Support Services High (15 Minute)	15 Minute	138	1564.83	9.11	1967272.98	
Homemaker Total:						123098.15
Homemaker	15 Minute	98	195.96	6.41	123098.15	
Personal Care Total:						1597192.36
Personal Care	15 Minute	135	1702.31	6.95	1597192.36	
Respite Total:						2667902.22
Respite Individual (15					2176587.75	

GRAND TOTAL:	116392087.14
Total Estimated Unduplicated Participants:	1850
Factor D (Divide total by number of participants):	62914.64
Average Length of Stay on the Waiver:	360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Minute Unit)	15 Minute	300	1000.73	7.25		
Respite Individual (Daily)	Daily	81	18.14	241.95	355506.81	
Respite Group (Daily)	Daily	6	44.86	130.04	35001.57	
Respite Group (15 Minute Unit)	15 Minute	40	686.69	3.67	100806.09	
Supported Employment Total:						1225697.89
Supported Employment Individual	15 Minute	8	31.30	9.05	2266.12	
Supported Employment SEFA	15 Minute	58	1713.18	8.98	892292.67	
Supported Employment Group	15 Minute	115	986.12	2.92	331139.10	
Dietician Services Total:						0.00
Dietician Services	Session	0	0.00	31.47	0.00	
Occupational Therapy Total:						200645.17
Occupational/Physical Therapy Group	Session	0	0.00	18.80	0.00	
Occupational Therapy Individual	15 Minute	35	227.76	25.17	200645.17	
Physical Therapy Total:						58703.07
Physical Therapy Individual	15 Minute	20	98.86	29.69	58703.07	
Skilled Nursing Total:						135183.37
Skilled Nursing Assessment	Session	3	1.00	77.52	232.56	
Skilled Nursing	15 Minute	13	525.08	19.77	134950.81	
Speech, Hearing and Language Services Total:						80275.07
Speech, Hearing, and Language Group	Session	0	0.00	16.04	0.00	
Speech, Hearing, and Language Individual	Session	32	58.53	42.86	80275.07	
Behavioral Support Services Total:						2577.75
Behavioral Support - BCaBA Level	15 Minute	0	0.00	9.36	0.00	
Behavioral Support - RBT Level	15 Minute	0	0.00	7.00	0.00	

GRAND TOTAL:	116392087.14
Total Estimated Unduplicated Participants:	1850
Factor D (Divide total by number of participants):	62914.64
Average Length of Stay on the Waiver:	360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Behavioral Support - BCBA Level	15 Minute	2	52.50	24.55	2577.75	
Child Habilitation Services Total:						388182.57
Child Habilitation (Ages 13 - 17)	15 Minute	69	1431.51	3.93	388182.57	
Child Habilitation (Ages 0 - 12)	15 Minute	0	0.00	3.61	0.00	
Cognitive Retraining Total:						0.00
Cognitive Retraining	15 Minute	0	0.00	9.64	0.00	
Companion Services Total:						8689774.02
Companion Individual	15 Minute	772	1465.67	7.22	8169410.07	
Companion Group	15 Minute	123	1215.69	3.48	520363.95	
Crisis Intervention Support Total:						98960.40
Crisis Intervention Support	15 Minute	1	12852.00	7.70	98960.40	
Environmental Modification Total:						12072.00
Environmental Modification (New)	Event	1	1.00	6036.00	6036.00	
Environmental Modification (Repair)	Event	1	1.00	6036.00	6036.00	
Individual Habilitation Training Total:						252355.04
Individual Habilitation Training	15 Minute	43	721.86	8.13	252355.04	
Special Family Habilitation Home Total:						0.00
Special Family Habilitation Home	Daily	0	0.00	253.05	0.00	
Specialized Equipment Total:						3507.52
Specialized Equipment (New)	Event	3	1.00	876.88	2630.64	
Specialized Equipment (Repair)	Event	1	1.00	876.88	876.88	
Transportation Total:						7377.60
Transportation (5 Miles)	Trip	4	135.00	13.04	7041.60	
Transportation (10 Miles)	Trip	0	0.00	16.33	0.00	

GRAND TOTAL:	116392087.14
Total Estimated Unduplicated Participants:	1850
Factor D (Divide total by number of participants):	62914.64
Average Length of Stay on the Waiver:	360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Multipass	Per Purchase	1	6.00	56.00	336.00	

GRAND TOTAL:	116392087.14
Total Estimated Unduplicated Participants:	1850
Factor D (Divide total by number of participants):	62914.64
Average Length of Stay on the Waiver:	360